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Evaluations by Staff, Residents, and Community Seniors of Patronizing Speech in the Nursing Home: Impact of Passive, Assertive, or Humorous Responses

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Two studies tested the impact of alternative communication in accommodation strategies. Nursing home staff and residents (and community-residing seniors in Study 2) rated nurse–resident conversational scenarios in which a resident responded passively, directly assertively, or humorously (indirectly assertively) to a patronizing nurse. The nurse then either maintained a patronizing manner or accommodated with a more respectful speech style. Even though all groups devalued the nurse who maintained a patronizing speech style, nursing home residents predictably showed the most acceptance. The directly assertive response by the resident elicited more devaluation of the nonaccommodating nurse than did either passive or humorous responses, but also the least favorable ratings of the resident. Ratings of the humorous response in Study 2 suggested that humor could be a good compromise response style for allowing the receiver of patronizing speech to express opposition to a request, yet still maintain an appearance of competence and politeness.

A colleague who is a gerontological nurse educator recounted a poignant experience regarding health professional communication and aging. During a hospital visit with her 90-year-old aunt, the doctor entered and began talking with the niece about her aunt's case. Feeling like a nonperson, the aunt managed to interrupt from her bed, "Excuse me, I'm here." Not only did the physician then include the aunt in his conversation, but he also returned the next day to thank her for a valuable lesson.

This example demonstrates the difficulties faced especially by older adults because of their age, perceived frailty, and lengthy exposure to dependency-inducing environments. Older adults who are repeatedly subjected to negative communication patterns may begin to feel helpless, less respected, too old, and invisible. Such experiences of demeaning communication lead to a dilemma regarding an appropriate response. Older adults may still want to appear polite and nonoffensive, yet they want to appear competent. They must also consider the danger of appearing impolite or aggressive to individuals who provide them with continuous care. On the other hand, passive acceptance by the older adult may encourage this demeaning behavior and facilitate even more negative stereotyping. The example also depicts the potential positive impact of conveying a message of dissatisfaction regarding a health provider's communication style.

The Communication Predicament of Aging Model was developed to provide a framework for research on the occurrence and impact of negative communication styles (Ryan, Giles, Bartolucci, & Henwood, 1986). Especially with strangers and in institutional settings, older adults tend to receive modified speech based on negative expectations of incompetence and dependency. Such modifications, which can occur independently of actual functioning (Whitmer & Whitbourne, 1997), constrain opportunities for satisfying communication and reinforce age-stereotyped behaviors (Baltes, Neumann, & Zank, 1994; Whitbourne & Wills, 1993). Repeated exposure to this predicament can lead to withdrawal from activities, lowered self-esteem, and loss of control. In a negative feedback loop, consequent changes in appearance, behavior, and health status can elicit even greater speech modifications (Kemper, Vandeputte, Rice, Cheung, & Gubarchuk, 1995; O'Connor & Rigby, 1996; Rodin & Langer, 1980). This predicament is likely to have greater consequences in nursing home and hospital situations, where the older person is more vulnerable, the context is more likely to elicit negative stereotypes, and a greater proportion of conversations are governed by caregiving staff (Hummert, 1994; Hummert, Shaner, Garstka, & Henry, 1998). The present study focused on alternative styles of responses that a nursing home resident can offer to inappropriate speech by care-

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givers and on the messages these alternative styles are seen to convey.

We have used the term *patronizing speech* to refer to speech modifications based on old-age stereotypes of incompetence and dependency (see reviews by Hummert & Ryan, 1996; Ryan, Hummert, & Boich, 1995). Field studies have identified numerous examples of patronizing communication, especially in nursing homes (Caporael, 1981; de Wilde & de Bot, 1989; Gubrium, 1975; Kemper, 1994; Lanceley, 1985; Sachweh, 1998). Some of the verbal characteristics of patronizing speech include simple or childish vocabulary, simplified grammar, redundancy, overly familiar forms of address (e.g., calling by nickname), terms of endearment (e.g., "dearie"), third-person reference, overly superficial topics, overly personal topics, interruptions, and exaggerated praise for minor accomplishments. Individuals who use some of the communication techniques when addressing an older adult may be unintentionally causing older adults to feel less respected and lower in confidence. These adjustments are compounded by vocal modifications of speech, such as high pitch, exaggerated intonation and pronunciation, as well as loud and slow speech. Patronizing messages are often characterized by a demeaning emotional tone, including nonlistening, overfamiliarity, and disapproval. Some of these modifications may be necessary in cases where the older adult experiences difficulty in communicating with others. However, by and large, these modifications are unnecessary and pose a potential threat to the confidence and self-esteem of the older adult.

There are several potential functions of such patronizing communication, and it is likely that these are not deliberately negative (Hummert & Ryan, 1996). For the most part, individuals who modify their speech in an effort to accommodate to the perceived communication skills of the older adult are doing so out of concern and caring (O'Connor & Rigby, 1996). Indeed, some older adults respond positively to that care and concern. However, the intended care and concern may also be interpreted as controlling and as showing a lack of respect to the recipient of patronizing communication. Furthermore, in an institutional setting, the communication style of the staff is often driven by task efficiency as opposed to care for the resident. Staff may use a communication style that conveys what has to be done quickly so that they can move on, without realizing the implications of using patronizing communication toward older adults who are already vulnerable.

In previous research, perceptions of patronizing versus neutral talk have been elicited from four observer groups: adults (young and middle aged), service providers, community-residing seniors, and elderly institutional residents (see Ryan, Hummert, & Boich, 1995). All groups have shown preferences for nonpatronizing talk (e.g., Edwards & Noller, 1993; Giles, Fox, & Smith, 1993; Ryan, MacLean, & Orange, 1994). As well, care providers using patronizing talk have been viewed as less respectful and less competent (Ryan, Bourhis, & Knops, 1991; Ryan et al., 1995). However, institutional residents have predictably shown more tolerance of patronization than community-dwelling seniors (O'Connor & Rigby, 1996; Ryan & Cole, 1990; Whitbourne, Culgin, & Cassidy, 1995). In support of the "blame-the-victim" hypothesis derived from the communication predicament model, recipients of such patronization were also rated as less competent in some studies (Giles et al., 1993; Harwood, Ryan, Giles, & Tysoski, 1997; Ryan, Boich, & Klemenchuk-Politeski, 1994; Ryan, Meredith, & Shantz, 1994). No evaluative studies have yet directly compared the views of institutional residents with those of staff.

Alternative responses to patronizing speech can also be studied in the speaker evaluation paradigm. Three studies within community contexts have contrasted two response styles of the original patronizing speech studies: the cooperative response style, where the target simply acquiesces to a request, and an assertive response style, where the target expresses opposition (Harwood & Giles, 1996; Harwood, Giles, Fox, Ryan, & Williams, 1993; Harwood et al., 1997). All three studies found that the assertive response elicits higher ratings of competence, but lower ratings of politeness and respect. Moreover, the patronizing speaker was rated less favorably after an assertive response than after a passive one. It is not clear whether assertiveness among nursing home residents, rather than the community dwellers studied so far, would be viewed as having any positive benefits.

Patronization often occurs unintentionally, and therefore older adults who wish to convey their feelings may find it difficult to do so without causing tension or dislike on the part of the social partner. Older adults are also less likely to respond assertively (Baffa & Zarit, 1977; Furnham & Pendleton, 1983). One communication device that could be used by older adults who experience patronization and have negative feelings about it, is humor. Humor has been shown to have several dimensions and functions (Rosenberg, 1986; Thorson & Powell, 1991, 1993) and has been discussed in the clinical literature as a successful and valuable strategy used by older adults—especially women (Thorson & Powell, 1996)—for coping with life stresses (Thorson, Powell, Sarmany-Schuller, & Hampes, 1997) as well as an effective communication tool (see review by Sparks, 1994). The humorous response can make light of a delicate situation and serve as a means to teach others about patronizing communication. The potential effectiveness of using humor lies largely in the fact that the older adult can be assertive, yet still appear to be competent and friendly (McGhee, 1986). As a result, a humorous remark about patronizing communication within a conversation may be more socially acceptable than direct assertiveness and can also be a way to prevent interactions from ending on a negative note (Brown & Levinson, 1987). Humor can be an indirect way to get the message across about preferred communication style. As well, older adults who can be humorous may be more likable. Being funny or witty shows others a side of one's personality and brings out individuality, resulting in less reliance on stereotypical cues by the conversational partner. It can make it easier for some elderly patients in nursing homes to experience a positive, human relationship with a nurse (Isola & Astedt-Kurki, 1997) and is seen as an effective nursing intervention to decrease tension and anxiety (Bakerman, 1997).

