Goffman and the Infantilization of Elderly Persons: A Theory in Development

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Infantilization is a behavioral pattern in which a person of authority interacts with, responds to, or treats an elderly person in a child-like manner. This paper uses Erving Goffman's theories as a framework from which to analyze the reasons for and the results of infantilization of elderly residents in partial and total institutions (i.e., adult day care centers and nursing homes). First, we review the literature on infantilization. Next, we offer a brief summary of Goffman's work and delineate his major theoretical assumptions. Then, we analyze the process of infantilization through Goffman's theories. Finally, we offer suggestions for advancing research using Goffman's premises. This paper asks whether infantilization can produce symptoms of dementia in institutionalized elders. If Goffman is correct, the answer may be yes. Six researchable propositions are offered to test Goffman's theoretical framework.

Key words: Infantilization, Goffman, Dramaturgical Model, Dementia, Institutional Living

Elder residents of partial institutions such as adult day care centers (see Salari, 2005) and total institutions (see Goffman, 1961) such as nursing homes experience many undeniable benefits. Adult day care centers and nursing homes provide much needed professional care that families are often ill equipped to provide. At the same time, elders also experience negative

effects in institutionalized settings, such as being infantilized. This practice has captured the attention of researchers over the past few decades (see Hockey & James, 1993; Marson, 2013a; Salari, 2005, 2013; Salari & Rich, 2001; Whitbourne, Culgin, & Cassidy, 1995). Infantilization is a behavioral pattern in which a person of authority (social workers, medical personnel, etc.) interacts with, responds to, or treats an elderly person as if he or she were a child. Using secondary baby talk when speaking to elders may be the most common form of infantilizing behavior. Secondary baby talk is a patronizing type of speech in which the speaker uses an exaggerated intonation, a higher pitched voice, and a child-like vocabulary while speaking slowly and loudly (Hockey & James, 1993; Whitbourne et al., 1995; Wood & Ryan, 1991). Other common infantilizing behaviors include using overly familiar forms of address, such as pet names, publicly disclosing the client's personal and medical information, and using age inappropriate recreational activities (Salari & Rich, 2001).

Our interest in this topic was spawned by two anecdotal situations. The first was a situation the Director of Nursing (DON) of a local nursing home shared with the first author. When a well-liked, competent caregiver left the staff to pursue other opportunities and was replaced by a social worker who used a different approach with the residents, the DON noticed a marked improvement in the elderly patients' verbal responses. The patients seemed more alert and less cognitively impaired in their interactions with staff and visitors. The DON noted that the only explanation she could offer was the difference in the caregivers' communication styles, since both were competent and caring staff members. In her attempt to be nurturing and comforting, the first caregiver spoke to the residents in a slow, sing-song voice using a child-like vocabulary. The caregiver who replaced her spoke to the residents with the same adult speech patterns she used with staff. Much to the surprise of the DON, some residents who had previously spoken very little or who had seemed to show signs of dementia started speaking and interacting in more normal ways. This anecdote caused us to question whether infantilization can alter the responses of elders to their caretakers and, in turn, increase the risk of the residents being labeled as cognitively incompetent.

The second situation occurred during the second author's

mother's last hospital stay as she was dying from cancer. She was quite angry with the nurses and doctors who infantilized her and told them: "Just because I'm old and can't hear you, don't think I'm stupid. Stop talking baby-talk to me and treating me like I'm not smart enough to make my own health decisions." This experience caused us to ask whether elders consider infantilization a form of mistreatment.

While we wish to question whether infantilization of elder residents may trigger responses that mimic cognitive impairment, we do not intend to minimize the very real and tragic effects of dementia. According to the Center for Disease Control (CDC, n.d.), the term dementia covers a multitude of cognitive disorders, including everything from mild cognitive impairment to advanced stage Alzheimer's. Moreover, the older a person is, the higher their risk for various forms of dementia, with an estimated 25% to 50% of all persons over the age of 85 experiencing some form of cognitive impairment (Centers for Disease Control and Prevention, n.d.; National Center on Elder Abuse, n.d.a). Since the 65 and older population is expected to increase by 36% to approximately 55 million by 2020 (National Center on Elder Abuse, n.d.a), the incidence of dementia is also likely to rise. Although only 4.1% of all persons 65 and older were living in nursing homes as of 2009, 14.3% of persons 85 years of age or older resided in nursing homes (National Center on Elder Abuse, n.d.b). The National Center on Elder Abuse (n.d.b) reports that elders with dementia experience higher levels of abuse from their caregivers than cognitively healthy elders. Based on these estimates, a large number of elders in nursing homes will experience some level of cognitive impairment and be at some risk for mistreatment.

