BELONGING TO THE OLD AND UNSUCCESSFULLY AGED:
LANGUAGE PRACTICES IN A NURSING HOME IN MAASTRICHT,
THE NETHERLANDS

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Abstract
Older people who live in a nursing home do not take the experience of belonging for granted. Until now little research has been done on the role that language practices can play in the experience of belonging in a nursing home. During conversations between nursing staff and residents, the former often adjust their language practices, producing cultural narratives on ageing to which residents in nursing homes are often exposed in the process of achieving belonging. However, older people do not necessarily identify with these narratives, which affect whether residents experience belonging. This article explores the adjustments in language practices made by nursing staff and shows how they reinforce the cultural narratives on ageing. The results demonstrate that these altered language practices reinforce cultural narratives on ageing, and that adjustments are made towards what is perceived to be a homogenous group of older people, thereby overlooking the individuality and capacities of residents.

I.   Introduction

For older people who make the transition to a nursing home, creating a place where they belong is not taken for granted (Boelsma et al. 2014: 48). The changes associated with their transition to a nursing home are often overwhelming for older people, who moreover may encounter many difficulties in creating a place where they belong after they move to the nursing home.

For the majority of nursing home residents, one of the main activities of the day is interaction with nursing staff or other residents. Language practices are therefore a critical factor which will affect the experience of belonging. Feelings associated with language pervade everyday life (Jørgensen et al. 2011: 35). Residents perceive that they are surrounded by 'others' (residents, staff, visitors) who speak the same

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language or dialect and therefore not only understand what they say but also what they mean, thus creating feelings of belonging in the nursing home (Antonsich 2010: 646). Simultaneously, language practices demarcate 'us' from 'them'. Language practices can therefore not only contribute to feelings of belonging but also to feelings of not belonging.

During everyday conversations, people adjust their language practices depending on their interlocutors. Looking at the adjustments of language practices made by the nursing staff in interaction with the residents of a nursing home, they are not made for the interlocutor so much as for older people as a homogenous group. Cultural narratives of ageing, whereby older people are seen as a homogenous group, are reinforced through the language practices of the nursing staff. This article discusses how this happens and how it contributes to the residents' experience of belonging. When residents' individual capacities are overlooked during their interactions with nursing staff, some residents perceive it as undermining their personal dignity.

II.   Cultural narratives on ageing

The demographic trends that are resulting in the proportion of older people in the population increasing (Swinnen and Port 2012: 9) have caused 'global ageing' to become an important topic (Sokolovsky 2009: xix), resulting in the emergence of university centres, NGOs, international research networks and venture capital companies (ibid.), who are all focusing on ageing-related phenomena and how to deal with growing proportions of older people. However, ageing also takes place locally within specific cultural contexts (Laceulle and Baars 2014: 34). Moreover, people are aged by culture (Gullette 2004: 12). In studies of the ways in which people grow old, various cultural narratives are encountered (Sokolovsky 2009: xxiii). In countries with a Westernized culture, two prevailing cultural narratives on ageing exist. The first is the cultural narrative of 'ageism', which holds stigmatized assumptions about older people, such that they are incompetent, dependent, passive, powerless, inferior, weak, depressed and frail (Cruikshank 2008: 149-150; Lagacé et al. 2012: 336; McHugh 2003: 180). The second cultural narrative that is perpetuated in Westernized cultures and societies is the 'successful ageing' narrative, according to which individuals are personally responsible for their health, physical and cognitive function, and sustained engagement in social and productive activities (Lamb 2014: 44; Rubinstein & De

Medeiros 2015: 38). The two narratives contradict each other, making it, in the perceptions of older people themselves, a complicated task to age successfully.

As a consequence of the successful ageing narrative, older people are expected to age healthily, avoid decline and stay active, while the same people are simultaneously influenced by the ageism narrative that assumes that older people will show some decline and are incompetent and frail. The contrast between the two narratives suggests that not everyone ages successfully. This means that the cultural narrative on successful ageing is always a double-edged sword: ageing successfully automatically implies that people can also age *un*successfully. Although there is no clear view on what 'unsuccessful ageing' includes, it is clear that, if people age unsuccessfully, they themselves bear responsibility for doing so (Rubinstein and De Medeiros 2015: 38).