The Present Investigation

We used a person perception paradigm to look at reactions to portrayals of conversational scenarios between a nurse, who opened the scenario with patronizing speech, and a nursing home resident. In particular, we focused on the impact of the resident's subsequent behavior and the nurse's response to it. Two studies examined the evaluations of the nurse and resident when the nurse either maintained a patronizing speech style to the resident or accommodated by shifting to a more respectful speech style. We also compared the effects of various alternative response styles by

the resident on both nurse and resident ratings. Participants were presented with two conversational scenarios (order counterbalanced) in one of three resident response conditions: passive, directly assertive, or humorous (indirectly assertive). The nurse's initial conversational turn was always patronizing. However, in one scenario, the nurse maintained a patronizing style for her second turn following the resident's response; in the other, she shifted to a more accommodating style.

The evaluative studies reviewed earlier all compared two distinct styles—a patronizing versus a neutral, institutional style. This study, however, is the first to examine the evaluative impact of a shift in talk to an older adult following a response by an older adult. Classical communication-accommodation experiments with accommodating shifts from one language or dialect to another suggest that participants would indeed be sensitive to such a shift (Giles & Coupland, 1991). We were also interested in whether a passive response by the resident would reduce the potential negative impact of the nurse's maintenance of a patronizing style as well as whether assertive responses might be considered an effective alternative for the resident. In addition, the effects of humorous responses by the resident were of particular interest. Predictions regarding evaluations of the resident were more tentative, given both the mixed findings regarding the blame-the-victim phenomenon discussed earlier and limited previous research concerning resident response alternatives. Finally, the possibility that nursing home residents would be more tolerant of patronizing behavior by the nurse was examined in comparison with nursing home staff (in both studies) and with community seniors (in Study 2).

In terms of perceptions of the nurse, we hypothesized that the nurse would be rated more positively in terms of her manner, competence, and appropriateness when she shifted to an accommodating style than when she remained patronizing throughout the conversation (Hypothesis 1). The difference between the ratings of the accommodating and patronizing nurse would be smallest for nursing home resident participants, as compared with nursing home staff (and community seniors in Study 2; Hypothesis 2). The difference between the ratings of the accommodating and patronizing nurse would be greater when the resident was assertive or humorous rather than passive in response (Hypothesis 3).

In terms of perceptions of the resident, we hypothesized that the assertive and humorous resident would be rated as more competent than the passive resident; the passive and humorous resident would be rated as more polite, cooperative, and respectful than the assertive resident (Hypothesis 4). Finally, in line with the "blaming-the-victim" hypothesis, we expected that the resident would be viewed more negatively in conditions where the nurse did not accommodate (Hypothesis 5).

Study 1

Method

Participants

Forty-eight nursing home staff and 48 nursing home residents participated in this study. They were selected from four nursing homes and two retirement homes that were easily available in rural Ontario. The average length of stay for members of the resident group (33 women, 15 men, *M* age = 80.0 years) was 34 months. Residents with no known cognitive impairment were selected by the staff. For the nursing staff (all women, *M* age = 41.0 years), the average length of time working in the establishment was 8.5 years. The data of five staff members were not included in the analyses because of failure to complete substantial portions of the questionnaire.

Procedure and Materials

A questionnaire booklet was made up in the following manner: A brief, written description of the context of an interaction between a nurse and a resident from a fictitious Eastern Ontario nursing home was followed by the first of two conversational scripts, in which the nurse was shown reminding the resident that it was time to go to a craft activity. In both conversations, the nurse had two turns and the resident one. In one conversation, the nurse addressed the resident with a patronizing speech style throughout. In the other conversation, her last turn depicted a switch to a more accommodating speech style, following the resident's response. The patronizing version contained an average of 62 words and the accommodating version 59 words. Each participant saw both conversations in counterbalanced order across subjects. There were three versions of the questionnaire, with each version presenting one of three resident response styles across both conversations. One style was passive, in which the resident hesitantly and reluctantly complied. Another was assertive, in which the resident was direct in denying the nurse's request. The third was humorous, in which the resident still denied the nurse's request, but did so in a humorous way ("Remember how the activity director glued my dress to the table last time? I think I'll just pass today.").

Each of the two conversations was followed by a list of 12 adjectives for the nurse and the same 12 for the resident. Four of the adjectives were *competent, respectful, likable,* and *helpful,* preceded with "From this conversation, I would say the nurse [resident] is: . . . " Three further adjectives were *polite, cooperative,* and *controlling,* preceded by "From this conversation I would say the nurse is trying to be: . . . "; two more judgments were *appropriate* and *typical* (e.g., "How typical is this nurse?"). The remaining adjectives were for predictions of *respectfulness, cooperation,* and *control in future interactions.* Each adjective was followed by a Likert-type scale ranging from 1 (*not at all*) to 3 (*somewhat*) to 5 (*very*).

The design of this study was therefore a 2 (participant group: staff or residents) × 3 (resident response: passive, assertive, or humorous) × 2 (nurse style shift: patronizing or accommodating) mixed between-subjects and within-subjects design, with nurse style shift being the within-subjects factor. Participants were equally and randomly distributed across the three response conditions. Staff participants were given the questionnaire to complete independently, whereas the residents completed it with the experimenter present in an interview setting. The experimenter read each conversation out loud while the resident read the script of the interaction, which was presented in large font. Following each conversation, the participants were asked to evaluate the nurse and the resident by choosing a number from 1 to 5 on the scale. The experimenter then recorded their responses.

Dependent Measures

Typicality was assessed separately to ensure that all of the conversations appeared to be relatively realistic.

The four dependent measures used in the analyses were mean ratings of competence, overall manner, control, and appropriateness, which were assessed separately for the nurse and for the resident. To simplify analyses and reporting of the results, we used the *manner* variable as a summary measure computed for each participant as the average of the ratings for respectfulness, respectfulness in the future, politeness, likability, helpfulness, cooperation, and cooperation in the future. The control measure for the nurse was computed by averaging the ratings of how controlling the nurse was in the conversation and how controlling she would be in the future. A similar control variable was computed for the resident. Initially, control was included with the other variables as an aspect of overall manner. However, a low Cronbach's alpha resulted in it being dropped from the composite variable and subsequently entered into the multivariate analysis of variance (MANOVA) separately. Alphas for the remaining

items in the manner composite were high, ranging from .87 to .94 for the different conditions and targets.

Results

Typicality Ratings

The ratings of typicality of the target nurse and target resident were generally at or above the midpoint of the scale, suggesting that the participants found the scenarios to be realistic. For the nurse typicality ratings, there was a main effect of nurse style shift, $F(1, 85) = 6.81$, $p < .05$, $MSE = .71$, $\eta^2 = .07$, with the accommodating nurse being rated as more typical than the patronizing nurse ($M = 4.01$ vs. 3.69). There was also a participant group effect, $F(1, 85) = 6.85$, $p < .05$, $MSE = 1.57$, $\eta^2 = .07$. The ratings by the resident participants were higher than those by the staff ($M = 4.08$ vs. 3.59). The mean ratings for the target resident ranged from 3.25 to 4.23. There was a significant Group × Resident response interaction, $F(2, 85) = 4.63$, $p < .05$, $MSE = 1.52$, $\eta^2 = .10$. The residents viewed all three resident responses as equally typical, but the staff found the humorous response to be more typical than the assertive response ($M = 4.23$ vs. 3.40) and just as typical as the passive response ($M = 3.93$).

The main 2 × 3 × 2 analyses of the nurse and resident evaluations were conducted using a MANOVA, followed by univariate analyses of variance (ANOVAs) and post hoc comparisons using t tests and Duncan's Multiple Range Test where applicable. Alpha level for significance was set at .05.

Ratings of the Target Nurse

Table 1 presents the means for ratings of the target nurse by condition. In the omnibus MANOVA, there was a significant main effect of participant group, Wilks' $\Lambda = .66$, $F(4, 82) = 10.77$, $p < .001$. For the target nurse, the resident group gave higher ratings than the staff for competence, $F(1, 85) = 25.88$, $p < .001$, $MSE = 1.47$, $\eta^2 = .23$; manner, $F(1, 85) = 29.07$, $p < .001$, $MSE = 1.17$, $\eta^2 = .25$; and appropriateness, $F(1, 85) = 40.77$, $p < .001$, $MSE = 1.91$, $\eta^2 = .32$. A significant main effect also emerged for nurse style shift, with all of the dependent variables contributing significantly to the effect, Wilks' $\Lambda = .70$, $F(4, 82) = 8.67$, $p < .001$. Compared with the nurse who maintained a patronizing style, the nurse who shifted to an accommodating speech style was rated as more competent, $F(1, 85) = 14.84$, $p < .001$, $MSE = .92$, $\eta^2 = .15$; more positive in overall manner, $F(1, 85) = 18.80$, $p < .001$, $MSE = .56$, $\eta^2 = .18$; less controlling, $F(1, 85) = 11.07$, $p < .01$, $MSE = .45$, $\eta^2 = .12$; and more appropriate, $F(1, 85) = 26.41$, $p < .001$, $MSE = .94$, $\eta^2 = .24$. There was no main effect for response style.