Infantilization: Nurturing or Disrespectful?

Although many health professionals consider infantilizing speech patterns as nurturing and supportive, most elders view them as patronizing and disrespectful (Caporael, Lucaszewski, & Culbertson, 1983). While there is support for the benefits of talking slowly and loudly to dependent, institutionalized residents to accommodate real needs, the practice of infantilizing elders is viewed negatively by elderly residents (Caporael et al., 1983; Marson, 2013b; Ryan, Kennaley, Pratt, & Shumovich,

2000). Although college students and caregivers who hold stereotypes about the elderly consider baby-talk the most appropriate way to communicate with elders (Caporael, 1981), most institutionalized elders view it as disrespectful and patronizing (Caporael et al., 1983; Whitbourne et al., 1995). Salari (2005) contends that the practice of infantilizing elders is a form of elder mistreatment because of the negative effects. The majority of elders believe they are infantilized not because of their individual conditions but because of age stereotypes about their mental and physical capabilities (Coupland, Coupland, Giles, & Henwood, 1988). To show their displeasure, some elderly institutionalized residents adopt defensive behaviors such as making sarcastic remarks, verbally attacking caregivers, and challenging punishments and reprimands, while others withdraw from social interactions with caregivers (Salari, 2005).

Language research shows that speakers tend to use accommodation strategies based on their assumptions of the listener's capabilities (Giles, Fox, & Smith, 1993). Unfortunately, elders are often stereotyped as having diminished cognitive and physical abilities, which can lead caretakers to accommodate residents by assuming a stereotypical level of incompetence rather than accommodating the individual client's communication needs (Wood & Ryan, 1991). Patronizing and infantilizing speech may be even more harmful to elders who passively accept being treated as confused or forgetful than to those who act defensively, since acceptance may actually create a sort of self-fulfilling prophecy by eliciting the expected behavior from the dependent elder (Wood & Ryan, 1991). Repeated use of patronizing speech with elders constrains them from being able to interact at their actual level of competence, which can result in lowered levels of capability (Nussbaum et al., 2005). Coupland et al. (1988) found that when caretakers use over-accommodating talk, some elders will accept the stereotypes and respond accordingly. Caregivers may believe that passive acceptance confirms their stereotypes of elderly incompetence (Ryan et al., 2000).

A common stereotype is that people become senile and cognitively impaired as they age (Cardinali & Gordon, 2002). Even doctors fall prey to ageist assumptions which can affect

their diagnoses (Lichtenberg, 2012). Most people, including doctors, have a tendency toward confirmation bias, which results in searching for supporting rather than contradictory evidence for their observations (Mendel et al., 2011). Thus, doctors who are not well versed in the various types of cognitive dysfunctions experienced by elders may be more prone to believe that all cognitive impairment in elders is a form of dementia, which increases the risk of misdiagnosis (Lichtenberg, 2012). However, a misdiagnosis of cognitive impairment can occur for a variety of reasons other than ageist assumptions. Merckelbach, Jelicic, & Jonker (2012) contend that failure to rule out other medical reasons and overreliance on brain imaging can increase the risk of misdiagnoses as well. They claim that various medications, as well as depression, can mimic cognitive impairment. Variability in cognitive ability over time also adds to the difficulty of accurate diagnoses. For example, in their five year study of elders diagnosed with mild cognitive impairment, Britt, Hansen, Bhaskerrao, Larsen, and Petersen (2011) found that some of the subjects returned to normal cognitive functioning by the end evaluation period, while others had fluctuations in their levels of cognitive impairment over the five year period. Cognitive ability does not necessarily remain static over time (Britt et al., 2011; Duffy & Healy, 2011).

Stolee, Hiller, Etkin, and McLeod (2012) claim that although much work has been done to identify best health care practices for the general population, very little has been done to help us identify elder neglect or abuse. If, as Salari (2005) claims, infantilization is a form of elder abuse, we need to develop better practices for the elderly. We argue that one place to begin this process is through gaining a theoretical understanding of the process. We contend that Erving Goffman's theories (1959, 1961, 1963, 1967, 1974, 1986) can provide some illumination on the effects of infantilizing elderly institutionalized residents which, in turn, may help develop better practices.