II.   Elderspeak

One common denominator that both cultural narratives in Westernized cultures share is that they both perceive older people as a homogenous group. According to Lagacé et al. (2012: 336), one way in which representations of ageing are communicated is through language practices. This is especially relevant to narratives of ageism. The cultural narrative of ageism shows that stereotyped perceptions of older people exist and that they influence the ways in which communication takes place with them. During conversations, people adjust their ways of speaking depending on their interlocutor (Samuelsson et al. 2013: 617). The negative stereotypes of older people that are communicated through the ageism cultural narrative affect the assumptions people have about their language skills and speech and therefore the ways in which people adjust their speech towards older people. Negative expectations regarding the language capacity of older people include the 'inevitable' decline in their language skills, incompetence, dependency, decline in hearing, and the loss of one or more languages for people who were formerly bilingual or multilingual (De Bot and Makoni 2005: 58; Coupland et al. 1991: 11; Lagacé et al. 2012: 336). All the negative expectations regarding the language capacity of older people may result in adjusted language practices towards them as a homogenous group in the form of 'elderspeak'. Elderspeak is an intergenerational speech style that people often adopt when they talk to older people, based on subconscious stereotypes that originate from cultural narratives of ageing. Elderspeak comprises various linguistic domains: prosodic features, semantics and syntax. The prosodic features are particularly prominent,

namely a slower rate of speech, exaggerated intonation, elevated pitch and volume, changes in emotional overtones and a patronizing voice (Samuelsson et al. 2013: 638, Williams et al. 2003: 243, Balsis and Carpenter 2006: 80). Semantic features often become apparent through situationally inadequate address terms and shorter words (Samuelsson et al. 2013: 638, Williams et al. 2003: 243). Finally, adjustments in elderspeak syntax manifest themselves as greater repetition, use of tag questions, simpler vocabulary and grammar, and shortened sentences (Samuelsson et al. 2013: 638; Williams et al. 2003: 243; Balsis and Carpenter 2006: 80-81). All the adjusted language practices in elderspeak are motivated by a desire to adjust to the presupposed lack of capacity of older people. However, elderspeak may in fact involve over-adjusting rather than just adjusting, since most of the adjusted features implicitly seem to question the competence of older people (Williams et al. 2003: 243).

Previous studies have shown that nursing staff often use elderspeak in speaking to nursing home residents (De Bot and Makoni 2005: 58; Lagacé et al. 2012: 336). By discussing a case study, I will show which features of elderspeak are used in this specific nursing home and how this influences the experience of belonging for its residents.

III.   Methodology

After consulting the relevant theories on elderspeak, on the assumed decline in the language competence of the older people and on the cultural narratives of ageing, I chose to adopt an inductive approach so as not to pre-empt what the collection of field data would find (Padgett 1998). Therefore, no hypothesis was formulated initially. The qualitative methodology was based on grounded theory (Hammersley and Atkinson 2007, Bernard 2002, Glaser and Strauss 1967) in order to understand the social meaning of language practices within a certain context, in this case a nursing home. Understanding the process of social meaning-making requires qualitative methodologies, which include ethnographic fieldwork, participant observation, informal and follow-up interviews and conversations, and audio recordings. Participant observation took place at different times and in different areas of the nursing home. Conversations between the researcher and the study's participants, as well as between the residents and with staff, were audio recorded in diverse contexts in which the researcher was also a participant observer. This provided insight into the

everyday language practices within the nursing home and made it possible to identify the adjustments that the nursing staff made to their speech in talking with the residents.

IIIa. Participants

Data were collected at a relatively large nursing home with 124 residents in downtown Maastricht, in the Netherlands. Maastricht is located in the province of Limburg and is only a few kilometres away from both the German and Belgian borders.