In addition to the main effects of participant group and nurse style shift, there were two significant two-way interactions. One interaction was between participant group and nurse style shift, Wilks' $\Lambda = .83$, $F(4, 82) = 4.15$, $p < .01$, which was significant for all four of the dependent variables: competence, $F(1, 85) = 4.39$, $p < .05$, $MSE = .92$, $\eta^2 = .05$; manner, $F(1, 85) = 6.23$, $p < .05$, $MSE = .56$, $\eta^2 = .07$; control, $F(1, 85) = 10.88$, $p < .01$, $MSE = .45$, $\eta^2 = .11$; appropriateness, $F(1, 85) = 5.87$, $p < .05$, $MSE = .94$, $\eta^2 = .06$. The interaction effects are shown in Figure 1. The staff rated the accommodating nurse as more competent, as having a more positive manner, as less controlling, and as more appropriate than the nurse who maintained a patronizing style: competence, $t(42) = 3.20$, $p < .01$; manner, $t(42) = 3.32$, $p < .01$; control, $t(42) = -4.08$, $p < .001$; appropriateness, $t(42) = 3.93$, $p < .001$. On the other hand, the resi-

Table 1
Staff and Resident Mean Ratings of the Target Nurse as a Function of Nurse Style Shift and Resident Response: Study 1

Dependent Measure	Resident response to patronizing nurse style shift			Resident response to accommodating nurse style shift		
	Passive	Assertive	Humorous	Passive	Assertive	Humorous
			Staff			
Competence	3.73	2.47	2.15	3.47	3.73	3.69
	(1.22)	(1.19)	(0.99)	(0.92)	(1.28)	(1.11)
Manner	3.49	2.47	2.34	3.31	3.51	3.75
	(1.06)	(0.78)	(0.94	(0.91)	1.04)	(0.87)
Control	3.87	4.13	3.79	3.67	3.13	3.02
	(0.81)	(0.74)	(1.42)	(0.90)	(1.08)	(1.38)
Appropriateness	3.07	1.87	1.77	3.27	3.33	3.39
	(1.33)	(1.06)	(1.54)	(1.22)	(1.45)	(1.19)
			Residents			
Competence	3.88	4.38	3.75	4.31	4.31	4.13
	(1.15)	(1.09)	(1.18)	(1.01)	(0.87)	(1.03)
Manner	3.94	4.16	3.63	4.28	4.42	3.65
	(0.96)	(1.01)	(1.01)	(0.80)	(0.59)	(1.07)
Control	3.81	3.93	3.65	4.36	3.60	3.42
	(1.09)	(1.18)	(1.03)	(0.53)	(1.05)	(1.04)
Appropriateness	3.82	4.00	3.88	4.13	4.50	4.25
	(1.11)	(1.32)	(1.25)	(1.09)	(0.73)	(0.93)

Note. Standard deviations are in parentheses.

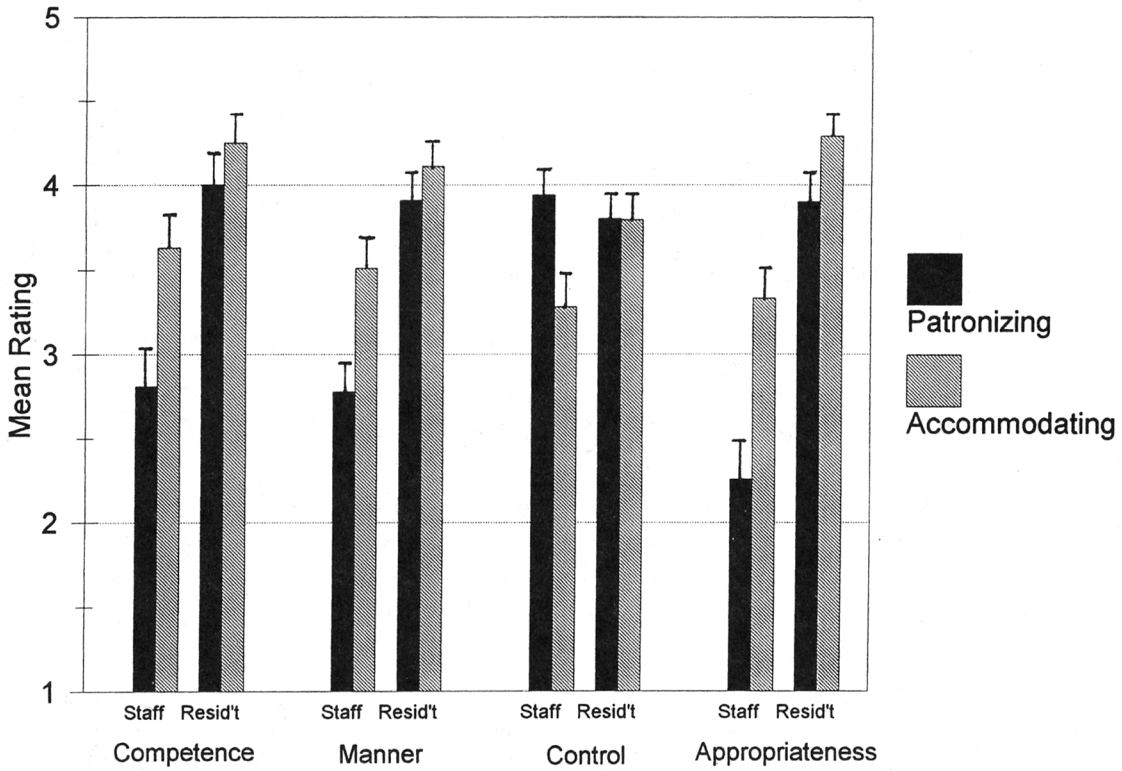

Figure 1. Mean ratings (+*SE*) of the target nurse as a function of participant group and nurse speech style shift (Study 1). Resid't = resident.

dents' ratings of nurse competence, manner, and control showed no differences by nurse shift style. Although the residents' ratings of appropriateness were significantly different for the two shift styles, $t(47) = 2.76$, $p < .01$, the difference was numerically smaller than that for the staff members' corresponding ratings.

The second significant two-way interaction in the MANOVA was between response style and nurse style shift, Wilks' $\Lambda = .79$, $F(8, 164) = 2.58$, $p < .05$. Competence, manner, and control all had significant univariate interaction effects: competence, $F(2, 85) = 3.14$, $p < .05$, $MSE = .92$, $\eta^2 = .07$; manner, $F(2, 85) = 3.40$, $p < .05$, $MSE = .56$, $\eta^2 = .07$; control, $F(2, 85) = 6.81$, $p < .01$, $MSE = .45$, $\eta^2 = .14$. As shown in Figure 2, the ratings of competence and manner were significantly higher for the nurse who switched to an accommodating style compared with the patronizing nurse when the resident gave an assertive or humorous response: assertive competence, $t(30) = 2.09$, $p < .05$; assertive manner, $t(30) = 3.36$, $p < .01$; humorous competence, $t(28) = 3.23$, $p < .01$; humorous manner, $t(28) = 2.98$, $p < .01$. The accommodating nurse was also evaluated as being less controlling in these two response conditions: assertive, $t(30) = -3.24$, $p < .01$; humorous, $t(28) = -3.22$, $p < .01$. In contrast, there were no significant differences between the accommodating and patronizing styles when the resident responded passively.

Finally, both of these two-way interactions were qualified by a triple interaction in the MANOVA between participant group, response style, and nurse style shift, Wilks' $\Lambda = .82$, $F(8, 164) = 2.12$, $p < .05$. Competence and manner both contributed significantly to the effect: competence, $F(2, 85) = 5.34$, $p < .01$, $MSE = .92$, $\eta^2 = .11$; manner, $F(2, 85) = 6.37$, $p < .01$, $MSE = .56$, $\eta^2 = .13$. Examination of the differences between the shift conditions for each group and each resident response type (see Table 1) revealed that the two-way interaction between resident response and nurse style shift, described earlier for competence and manner, was due mainly to the staff ratings. The staff rated the accommodating nurse as being more competent and as having a more positive manner than the patronizing nurse when the resident gave an assertive or humorous response: humorous competence, $t(12) = 3.83$, $p < .01$; humorous manner, $t(12) = 4.41$, $p < .01$; assertive competence, $t(14) = 3.20$, $p < .01$; assertive manner, $t(14) = 3.67$; $p < .01$. There were no differences in ratings of nurse styles following a passive response. The residents, on the other hand, showed no discrimination between the nurse's shift styles across any of the three response alternatives.