Goffman's Dramaturgy and Frame Analysis Theories

Goffman developed two theories that, when combined, can help illuminate the impact that a caregiver's presentation style has on the elderly: Dramaturgy and Frame Analysis. His

theory of Dramaturgy is based on Shakespeare's observation in Act II, Scene 7 of *As You Like It*: "All the world's a stage and all the men and women merely players. They have their exits and entrances; and one man in his time plays many parts." Goffman (1959) built upon this idea by asserting that in our everyday lives, we are analogous to actors who try to manage the audience's impressions on the front stage and then retreat back stage to recuperate, rest, and prepare ourselves for the next act. This theory outlines how we attempt to manage the impressions others have of us by using common cultural scripts as we act out our roles. However, taken alone, Goffman's Dramaturgy theory does not explain where our cultural scripts come from. His Frame Analysis theory provides that answer. Goffman (1974) posits that we organize our experiences into basic cognitive schema that he calls frames. Primary frameworks are those widely shared culturally bound schemas that orient our attitudes and actions. So the scripts we select to manage impressions come from the primary frameworks of our culture.

Dramaturgy: A Theory of Impression Management

Goffman (1959) claims that, like actors, our lives are played out in front regions or back regions. Front regions are those spaces wherein we try to manage the impressions others form of us by giving a convincing performance. Since playing a successful role not only requires the actor to be a good actor but also requires the audience to accept the role the actor is playing as valid, impression management is a team effort. Part of the success of a play also depends on the actor being able to retreat to the back stage region of the theater out of view of the front stage audience to change costumes, to rest, and to prepare for the next scene. In other words, back stage regions are not impression management platforms, since it would be difficult to maintain impressions if the audience could see the mess, the errors, or the practices involved in giving a convincing front region performance. For example, caretakers who are expected to follow a script of caring in the front region may express dislike or anger toward the residents among colleagues in a back region. Occasionally, the audience does have a chance to view an error or the covering up of an error. Doctors or

supervisors may scold caregivers for mistakes within hearing of residents without realizing they can be heard, for instance. According to Goffman (1967), the actor may be able to recover if the audience is willing to overlook the error, but sometimes, the impression the actor is trying to convey is ruined.

Goffman (1959) describes two types of actors: the sincere actor and the cynical actor. Sincere actors believe in the impressions they are trying to convey. For example, caregivers who consider themselves competent will believe in their own performance as they strive to impress both staff and residents with their abilities. Cynical actors do not believe in their own performances. However, there are two types of cynical actors. One type deliberately tries to mislead their audience through presenting a misleading performance as illustrated by magicians or con artists. Caregivers who do not enjoy working with elders may try to "con" their patients by putting on a on a pleasant front because their jobs depend on certain performances. The second type of cynical actor is the person who does not fully believe in their performance because they lack the confidence to believe in the impression they are trying to make. For example, when people first begin a job, they often go through the motions until they feel confident in the position. Until they become confident that their impressions represent their actual skill levels, they are cynical actors (Goffman, 1959).

How do actors manage the impressions of their audiences? Goffman (1959) claims that the actor uses "sign vehicles" which the audience reads and either accepts or rejects. Sign vehicles include such things as the setting for the act and the actor's personal front, which includes both appearance and mannerisms. He asserts that in addition to giving signs intentionally to help create an impression, actors also unconsciously give off signs that can alter the impression they are trying to make on the audience. A social worker may be unaware that her frustration or impatience with a client shows for a brief moment in her facial expression, for instance. The audience uses both the intentional signs and the unintentional signs to decide whether or not to accept the impression the actor is trying to convey.

Goffman (1986) also points out that actors and their audiences sometimes interpret signs through stereotypes which stigmatize entire groups and carry expectations that do not

match the reality of the signs that are presented. He contends that recipients of stereotyping face reduced opportunities to live up to their potential or to make the kinds of impressions they desire to make.

Goffman (1961) paid special attention to the setting of total institutions. Total institutions are places where residents are housed in an institutional setting controlled by staff members who set schedules. Residents are under constant surveillance and have little to no agency in determining their own care. Goffman's (1961) research shows that residents come to orient themselves to the expectations of their caregivers for fear of being punished or losing care and privileges. However, actors cooperate in social interactions for multiple reasons in addition to fear (Goffman, 1983). Goffman (1983) posits that an actor's status can sometimes make the cost of not cooperating higher than the cost of cooperating because they could be labeled or ostracized for not cooperating. Residents who rebel against caretakers can be labeled as uncooperative troublemakers, for example.