The data collected between August and November 2015 came from a sizable number of participants, including 28 residents and six nursing staff. Of the 28 residents who participated, eight were men and twenty were women. Residents were asked to participate after a short explanation of the research. If they were willing to participate, written consent was requested and collected every four months. Of the nursing staff, two were men and four were women. Nursing staff were asked to participate after a short explanation of the research during breaks and staff meetings. When they were willing to participate, written consent was obtained.

The majority of the residents had lived their entire lives in Maastricht or another town in the province of Limburg, and therefore mainly spoke the Maastricht dialect or another local dialect in addition to Standard Dutch. Other residents had lived in other provinces of the Netherlands and had moved to Maastricht in order to be closer to their children. For those residents the main language was Dutch. Based on the parameters of this study, none of the participants presented symptoms of dementia or cognitive decline.

IIIb. Data collection

Ethnographic fieldwork was undertaken for the duration of the researcher's presence in the nursing home. Everyday practices such as cleaning the beds, handing out meals, dining in the common area and engaging in communal and individual activities were observed in the course of the fieldwork.

In addition to the audio recordings, field notes from participant observation documented non-verbal communications, the layout of the nursing home and the identity of participants in interactions. Although other types of interaction will also be

taken into consideration for the wider research project, this article focuses on the interactions between nursing staff and the residents of the nursing home.

IIIc. Data Analysis

The first stage of data analysis involved the transcription of collected audio recordings between nursing staff and residents, according to a specifically adapted convention, detailed below. The transcription itself forms a crucial part of the linguistic analysis, since the transcript is not neutral, but rather reflects representational decisions (choice of data fragments) and interpretive decisions (choice of conventions; see Bucholtz 2000). In order to provide a clear analysis of the transcript, the representational decision was made to show the entire conversation between the nurses and Mr Sigar (see Appendix), and also to reproduce separate parts for further analysis. The choice of the convention was made in order to focus on the language practices of the nursing staff in relation to the nursing home's residents. The convention that is followed can be found in a footnote under the first page of the transcript (in the Appendix) and below. Although the researcher consulted all the conventions that could be of interest, one critical note can be made with respect to them. Despite the fact that the researcher does not consider bilingual talk as talking in two separate languages (Auer 2007), a distinction was made between standard Dutch and the Limburgian dialect, as it is important to understand that some words occur in both standard Dutch and the dialect but have different social meanings. Therefore the choice was made to indicate the use of dialect in the transcript. The transcriptions relate the content of what was said in the recordings, complemented by field notes that related the context, including the emotional context, and non-verbal communication. In order to analyse the transcriptions and field notes together, NVivo 10.2.2 was used. Within this qualitative data analysis program, words, phrases or sentences from both the transcriptions and the field notes were assigned open codes. As the process of the collection and analysis of data evolved, the codes could be corrected when new features were identified and overarching patterns became apparent. The patterns, thus arrived at inductively, revealed adjustments in the speech of nurses towards residents.

IV. Case study

At the end of October 2015 Mr Sigar invited me to have a chat. On the 29th of October I met with him in his room. The audio recording that is transcribed below was made during this meeting. Mr Sigar is 94 years old and has lived in Maastricht his entire life. Before moving to this nursing home he had lived in another nursing home in Maastricht, which closed down as a result of the government's financial cuts. Mr Sigar has lived in this nursing home for the past eighteen months.

The transcript below is part of a longer conversation that took place at around 4.30 pm. Fifteen minutes prior to the moment when the nurse walked into the room, Mr Sigar had called a nurse through the intercom to ask when one of the nurses would come to make his bed and empty the bin. At that moment his bed had not been made and used incontinence equipment was clearly visible on it. Through the intercom the nurse made it clear that somebody would come shortly and that he should wait. After the exchange through the intercom, Mr Sigar and I resumed our conversation. Moments before the nurse walked into his room, Mr Sigar had told me that every night when he goes to bed he hopes he will not wake up anymore. During the entire conversation between Nurse 1 and Mr Sigar, the nurse kept a distance of about three metres between herself and him.