Ratings of the Target Resident

A MANOVA conducted on the ratings of the target resident revealed two effects. There was a main effect of resident response, Wilks' $\Lambda = .76$, $F(8, 164) = 3.01$, $p < .01$, with manner contributing significantly to the effect, $F(2, 85) = 6.03$, $p < .01$, $MSE = 1.13$, $\eta^2 = .12$. The assertive and humorous residents did not differ from each other, and they were both rated as being less positive in overall manner than the passive resident (passive $M = 3.90$, assertive $M = 3.47$, humor $M = 3.19$). This resident response effect was qualified by a two-way interaction between participant group and resident response style, Wilks' $\Lambda = .74$, $F(8, 164) = 3.25$, $p < .01$, with competence, manner, and appropriateness contributing significantly: competence, $F(2, 85) = 6.13$, $p <$

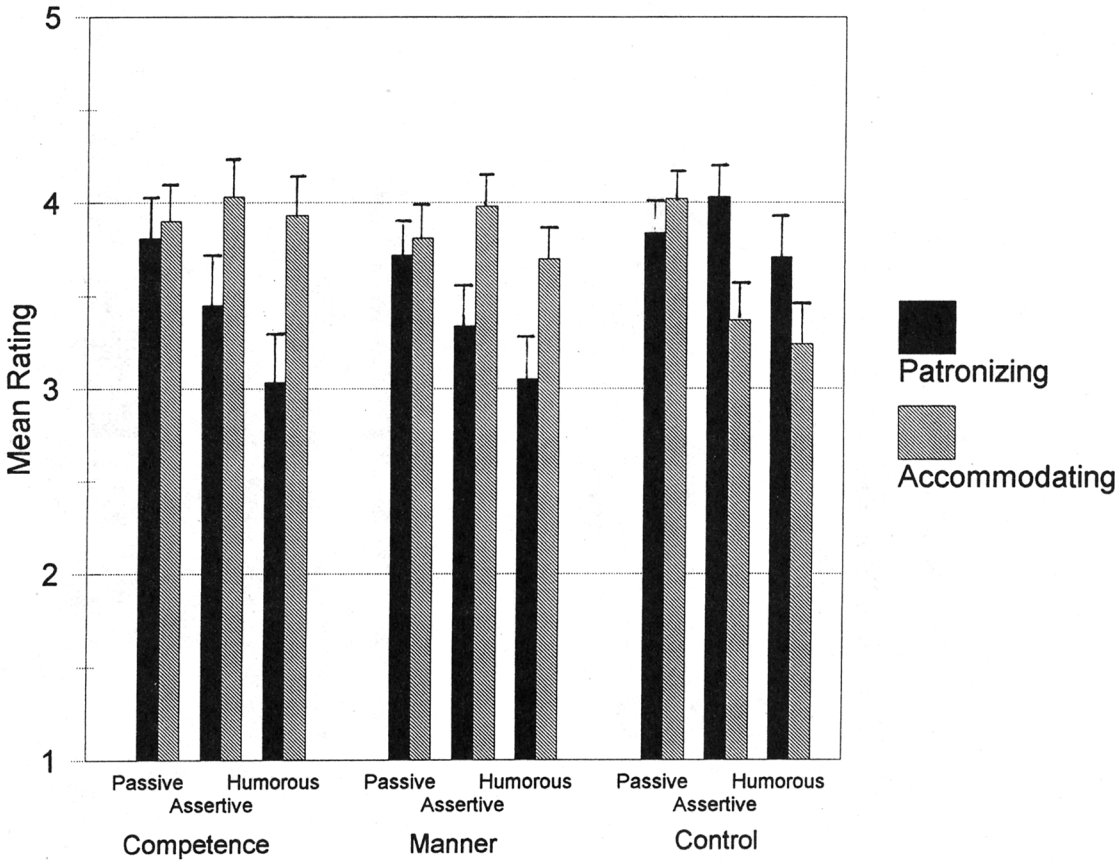

Figure 2. Mean ratings (+*SE*) of the target nurse as a function of resident response and nurse speech style shift (Study 1).

.01, $MSE = 1.58$, $\eta^2 = .13$; manner, $F(2, 85) = 5.01$, $p < .01$, $MSE = 1.13$, $\eta^2 = .11$; appropriateness, $F(2, 85) = 3.38$, $p < .05$, $MSE = 1.53$, $\eta^2 = .07$. The interaction effects for the three dependent measures are shown in Figure 3. Both groups viewed the assertive resident in the same way, although there was a marginal effect where the staff viewed that response as more competent than did the residents. Compared with the staff, the resident group viewed the humorous target as less competent, $t(27) = -2.75$, $p < .05$; having a more negative overall manner, $t(27) = -3.03$, $p < .01$; and as being less appropriate, $t(27) = -3.37$, $p < .01$; and they saw the passive target resident as more competent, $t(29) = 2.25$, $p < .05$. They preferred the passive response to the assertive and humorous behaviors, as shown by significantly higher competence and manner ratings and numerically higher appropriateness ratings. The staff, on the other hand, showed no preference for one resident response style over another.

Discussion

The results from this first study demonstrated that the participants were indeed able to discriminate a subtle difference between the maintenance of the patronizing speech style and a shift to a more accommodating one, although this was more apparent among the staff than for the resident group. The interpretation of the nurse's shift style appeared to depend on how the resident had responded before the nurse's final turn. The triple interaction for perceptions of the nurse further indicated that the staff discriminated among the different resident responses and the nurse style shifts in their ratings of the nurse more than did the residents. In contrast, the interaction between participant group and resident response condition for ratings of the target resident, showed that the resident group discriminated among the resident response alternatives more than did the staff. However, the findings with regard to the contrasting resident response styles and their interaction with the nurse speech styles were not straightforward and called for replication. In particular, the assertive resident was not viewed as more competent, and the humorous response appeared generally to be viewed in a negative way, especially by the nursing home residents.

The purpose of Study 2, then, was to replicate the first study and add a number of refinements. First, the questionnaire was audiotape recorded to provide a more standardized format for presentation. Second, a third participant group, made up of elderly adults from the community, was added to the design to examine whether their perceptions would resemble those of staff or nursing home residents. Third, the humorous response was reworded; the participants in Study 1 seemed to have reacted negatively to that particular example of humor. Fourth, a second recreational activity was added to the scenarios to provide more generalizability. Finally, the evaluative adjectives used for rating the target nurse and

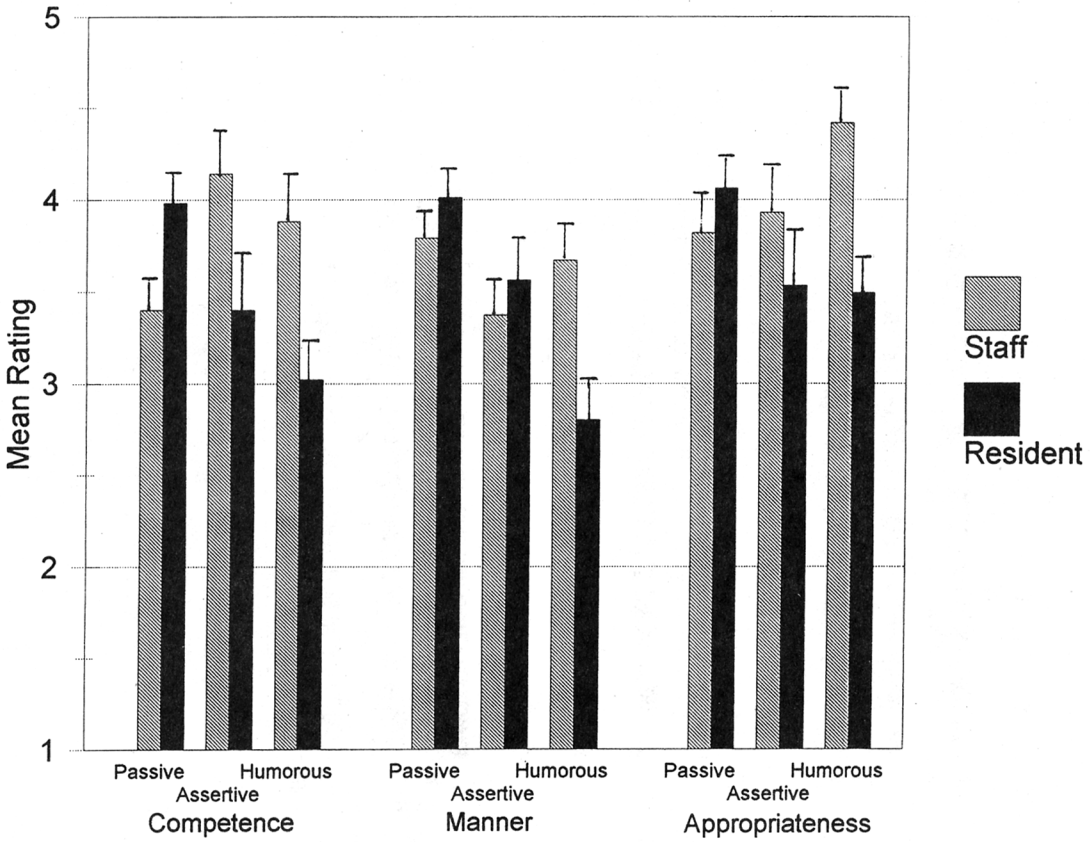

Figure 3. Mean ratings (+*SE*) of the target resident as a function of participant group and resident response style (Study 1).

resident were modified to better reflect their roles in the scripted settings as they were developed.