Primary Frameworks and Social Scripts

Goffman (1974) claims that actors rely on primary frameworks to select scripts appropriate for particular situations. Primary frameworks are culturally bound cognitive schemas that can be understood as a way of organizing and interpreting the situations around us into meaningful information. Frameworks differ in the amount of organization they provide, with some offering a complete interpretation and others offering only a guiding perspective (Goffman, 1974). For example, while the primary framework identifying something as a physical attack tends to be fully developed, the framework for identifying an insult relies more heavily on a perspective. In a culturally diverse country such as the U.S., we have multiple frameworks from which to choose for most situations, which makes it more difficult to frame some scenarios. If an elder person doesn't answer when spoken to, it could mean they have poor hearing (especially presbycusis), they are depressed, they have cognitive impairment, or that they are purposely ignoring the speaker. Thus, actors and audiences usually rely on accompanying signs such as setting, appearance, and manner to help us determine which frame to use.

Unfortunately, we may also pick our framework from stereotypes (Goffman, 1986). This means that we can, and sometimes do, select a frame or script that resonates with us but does not necessarily work for our audience. Of particular interest in this paper are the frameworks used by social workers and other caregivers within partial and total institutions.

A Goffmanian Analysis of Infantilization

Previous research provides a clue as to why caregivers infantilize elderly residents by showing that the elderly are often viewed through negative, stereotypical frameworks (Montepare, Steinberg, & Rosenberg, 1992; Whitbourne et al., 1995). Cuddy, Norton, and Fiske (2005) find that the elderly are often treated with pity and infantilized because they are viewed as less competent. Elders are often treated as though they are helpless and spoken to in condescending, patronizing ways (Caporael, 1981; Cuddy et al., 2005). This kind of treatment can elicit responses from elders that mimic cognitive impairment. For example, when caregivers interact with residents based on stereotypical assumptions, it can create a vicious cycle where stereotypes seem to be confirmed because being infantilized constrains normal responses (Bonnesen & Hummert, 2002). Sabat, Johnson, Swarbrick, and Keady (2011) point out that when people are labeled, their actions and responses are interpreted through the label. Hence, when caregivers frame elderly residents through ageist assumptions of incompetence and cognitive impairment, they will use inappropriate infantilization scripts with the residents.

If, as Goffman (1974) claims, we pick our scripts from primary frameworks, why would caring, nurturing caregivers select a stereotypical frame that results in an inappropriate script rather than a frame based on the individual resident's condition? Goffman (1974) asserts that both education and job training provide us with frames through which we understand our job tasks. Regrettably, researchers find a lack of focus on, or interest in, gerontology classes within the education system (Duffy & Healy, 2011). Moreover, Cherry, Allen, Jackson, Hawley, and Brigman (2010) found that social workers had gaps in their knowledge about memory aging, specifically, and could use further training. They claim that caregivers' overall

knowledge of aging would be improved by more of a focus on the aging process throughout social science curriculums. Futhermore, Schiamberg, Barboza, Oehmke, Zhang, Griffore, Weatherill, VonHeydrich and Post (2012) assert that nursing home staff could benefit from training in how to minimize elder abuse because their personal prejudices and issues can and do affect their work. Supporting that claim, Dunworth and Kirwan (2012) found that workers trained in elderly care are more responsive to actual needs and less likely to make ageist assumptions.

If a majority of elders find infantilization demeaning and disrespectful, why do some of them passively accept this treatment? Goffman (1959) claims that successful performances require teamwork. Actors cannot create impressions without the cooperation of the audience and fellow actors. Goffman (1961) explains how residents in total institutions often respond in ways to accommodate caregivers' expectations from fear of losing quality care or being punished. Elderly nursing home residents are dependent on their caregivers for their daily personal and medical needs. So as not to antagonize their caregivers, some may become what Goffman (1959) calls cynical actors by passively accepting infantilization because they fear that their dependent status puts them at risk if they do not cooperate. Thus, if nursing home staff use "baby-talk" with them, rather than responding as a sincere actor by withdrawing or refusing to cooperate, elders may succumb to the strategy taken by many residents of total institutions: acceptance of the situation (Goffman, 1961). For example, Coupland et al. (1988) found that elders use several types of what Goffman (1959) would call cynical actor strategies to deal with ageist stereotypes. Some selectively edit their responses to caregivers so as to hide their true feelings and opinions. Others use ageist stereotypes, such as poor memory or poor physical ability, to excuse themselves from activities in which they have no interest. At the same time, residents who get little social support for normal mental functioning often reframe their understanding of themselves to fit the frame of their caregivers and become sincere actors, over time (Goffman, 1961; Ryan et al., 2000).