IVa. Adjustments in elderspeak
IVa.i. Prosody

Although adjustments in language practices towards older people involve various linguistic domains, adjustments in prosodic features are most prominent. The transcription notations capture the following elements:

WORD = loud voice, relatively to surrounding talk

ºwordº = quiet voice, relatively to surrounding talk

=word= = simultaneous speech

word = in dialect

{word} = words articulated slowly

word = stress on (part of) the word

wo:rd = prolonged vowels

wor/ = interruption

(.1) = pause in seconds

() = inaudible

The first prosodic adjustment becomes apparent at the beginning of the conversation.

6.NUR1: MENEER**?**
     MISTER.?
7.SIG: *Jao*.
     Yes.
8.NUR1: BOUILLON**?**
      BROTH?

Right after the nurse and Mr Sigar exchange their greetings, the nurse starts to talk in a loud voice: 'MENEER' (MISTER), especially considering the volume of Mr Sigar's '*Jao'* (*Yes*). The adjustment in speech volume not only takes place in this part of the conversation, but rather informs the whole conversation. There is, however, some variation.

22. NUR1: {IK *HÖB GEIN HÖLP NOE}*.
      {I *HAVE NO HELP NOW}*.

In sentence 22 above, Nurse 1 maintains a loud voice for the entire sentence. This happens five times during this conversation. Partial adjustment occurs in sentence 12.

12. NUR1: {*IECH NEET*} in ieder geval, *ich {bin D'N PILLEN} aon 't doen.*
    {*I'M NOT*} anyway, I {*am*} doing {*THE PILLS*}.

In contrast with sentence 22, Nurse 1 raises her voice in parts of sentence 12, namely when she says '*IECH NEET*' (*I AM NOT*) and '*D'N PILLEN*' (*THE PILLS*). During the entire conversation, Nurse 1 raises her voice in parts of sentences, or in just one word of a sentence, six times. Such adjustments were often accompanied by a slower speaking speed.

12. NUR1: {*IECH NEET*} in ieder geval, *ich {bin D'N PILLEN} aon 't doen.*
    {*I'M NOT*} anyway, I {*am}* doing {*THE PILLS}.*

In sentence 12 the words pronounced in a loud voice, {*IECH NEET*} and {*D'N PILLEN*} are also spoken slowly. The adjustment to a slower speaking speed happened seven times during the entire conversation.

In addition to the slower speed, the louder voice was also often accompanied by an alteration in emotional overtones. The manner in which the emotional expression is adjusted varies from what is perceived as patronizing to controlling. The perceived patronizing voice is regularly used in this conversation.

12.NUR1: {*IECH NEET*} in ieder geval, *ich* {*bin <u>D'N</u> PILLEN*} *aon 't doen.*
     {*I'M NOT*} anyway, I {*am*} doing {<u>*THE PILLS*</u>}
13.SIG: *Wa blief?*
     What do you say?
14.NUR1: °Ik zeg° {IK *BIN D'N* PILLEN *AON 'T* DOEN} <u>HE?</u>
     °I say° {I *AM* DOING *THE* PILLS} <u>HUH?</u>
15.SIG: Oh
     Oh
16.NUR1: {*DAAN* KOM *ICH* STRAKS *eve}* tr*ö*k, {*MER NOE NEET, NOE RED ICH DA NEE:T*}.
     {*THEN I* COME SOON *shortly*} back {*BUT NOT NOW, NOW I CANNOT MAKE IT*}.

Above, we see an example of the use of the patronizing voice directed at Mr Sigar. During this part of the conversation, Nurse 1 explains in a condescending way that she will not make Mr Sigar's bed because she is handing out pills to residents and does not have time to do it. The patronizing voice of Nurse 1 continues until sentence 28.