Study 2

Method

Participants

Participants for this study consisted of 48 community seniors from the Hamilton and Oshawa areas, 49 nursing home residents (with no known cognitive impairment), and 48 nursing home staff from three Hamilton and three Oshawa urban area nursing and retirement homes. These sites were selected for their different geographic location from those in Study 1 and for their availability. The community seniors (*M* age = 71.6 years, 30 women, 18 men) were members of the local Hamilton community and a senior's recreation center and members of two senior citizen centers in the Oshawa area. The nursing home residents (*M* age = 78.5 years) consisted of 38 women and 11 men, and their average length of stay was 4.7 years. The staff (*M* age = 38.4 years) of the nursing homes consisted of 45 women and 3 men who had worked at their facilities for an average of 9.8 years.

Procedure and Materials

The questionnaire used in Study 1 was modified in several ways. In the conversational scripts, the humorous response for the craft activity was changed to "I think I'll just pass today; I've made more crafts in my lifetime than an over-achieving Girl Guide group at Christmas." As well, a second recreational activity, the sing-along, was added. For this activity the humorous response was "I think I'll just pass today. I've sung more in my lifetime than a chickadee in spring." It seemed likely that these examples of humor might be seen as less negative. The conversational scripts for the crafts activity, showing both of the nurse's shift styles and the three versions of the resident's response are shown in the Appendix. Other modifications to the questionnaire included refining the evaluative dimension of *control* (defined as controlling in Study 1) by labeling it as *in control* in response to several participant queries about the term. The scales for *competent, respectful, likable, helpful,* and *trying to be polite* were presented for both targets. For the target nurse, other measures were, *trying to be supportive* and *trying to be in control,* whereas for the resident, *trying to be cooperative* was added. The wording of the typicality scale was changed from "How typical is this nurse [resident]?" to "How likely is it that the nurse [resident] would talk like this?" The appropriateness ratings of the target nurse and resident in each scenario were both followed by the phrase "Please explain . . . ," in order to obtain more detailed information about the perceptions of the targets' behaviors. In addition, manipulation checks were also incorporated into the questionnaire, in the form of a patronizing scale for the nurse ("In this case, I think the nurse is trying to be . . . ") and assertive and humorous scales for the resident ("In this case, I think the resident is trying to be . . . "). The scales for future interactions of the nurse and resident presented in Study 1 were dropped.

The conversation with the nurse who maintained a patronizing speech style contained an average of 56 words, whereas the conversation depicting the more accommodating nurse contained an average of 55 words. Again, there were three versions, one for each of the target resident responses. Finally, in addition to the written conversational scripts between the target nurse and the resident, audiotapes were prepared for the conversations. The

two female readers were only instructed to use intonation natural to the different conversations.

The data were collected by two of the authors, each of whom collected half of the data for each cell of the design. Testing was carried out individually in an interview setting. All participants responded to two conversational scripts in counterbalanced order from the same response condition (one with nurse style shift and one with the nurse remaining patronizing), with both conversational scripts referring to the same recreational activity. Each participant was given the first conversational script and told to read it carefully. At the same time, the audiotape of the corresponding vignette was played. Following the first conversation, the participants completed the evaluative dimensions for the nurse and the resident by indicating, for each one, a number from 1 to 5. The experimenter recorded each response on the questionnaire booklet. Then the second vignette was played and read, and the same procedure followed. Therefore, this study was a 3 (participant group: staff, community seniors, or nursing home residents) × 3 (resident response: passive, assertive, or humorous) × 2 (nurse style shift: patronizing or accommodating), mixed between-subjects (participant group and resident response) and within-subjects (nurse style shift) design. Respondents in each participant group were randomly assigned to one of the three resident response conditions. Each condition contained approximately the same number of participants, with half receiving the craft activity and half the sing-along activity.

Dependent Measures

Typicality was again assessed separately to ensure that all of the conversations appeared to be realistic.

The dependent measures for both the target nurse and the target resident were competence, overall manner, and appropriateness. As in Study 1, overall manner was a summary variable and was computed for each participant from the averaged ratings of respectfulness, politeness, likability, helpfulness, and supportiveness of the nurse, and from respectfulness, politeness, likability, helpfulness, and cooperation of the resident. Cronbach's alpha for the composite ranged from .83 to .88 for the different conditions and targets. Control again did not fit well into the overall manner variable for the nurse ratings and was entered separately as a variable in the MANOVA. Manipulation checks included patronization evaluations of the nurse's speech style and evaluations of how assertive and how humorous the resident was attempting to be.

Results

Typicality ratings of the nurse were generally at or above the midpoint of the rating scale. There was a main effect of group, $F(2, 136) = 5.15$, $p < .01$, $MSE = 1.67$, $\eta^2 = .07$, and a significant interaction between resident response and nurse style shift, $F(2, 136) = 4.80$, $p < .05$, $MSE = .96$, $\eta^2 = .07$. Unlike Study 1, the residents' typicality ratings were significantly lower than those of the community and staff: community, $M = 3.94$; residents, $M = 3.52$; staff, $M = 4.10$. Examination of the two-way interaction between resident response and nurse style shift revealed that, only when the resident gave an assertive response did the typicality ratings differ between the patronizing and accommodating conditions, with the accommodating nurse rated as more typical (passive: $M_{\text{Patronizing}} = 3.82$, $M_{\text{Accommodating}} = 3.83$; assertive: $M_{\text{Patronizing}}$ 3.34, $M_{\text{Accommodating}} = 4.06$, $t(47) = 3.84$, $p < .001$; Humorous: $M_{\text{Patronizing}} = 4.06$, $M_{\text{Accommodating}} = 3.98$). There were no effects of any of the independent variables on typicality ratings of the resident. Again, the mean ratings for the resident were generally at or above the midpoint of the scale ranging from 2.88 to 4.00.

Analyses were 3 × 3 × 2 MANOVAs with participant group, resident response, and nurse style shift as independent variables. For evaluations of the nurse, the main analyses included competence, overall manner, control, and appropriateness as dependent variables. For evaluations of the resident, the variables were competence, manner, and appropriateness. Separate MANOVAs and ANOVAs were conducted for the relevant manipulation checks. Univariate effects with post hoc t tests and Duncan's Multiple Range Test, where appropriate, were then examined. The alpha level for significance for all tests was set at .05.

Ratings of the Target Nurse

Recall that for all conditions, participants were also asked to rate how patronizing they felt the target nurse to be. As expected, there was a significant effect of nurse style shift, $F(1, 136) = 11.93$, $p < .01$, $MSE = 1.23$, $\eta^2 = .08$, with the patronizing nurse being evaluated as more patronizing than her accommodating counterpart. There were no other effects for this measure.

For the overall analysis, there was a main effect of nurse style shift, Wilks' $\Lambda = .66$, $F(4, 133) = 16.99$, $p < .001$, with all of the dependent measures in the analysis contributing significantly: competence, $F(1, 136) = 16.91$, $p < .001$, $MSE = .52$, $\eta^2 = .11$; manner, $F(1, 136) = 55.46$, $p < .001$, $MSE = .33$, $\eta^2 = .29$; control, $F(1, 136) = 4.09$, $p < .05$, $MSE = .84$, $\eta^2 = .03$; appropriateness, $F(1, 136) = 36.33$, $p < .001$, $MSE = .79$, $\eta^2 = .21$. The accommodating nurse was rated as more competent, as having a more positive manner, as being less in control, and as being more appropriate than the patronizing nurse.