Research suggests that treating residents in an adult-like manner has positive results (see Castelli, Zecchini, & Deamicis, 2005). Matusitz, Breen, Zhang, and Seblega (2013)

found that an important part of elder residents' satisfaction in nursing homes is the preservation and maintenance of their individuality and integrity. According to the Administration on Aging (2014), the second most frequent complaint about nursing homes in 2011 was lack of respect for residents and poor attitudes among staff. The way caregivers treat elder residents in total institutions can either help or hinder an elder's experience (Duffy & Healy, 2011). Because symptoms and diagnoses can change over time, caregivers who focus on elders' weaknesses may impede chances for improvement (Duffy & Healy, 2011). As Dunworth and Kirwan assert (2012), training can help caregivers choose more appropriate scripts for dealing with nursing home residents. Giles et al. (1993) found that elders view a neutral style of speech as more affirming than patronizing speech. Nursing home residents want to be treated as individuals with specific characteristics and needs instead of as a stereotyped group (Hjaltadottir & Gustafsdottir, 2007).

If, as Salari (2005) claims, infantilization is a form of elder mistreatment, it befits us to think seriously about how to provide nurturing care without relying on infantilization. One of the standard behaviors designated as elder abuse is professional non-intentional verbal abuse. Infantilization of elders clearly falls into this category. Since the problem seems to stem from stereotypes and possible misinterpretations of cognitive impairment, we suggest that in a world of multivariate analysis in which we make Herculean efforts to control for alternative explanatory and spurious variables, the problem of infantilization is relatively simple. The key to resolving the problem of infantilization is in-service training. Medical staff, particularly in nursing homes, are required to attend in-service training. These federally mandated training sessions are the ideal venue for addressing infantilization. After such training, supervisory staff could include infantilization as an item for annual evaluation.

Advancing Research

If a theory cannot be tested, most social scientists would suggest that it lacks trustworthiness. Thus, in contemporary social science, it is vital that theories be tested. Following

are a series of propositions which are delineated from the body of this paper. These propositions need to be tested to determine whether Goffman's theories are applicable. It is important to note that these propositions were constructed within the context of what Goffman calls the "total institution." Thus, these propositions are only applicable to partial or total institutions such as adult day care centers or nursing facilities and not to elders who live in the community.

Qualitative behavioral differences exist for institutionalized elders between two types of social interaction: (a) elders' social interaction with nursing home staff (front region); (b) elders' social interaction with other institutionalized elders (back region).

Elderly patients in an institutionalized setting will act more lucid in the presence of other institutionalized elders (back region) than they will the staff (front region).

Elderly patients in an institutionalized setting who are treated in a non-adult manner will be less lucid (front region) than elderly patients in an institutionalized setting who are treated in an adult manner.

There is a quantitative difference in the amount of time that staff devotes to elders who rebel against their "dementia" label compared with those who comply with the label expectations.

The amount of time that staff will spend with elderly patients who rebel against their dementia label is filled with negative social sanctions, while the amount of time that staff spends with elderly patients who do not rebel against their dementia label is filled with neutral and some positive social sanctions.

When surveyed separately, caregivers and residents will provide different "impressions" of caregiving interactions.

Support for using Goffman's theoretical models will be derived if research confirms these propositions.

Conclusion

We suggest that Goffman's theories may improve our understanding of the practice and results of infantilization. A major strength of Goffman's approach is his focus on specific behaviors within institutions. Goffman provides an excellent framework from which one can study specific service-provider/patient interactions. We contend that investigating whether or not caregiver practices can impact the cognitive and behavioral responses of elderly residents in such a way as to mimic cognitive decline can add to knowledge of "best practices." Because Goffman offers both a macro theory that elucidates the cultural frames actors use to understand the world around them and a micro theory that explains how actors use various signs to create specific impressions, he provides an opportunity to understand both structure and interaction. Using these theories, researchers can begin to explain how the structure of total institutions for the elderly affects service-provider/resident interactions. We assert that the more we learn about how structural forces and personal interactions affect quality of care for elder residents of partial and total institutions, the better care we can provide.

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