28. NUR1: En *NOG ME:R KLAOGE* he, <u>*ZEEN'S IEMAND*</u> he?
  NUR1: And *YET BU:T COMPLAINING* huh, <u>*SEE ONCE SOMEBODY*</u>, huh?
29. RES: =Lacht=
  RES: =Laughs=
30. SIG: =Ja= (.1)
  SIG: =Yes= (.1)
31. SIG: *Klaoge* dat ze /
  SIG: *Complaining* that they /
32. NUR1: {JA JA}
  NUR1: {YES YES}

33. SIG: Ja ( ) *vemurge*, wee *weetsje* hoe laat ze me *woue koume wasse, tien eur. Woue* ze me *koume wasse.* (.1) Heb 'k ze *weggesjikt.*

  SIG: Yes ( ) *this morning,* kno *do you know* what time they *wanted to wash* me, *ten o clock* they *wanted to wash* me. (.1) I have them *arranged away.*

After sentence 28 Mr Sigar indeed does elaborate on his complaint, but this is not, as Nurse 1 maintains, a complaint about a lack of visitors; rather, his complaint is about the quality of the nursing care he is receiving.

Later on in the conversation, the emotional voice of Nurse 1 gains different overtones.

40.NUR1: <u>Maar</u> dat *hub* ik al *gedoon wienie kriege veer* de waterkoker *joong?*
    <u>But</u> I *have* already *done that when do we get* the kettle *honey*?
41.SIG: *Wa blief*?
    What do you say?
42.NUR1: *Wienie kriege veer* de waterkoker?
    When do we get the kettle?
43.SIG: Nee, ik *hub gein* cent *joong* ( )
    No, I *do not have* pennies *honey* ( )
44.NUR1: *Blijf <u>GIJ</u>* dat *ZOE <u>DA:ON</u>*?
    Keep <u>*YOU*</u> it <u>*DO:ING*</u> it *THIS WAY*?

In the transcript above, we see an excerpt from the conversation where the nurse exchanges her emotional voice for a controlling voice. This corresponds with what the nurse is trying to say: a new kettle is needed since at the moment they are making the broth with hot water out of the water dispenser. When, in sentence 43, Mr Sigar's response makes clear that he has no intention of buying a new kettle, Nurse 1 again uses a controlling voice by saying:

44.NUR1: *Blijf <u>GIJ</u>* dat *ZOE <u>DA:ON</u>*?
    Keep <u>*YOU*</u> it <u>*DO:ING*</u> it *THIS WAY*?

Through the controlling voice in sentence 44, Nurse 1 implies that it is not usual to make broth in this way and that he should buy a new kettle. In contrast with the patronizing voice, the controlling voice is not always accompanied by a shift to a louder speech volume.

40. NUR1: <u>Maar</u> dat *hub* ik al *gedoon wienie kriege veer* de waterkoker *joong?*
     <u>But</u> I *have* already *done that when do we get* the kettle *honey*?

In sentence 40, Nurse 1 adjusts to a controlling voice while her speech volume remains the same, while later in sentence 44 she raises her speech volume.

IVa.ii. Semantics

There is also an adjustment at the level of semantics. In this short conversation between the nurse(s) and Mr Sigar, Nurse 1 frequently uses the address term *joong* ('honey').

10. NUR1: *Weet* 'k *neet joong.*
     I *do not know*, *honey*.

Sentence 10 serves as an example here. In literal translation it means 'boy', but is used like the English 'honey'. *Joong* is a word that is often used in the Maastricht dialect to address or refer to a younger male person. The word *Joong* in this conversation is therefore inappropriately used because Nurse 1 is addressing Mr Sigar, who is more than forty years her elder. This leads to a reversed age hierarchy and, conjointly, an inversed power relation. Although the address term *joong* is inappropriately used in this conversation, Nurse 1 uses this expression four times within one and a half minutes.