As in Study 1, there was a two-way interaction (see Figure 4) between participant group and nurse style shift, Wilks' $\Lambda = .80$, $F(8, 266) = 3.96$, $p < .001$, which was significant for competence, $F(2, 136) = 5.36$, $p < .01$, $MSE = .52$, $\eta^2 = .07$; manner, $F(2, 136) = 3.50$, $p < .05$, $MSE = .33$, $\eta^2 = .05$; control, $F(2, 136) = 7.08$, $p < .01$, $MSE = .84$, $\eta^2 = .09$; and appropriateness, $F(2, 136) = 7.65$, $p < .01$, $MSE = .79$, $\eta^2 = .10$. Post hoc t tests revealed that the residents only discriminated between the two speech styles for the manner variable: competence, $t(48) = .04$, $p > .10$; manner, $t(48) = 2.90$, $p < .01$; control, $t(48) = -1.17$, $p > .10$; appropriateness, $t(48) = 1.23$, $p > .10$. The accommodating nurse was rated as having a more positive manner. The community and the staff, on the other hand, rated the accommodating nurse as being not only more positive in manner [community: $t(47) = 3.92$, $p < .001$; staff: $t(47) = 5.51$, $p < .001$], but also more competent [community: $t(47) = 2.92$, $p < .01$; staff: $t(47) = 4.45$, $p < .001$] and more appropriate [community: $t(47) = 2.69$, $p < .05$; staff: $t(47) = 6.15$, $p < .001$]. Further, the staff rated the accommodating nurse as being less in control, $t = -3.37$, $p < .01$, whereas the community group and residents saw no difference. Of particular interest, however, is that whereas the community and staff groups clearly found the patronizing nurse to be less appropriate than the accommodating nurse, the residents saw no difference between the two. The staff also gave significantly lower ratings of appropriateness to the patronizing nurse than did the community seniors or nursing home residents.

There was also a significant interaction (see Figure 5) between resident response and nurse style shift, Wilks' $\Lambda = .84$, $F(8, 266) = 3.13$, $p < .01$. Competence, overall manner, and appropriateness each contributed significantly to the effect: competence, $F(2, 136) = 6.13$, $p < .01$, $MSE = .52$, $\eta^2 = .08$; manner, $F(2, 136) = 3.87$, $p < .05$, $MSE = .33$, $\eta^2 = .05$; appropriateness, $F(2, 136) = 7.08$, $p < .01$, $MSE = .79$, $\eta^2 = .09$. Compared with the

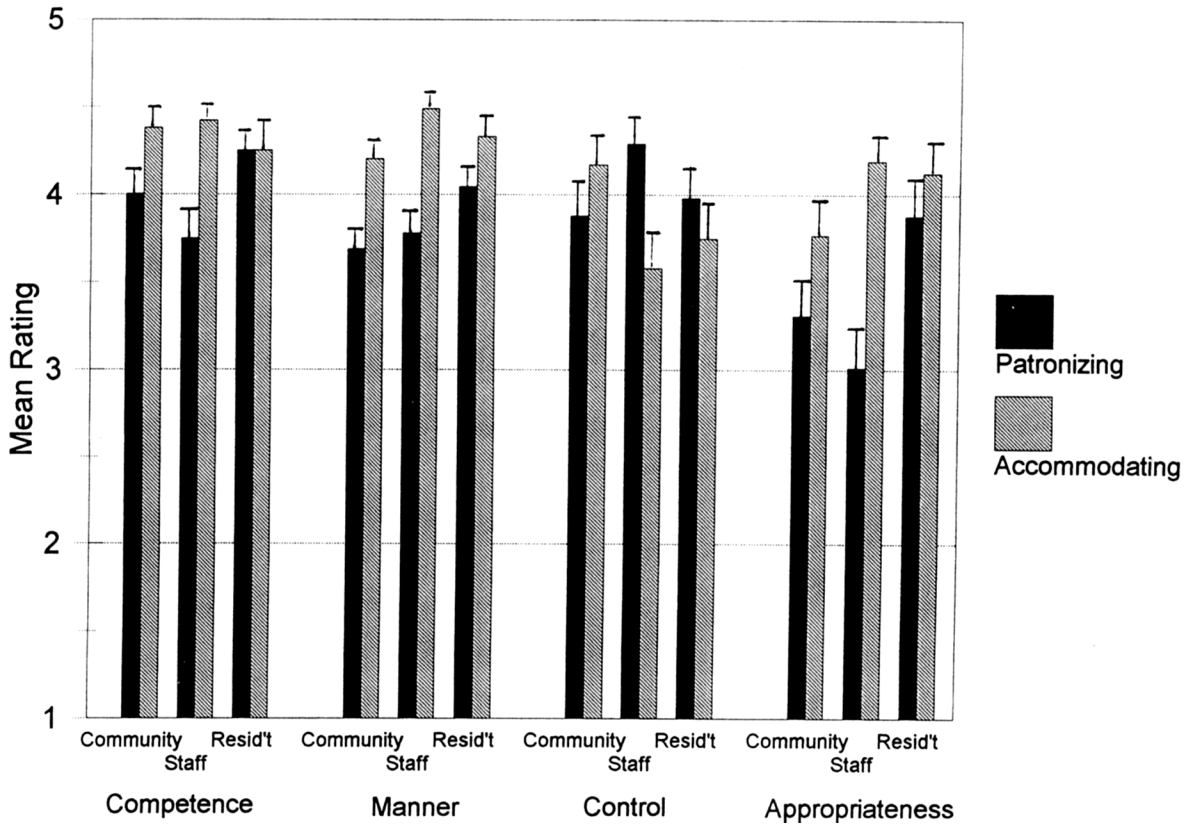

Figure 4. Mean ratings (+*SE*) of the target nurse as a function of participant group and nurse speech style shift (Study 2). Resid't = resident.

accommodating nurse, the patronizing nurse was viewed as less competent, $t(47) = 4.40$, $p < .001$, having a less positive manner, $t(47) = 5.28$, $p < .001$, and as less appropriate, $t(47) = 6.16$, $p < .001$, following an assertive response. Although she was also seen as less appropriate and as having a less positive manner than the accommodating nurse following a passive response, she was not seen to be less competent, $t(47) = 1.83$, $p > .10$. The accommodating nurse, on the other hand, was rated the same regardless of the resident's response. When the resident gave a humorous response, the patronizing and accommodating nurses were viewed as equally competent and appropriate: competence, $t(48) = .31$, $p > .10$; appropriateness, $t(48) = 1.10$, $p > .10$; the patronizing nurse, on the other hand, was seen to have a less positive manner, $t(48) = 2.55$, $p < .05$. There were no other effects in the overall MANOVA.

Ratings of the Target Resident

Participants in every condition were also asked to rate how assertive and humorous they felt the resident was attempting to be. MANOVA analyses of these two variables were conducted with participant group, nurse style shift, and resident response as independent variables. There was a nurse style shift main effect, Wilks' $\Lambda = .95$, $F(2, 135) = 3.73$, $p < .05$, with humor contributing significantly. The ratings of humor were higher when the nurse became accommodating than when she remained patronizing: humor patronizing, $M = 2.22$; humor accommodating, $M = 2.38$; $F(1, 136) = 4.67$, $p < .05$, $MSE = .44$, $\eta^2 = .03$. Both humor and assertiveness ratings contributed to a resident response effect, Wilks' $\Lambda = .41$, $F(4, 270) = 37.47$, $p < .001$. As expected, the ratings of humor, $F(2, 136) = 84.85$, $p < .001$, $MSE = 1.74$, $\eta^2 = .56$, were significantly higher when the resident used a humorous response than when she used either of the other two (passive, $M = 1.43$; assertive, $M = 1.74$; humorous, $M = 3.70$). Interestingly, the ratings of assertiveness, $F(2, 136) = 6.29$, $p < .01$, $MSE = 2.51$, $\eta^2 = .08$, for the humorous and assertive responses were similar, and both were higher than the passive response (passive, $M = 2.84$; assertive, $M = 3.57$; humorous, $M = 3.49$). There were no other effects.

For the main analysis of the resident ratings, findings differed slightly from Study 1. Instead of a participant group by resident response interaction, there were two main effects only. First, the MANOVA revealed a significant participant group effect, Wilks' $\Lambda = .86$, $F(6, 268) = 3.48$, $p < .01$. All three dependent variables contributed significantly: competence, $F(2, 136) = 4.46$, $p < .05$, $MSE = 1.54$, $\eta^2 = .07$; manner, $F(2, 136) = 7.28$, $p < .01$, $MSE = 1.20$, $\eta^2 = .10$; appropriateness, $F(2, 136) = 4.67$, $p < .05$, $MSE = 1.65$, $\eta^2 = .06$. Post hoc tests revealed that the staff viewed the resident more positively than did the community and resident groups, who did not differ from each other (competence: community, $M = 3.79$, residents, $M = 3.67$, staff, $M = 4.20$; manner: community, $M = 3.46$, residents, $M = 3.67$, staff,