IVa.iii. Syntax

A few adjustments in syntactic features are apparent in the conversation between the nurses and Mr Sigar. The first adjustment occurs at the beginning of the conversation:

6. NUR1: MENEER?
   NUR1: MISTER?
7. SIG: *Jao.*
   SIG: *Yes.*
8. NUR1: BOUILLON?
   NUR1: BROTH?

After the greetings, the conversation continues with a shortened sentence in (6). According to the nursing home's language norms, it would have been more appropriate to say 'Mister Sigar'. In earlier conversations with the nursing staff it was established that staff would call residents Mister or Mrs together their last name (while in other nursing homes the norm was to call residents by their first name). According to the manager of this nursing home, they chose to call residents by their last name to show them more respect. Nurse 1's 'Mister' is therefore inappropriate and a sign of disrespect.

Nurse 1's next sentence is also shortened. Instead of asking Mr Sigar if he would like to have some broth, Nurse 1 only says 'Broth?' in line 8. The fact that this could be uttered with a longer sentence becomes clear when Nurse 2 walks in and says:

39. NUR2: {*IECH* KOM U BOUILLON *MAKE MER*}/
39. NUR2: {*I* COME TO *MAKE* YOUR BROTH *BUT*}/

Another adjustment in the syntactic features is the regular use of tag questions:

14.NUR1: °Ik zeg° {IK *BIN D'N* PILLEN *AON 'T* DOEN} <u>HE</u>?
    °I say° {I *AM* DOING *THE* PILLS} <u>HUH?</u>

Line 14 provides an example of the tag question 'HE?'(HUH?). The nurse uses the tag question 'He?' (huh?) four times during the conversation.

IVb. Reinforcing the cultural narrative of ageism

The categories of belonging experienced as senses of 'us' and 'them' are not static, but rather denote shifting social identities which are themselves negotiated and achieved through language practices (Sebba and Wooton 1998: 282). Language practices reveal how people position themselves and others in alliance with, or in opposition to, people whom they see as (not) belonging to their own group(s) (Meinhof and Galasiński 2005: 102). The language used in everyday practices serves to achieve and confirm (multiple) belongings (ibid.: 13).

The adjustments in the speech of Nurse 1 towards Mr Sigar contribute to how she frames Mr Sigar's belonging. So far, I have discussed the observable adjustments in the nurse's speech. However, to understand how the nurse constructs belonging, it is

important to understand the meaning of her adjustments and the assumptions that are related to them.

It is likely that Nurse 1 adjusted her speech volume to be certain that Mr Sigar could hear her. It might therefore be thought that this adjustment in speech volume is in Mr Sigar's best interests. However, although Mr Sigar's hearing might show some decline, during the one and a half hour conversation that I held with him, during which I did not raise my voice, he seemed perfectly capable of hearing what I said and actively took part in our conversation. During the conversation with Nurse 1, Mr Sigar indicated twice that he did not hear what the nurse was saying. In one such situation, Nurse 1's turn had already been spoken in a loud voice. It is therefore a moot point whether the reason for Mr Sigar's interjection was auditory or something else. If it was indeed an auditory problem, Mr Sigar thus demonstrated his ability to let people know that he had not heard what had been said. At those junctures it would be appropriate to adjust the speech volume for his benefit. However, doing so throughout the conversation, as Nurse 1 does, implies that his hearing is seriously impaired. Instead of adjusting her language practices towards Mr Sigar's individual capacities, Nurse 1 adjusts her language practices towards a preconceived idea about 'the elderly' as a homogenous group. The adjustment is therefore rather a reinforcement of the ageism narrative whereby all older people are assumed to be frail and deaf.

In addition to the louder speech volume, the nurse's slower speaking rate also reinforces the ageism narrative. As discussed above, during the conversation Nurse 1 often speaks at a slower speaking speed. This adjustment is not the result of Mr Sigar signalling that he could not follow the conversation at a normal speed. The adjustment in Nurse 1's speech rate was therefore not an adjustment to Mr Sigar's needs, but rather a part of the ageism narrative according to which the competence of older people is questioned. In slowing her speaking rate, Nurse 1 reinforces the assumptions about the incompetence of older people with regard to language skills in general, and in this case more specifically Mr Sigar's incompetence.