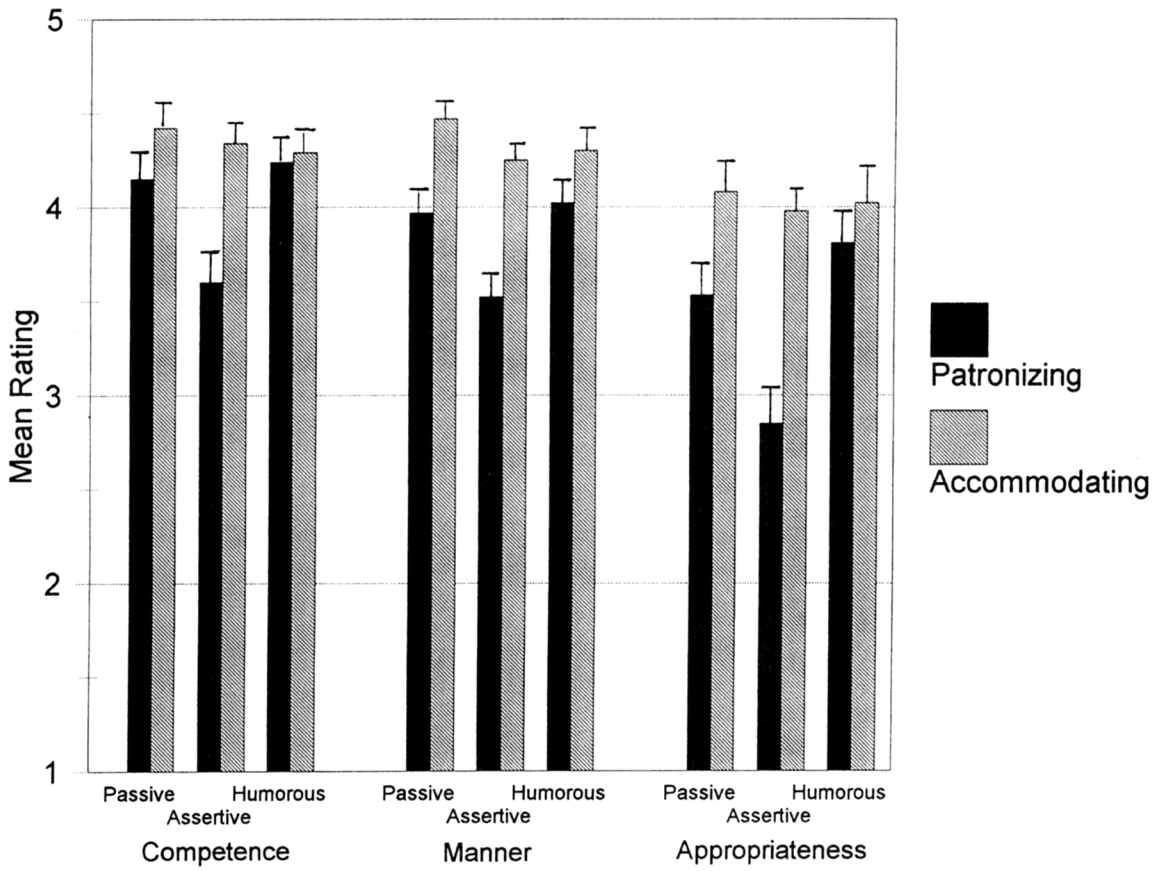

Figure 5. Mean ratings (+*SE*) of the target nurse as a function of resident response and nurse speech style shift (Study 2).

M = 4.07; appropriateness: community, M = 3.79, residents, M = 3.64, staff, M = 4.21).

In addition to the main effect of participant group, there was a significant main effect of resident response, Wilks' Λ = .87, $F(6, 268) = 3.36$, $p < .01$. Again, competence, $F(2, 136) = 3.75$, $p < .05$, $MSE = 1.54$, $\eta^2 = .05$; manner, $F(2, 136) = 9.73$, $p < .001$, $MSE = 1.20$, $\eta^2 = .13$; and appropriateness, $F(2, 136) = 3.10$, $p < .05$, $MSE = 1.65$, $\eta^2 = .04$, all contributed significantly to the effect. The assertive resident was viewed more negatively than either the passive or the humorous residents except for ratings of appropriateness, where assertive and passive responses were not significantly different (competence: passive, M = 3.97, assertive, M = 3.59, humorous, M = 4.09; manner: passive, M = 3.94, assertive, M = 3.32, humorous, M = 3.94; appropriateness: passive, M = 3.93, assertive, M = 3.60, humorous, M = 4.09). Overall, the ratings of the passive and humorous responses were consistently higher than those of the assertive resident. Ratings for the passive and humorous conditions did not differ.

General Discussion

In support of the first hypothesis, the nurse was rated more positively in both studies on all the measures when she shifted to an accommodating style. This result is clearly consistent with past findings with regard to the negative role of patronizing speech (see review by Ryan et al., 1995), but this is the first time this issue has been studied in a context where the rater is responding to whether or not the nurse shifts away from a patronizing style. Examination of the qualitative responses obtained from respondents in Study 2 also suggested that they could detect the differences between the two conversations quite clearly and had formed different impressions of the two nurses on the basis of these brief vignettes. For example, when asked to explain how appropriate the patronizing nurse was, one community participant wrote "nurse's tone sounded condescending (slightly)." When asked the same question after the nurse had shifted to an accommodating style, the same participant wrote "nurse's attitude and tone are correct."

It was predicted (Hypothesis 2) that nursing home resident raters would make a smaller distinction between the nurse's two styles of accommodating than would other groups. Significant interactions between nurse style and respondent group showed that this was indeed the case. The community seniors in Study 2 were more like the staff than the residents. These findings fit well with an earlier report that institutional residents are somewhat more tolerant of patronization than are other groups (O'Connor & Rigby, 1996; Whitbourne et al., 1995). Again, the qualitative responses provided a good illustration: When one resident was asked about the appropriateness of the patronizing nurse's behavior, she responded "[it's] the only way to talk in this business." Another resident said "her speech is fine." Despite the plausibility of these findings for residents, who must spend their daily lives vulnerable to such

interactions, these results are disturbing. They suggest that a tolerance for forms of address that outside observers find negative may have been established among these older adults, and this certainly may be a risk factor for disrespectful interactions in the future (see Baltes et al., 1994).

In support of Hypothesis 3, the ratings of the nurse were moderated by the type of resident response. The assertive response style led to significantly lower ratings of the patronizing than of the accommodating nurse in both studies. In Study 1, however, this interaction was significant only for the staff. The finding that an assertive response to patronizing speech makes the patronizer appear less satisfactory than does a passive response is consistent with past results (Harwood et al., 1993, 1997; Harwood & Giles, 1996), but extends them by including different respondent groups. The humorous style behaved like the passive style in Study 2, but more like the assertive style in Study 1. The three-way interaction also showed that staff were more sensitive to the resident responses when the nurse remained patronizing, whereas the residents were more sensitive to the resident responses when the nurse accommodated. The tone of the humorous condition in Study 1 (as compared with Study 2) appeared to convey a greater sense of recipient dissatisfaction, with lower nurse ratings by the staff in the patronizing condition and lower nurse ratings by the resident respondents in the accommodating condition. In contrast, the humor of Study 2 did not convey such negativity about the nurse.

Hypothesis 4, of central interest here, focused directly on the extent to which the three response styles of the resident to patronizing speech would be differentiated in ratings of the resident herself. There was an overall main effect of resident response style as expected, with the assertive resident being viewed less favorably. In both studies, there was general support for the predicted negative ratings of manner and appropriateness for the assertive resident, but the expectation of higher competence ratings for the assertive resident was directly contradicted. This pattern was true for all groups in Study 2, but the two-way interaction in Study 1 indicated that only resident respondents (not the staff) differentiated on the basis of response style.

The finding of lower competence for the assertive resident contrasts with results of previous investigations of responses to patronization, all of which have been done using scenarios set within community contexts (Harwood et al., 1993, 1997; Harwood & Giles, 1996). It seems likely that the nursing home context here elicited a more dependency-oriented script (Baltes et al., 1994) in which the overtly assertive response was judged inappropriate, perhaps risky, and thus relatively incompetent as a style. One resident's opinion of the assertive response to the patronizing behavior was that it was "not appropriate for here."

Interestingly, the humorous response was rated negatively by resident respondents in Study 1, but the humorous responses of Study 2 were rated positively by all groups, as predicted. The more modulated humorous response style in Study 2 was successful in avoiding the negative judgments (like the passive response), but was still viewed as being as assertive as the directly assertive response style. Thus, this latter humorous style seemed to provide the best of both of the alternatives (passive or assertive) in some respects, especially given that the humorous respondent managed not to comply with the nurse's request.

A small follow-up study was conducted with a new sample of 45 community residing seniors (M age = 71.4 years; 26 women, 19 men) to examine the differences between the types of humor used in the two studies. Sixty-one older adults were mailed a booklet containing the same vignette as that given to the Study 1 and Study 2 participants. The vignette was followed by three versions of part of the conversation between the nurse and resident. These versions all consisted of one turn each from the nurse and resident, with the nurse requesting that the resident go to crafts and followed by the passive, assertive, or humorous reply from the resident. The humorous response was either from Study 1 or from Study 2, with 22 participants receiving the Study 1 version and 23 receiving the Study 2 version. Each conversational excerpt was followed by 11 adjectives describing the resident, with a Likert-type scale ranging from 1 (*not at all*) to 7 (*extremely*) for each. The adjectives were: cooperative, assertive, funny, sarcastic, gentle, demanding, humorous, respectful, likable, helpful, polite. Mean ratings for each adjective were computed, and independent one-tailed t tests were done to compare the two humor conditions for each variable (with humor as the focus, the passive and assertive responses were included in the study only to make the task more meaningful and were not considered in the analyses). Results revealed that the resident using the humor of Study 1 was considered significantly more sarcastic, $M_{\text{Study 1}} = 3.18$, $M_{\text{Study 2}} = 2.26$, $t(43) = 1.72$, $p < .05$, and more demanding, $M_{\text{Study 1}} = 2.22$, $M_{\text{Study 2}} = 1.47$, $t(43) = 2.39$, $p < .01$, but was viewed as being equivalent on all of the other characteristics. Further systematic study of the various elements of humor (e.g., Thorson & Powell, 1991) and their effects on communication are needed to clarify the conditions where humor works to the advantage of the resident.

Finally, Hypothesis 5 predicted that the resident would be viewed more negatively when the nurse failed to accommodate following the resident response; this hypothesis was based on the "blaming-the-victim" patterns observed in some previous studies using this communication paradigm (e.g., Ryan, Hamilton, & Kwong See, 1994; Ryan, Meredith, & Shantz, 1994). However, there were no effects of nurse style on any of the ratings of the resident in either study. It is unclear why this effect was not obtained, but studies showing such a pattern were all based on simple contrasts between patronizing versus nonpatronizing talk, which is arguably a much stronger manipulation than the more subtle shift manipulation studied here. It is possible that blaming the victim occurred at the outset of our study with the nurse's initiation of patronizing speech in all of the conditions and hence was not detectable within the present design.

Limitations

In terms of overall limitations, we can identify several important areas. First, the presentation of the conversations was more controlled in Study 2 than in Study 1, perhaps accounting for greater agreement among the participant groups in the second study. Second, greater variation in situation, activity, and especially specific conversational utterances is needed to asses generalization of these effects (see Ryan, Meredith, & Shantz, 1994). Third, although scenario studies allow for systematic manipulations of conversational and other variables, they need to be complemented by field studies (e.g., Kemper, 1994; Sachweh, 1998) and laboratory analogue studies (e.g., Kemper et al., 1995; Hummert et al., 1998). Fourth, the present paradigm was indirect in its focus on reactions to patronization because resident response scripts were actually reactions to the content of the nurse's requests and not to her patronizing manner. It would be important to extend this work

by studying direct reactions to different styles of patronizing speech. Finally, we should also address the issue of relatively few men being available for participation in these studies, especially within the group of nursing home staff. We performed post hoc examinations of the gender distribution in the various cells in the two studies. There were no male nursing home staff in Study 1, and the proportion of residents in each response condition ranged from .25 to .50. In Study 2, the proportion of men in the community group was .38 in each condition and ranged from .14 to .34 for the residents. Again, the nursing home staff proportions were lower, ranging from .00 to .13. Respondent gender has been of limited interest in evaluations of patronizing speech (Hummert, 1994; O'Connor & Rigby, 1996; Ryan et al., 1995), but future research might compare evaluations by men and women of patronizing speech and recipient responses.

Future Research

The differences in responses to the two types of humor used in the two studies suggest that further work on the role of humor as a strategy for older adults in dealing with patronization should prove fruitful. Particularly in Study 2, it seemed that the use of that style of humor allowed the resident to express her opposition to the nurse, thus avoiding a face-threatening act of capitulation (e.g., Brown & Levinson, 1987), yet still be rated as both competent and relatively polite by respondents. This was not true for the more sarcastic and demanding humor of Study 1, however. It would be interesting to further compare several types of humorous styles within the same study as a way of clarifying perceived differences among these resident responses. As well as focusing on variations in the response, future research could also evaluate the effects of varying the topic of the conversation, such as public versus private issues as in Ryan, Meredith, and Shantz (1994), and the role status of the speaker as in Ryan, Hamilton, and Kwong See (1994).

The conversational protocol between nurse and resident used in these studies allows the investigation of a range of different types of resident responses to patronization, which also can be systematically manipulated in terms of the effectiveness of the response in influencing the nurse. The generally clear and interpretable effects found in the present studies suggest that further use of this type of vignette is warranted. Such controlled studies comparing various conversational contexts can provide further evidence regarding the impact of more or less resident assertion in attempting to manage the dilemmas of this conversational predicament for the elderly person (e.g., Ryan, Meredith, & Shantz, 1994). It would also be informative to collect ratings of both the nurse and resident targets after each turn in the conversation, using the segmented dialogue technique of Genesee and Bourhis (1982). Such on-line monitoring of perceptions might more readily reveal subtle changes in impressions as the conversation proceeds.

It is also important to continue to expand evaluative studies of patronizing speech to at least the three populations examined. It was evident, especially in Study 1, that the residents were more sensitive to the responses of the target resident, whereas the staff were more sensitive to the behavior of the target nurse. There is value, therefore, in examining different perspectives on the effects of patronizing speech and educating the parties involved (especially staff). Given that the community group's perspective of patronizing speech provided an intermediate view of the scenarios, further research should highlight the circumstances when their views are more like those of one group than the other.

Future studies should also consider individual differences in the reaction to patronizing talk and the appropriate resident responses. Individual residents may differ in whether their self-esteem is threatened by the constraining talk typical within nursing home environments. In fact, some of them may prefer that form of address from the nurse. The work of O'Connor and Rigby (1996) suggests that such factors as need for succorance and poor functional health can affect perceptions of baby talk, with those having higher needs for succorance and lower functional health viewing patronizing speech more positively. Whitmer and Whitbourne (1997) also demonstrated that older and more dependent clients of a rehabilitation facility were more tolerant of both the content and intonation of patronizing speech. However, linking to social selectivity theory, some residents could learn to like patronizing speech and the dependence that follows (Baltes & Carstensen, 1996), adapting their goals according to possible reinforcements. This may be their only route to social attention in the nursing home environment.

In summary, the present investigation focused on different coping strategies for managing the conversational predicament of elderly adults when addressed in a patronizing fashion by care providers. By manipulating the nurse's subsequent behavior, we were able to evaluate the effectiveness of responses provided by the resident in attempting to alter patronization. It was found that directly assertive response styles were very effective in highlighting the inappropriateness of the unresponsive nurse, but were not seen as competent, polite, or appropriate. Passive responses, in contrast, were seen as polite and appropriate, but did not call attention to the patronization of the nurse, even when she continued to be patronizing. The present research suggests that humor may have beneficial consequences as a tactic for dealing with issues of status and power negotiation in later life. Humorous responses showed some potential for combining the positive aspects of both the assertive and passive styles. Further work on these styles is needed, however, to clarify how this effect may operate. This research should have interesting theoretical implications for models of face management and communication and important practical consequences for aging adults in dependent circumstances.

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Appendix

Scripts for the Crafts Activity

The following is a conversation between a nursing home resident (age 86) and a nurse (age 34). The nursing home is situated in Eastern Ontario and has about 50 residents. Twice a week, the activity director holds a crafts session for the residents. Mrs. Smith (a nurse) has come to remind Mrs. Brown (a resident) that crafts are being held in the activity room. This is how the conversation went:

No nurse style shift (Nurse remains patronizing following the resident's response)

Mrs. Smith: Did we forget again, sweetie? It's time for crafts!
Mrs. Brown: I know it's time to go. I'd rather not, but if you insist, I'll go. (Passive response)
OR
Mrs. Brown: I've already planned to watch my favorite TV program, so I won't have time to go today. (Assertive response)
OR
Mrs. Brown: I think I'll just pass today. I've made more crafts in my lifetime than an over-achieving Girl Guide group at Christmas. (Humorous response)
Mrs. Smith: Now, now, I just know we'll have a nice time. It's important that we get out of our room for awhile, dear. You just have to give it a try!

Nurse style shift (Nurse shifts to an accommodating style following the resident's response)

Mrs. Smith: Did we forget again, sweetie? It's time for crafts!
Mrs. Brown: I know it's time to go. I'd rather not, but if you insist, I'll go. (Passive response)
OR
Mrs. Brown: I've already planned to watch my favorite TV program, so I won't have time to go today. (Assertive response)
OR
Mrs. Brown: I think I'll just pass today. I've made more crafts in my lifetime than an over-achieving Girl Guide group at Christmas. (Humorous response)
Mrs. Smith: I can see that you are not eager today. But it is important for you to get out of your room for awhile. Mrs. Brown, please consider joining us.

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