During this conversation, the slower speaking speed and louder speech volume are often accompanied by a patronizing voice. A good example of this is when Nurse 1 says, 'Then I [will] come soon shortly back, but not now, now I cannot make it' in line 16, when rebuffing his request for bed-cleaning and waste removal. The patronizing voice in this sentence is apparent not only to the researcher and Mr Sigar,

but also to a test audience that listened to the audio recordings. By exchanging the emotional voice for a patronizing voice, Nurse 1 reinforces the perspective that older people are inferior and powerless. In using a patronizing voice, she performed a superior identity towards Mr Sigar. Moreover, she also mentioned that she was not going to make Mr Sigar's bed at the time of the conversation but later when she comes back. It was made clear that Mr Sigar had no control over when his bed was made and thus was dependent on Nurse 1.

But this power positioning does not go unchallenged by Mr Sigar. In the conversation, Nurse 1 uses the address term *joong*, which, as we have seen, is inappropriate. However, Mr Sigar's behaviour suggests that he tries to re-negotiate his position. As a man who has lived his entire life in Maastricht, he must know that the word *joong* is not used to address women. However, in line 43 he uses the word *joong* to address Nurse 1 in an ironic mimicry of her condescension. His knowing (mis-)use of the word *joong* indicates that he opposes it as a term of address, simultaneously showing that he is not passive and inferior and that he does not appreciate her patronizing voice.

Finally, by implying that Mr Sigar is depressed because he rarely has visitors, in line 28, Nurse 1 also reinforces the ageism narrative:

28. NUR1: En *NOG ME:R KLAOGE* he, *ZEEN'S IEMAND* he?

   NUR1: And *YET BU:T COMPLAINING* huh, *SEE ONCE SOMEBODY*, huh?

By saying this, Nurse 1 constructs a view of Mr Sigar as being depressed because he does not receive visitors. She also depicts him as passive, resorting to complaining about his supposed loneliness, rather than taking action by meeting some of the other residents in the common area. In fact, his complaints are about the quality of the care in the nursing home, which he is seeking to improve especially with respect to cleaning his bed.

V.   Conclusion: belonging to the old and unsuccessfully aged

Belonging is always a continuous process, and its discursive processes construct, claim or resist the formation of borders of inclusion and exclusion (Antonsich 2010: 646). Belonging to one group simultaneously indicates not belonging to another

group, but this can misfire. One can claim to belong to a certain group, but this might not be recognised externally.

By using elderspeak, the nurse in the nursing home indexed her attribution of the ageist narrative to Mr Sigar. From the nurse's language practices, it is evident that she sees Mr Sigar as belonging to a group of 'the elderly' who are incompetent, dependent, passive, powerless, inferior, weak, depressed and frail (Cruikshank 2008: 149-150; Lagacé et al. 2012: 336; McHugh 2003: 180). Mr Sigar, however, does not identify with the belonging that the nurse tries to impose on him and therefore negotiates it, for instance, through his ironic misuse of the word *joong*.

In order to achieve belonging to the standard of people who age successfully, those people must be responsible for their health, physical and cognitive functions, and sustained engagement in social and productive activities (Lamb 2014: 44; Rubinstein and De Medeiros 2015: 38). People who show any decline physically or cognitively and who are not active in social and/or productive activities are ageing unsuccessfully, and it is implied that this is their own fault. In the excerpts presented in this article, the nurse uses elderspeak to attribute the characteristics of deafness, incompetence, inferiority, powerlessness, dependence, depression and passivity to Mr Sigar. Therefore, elderspeak used in talking to residents not only reinforces older people's place in the ageism narrative, but also their belonging to the group of people who age unsuccessfully.

As shown above, elderspeak is not an adjustment in language practices that is made for Mr Sigar as an individual, but rather for a prejudiced projection of Mr Sigar in the ageist narrative, whereby all older people belong to a homogenous group. Here, all the adjustments in the language practices of the nurse were unnecessary and were not based on Mr Sigar's capabilities. Obviously the capabilities of residents vary, and for some, one or more of the adjustments in language practices that are related to elderspeak may be necessary and appropriate. As the transcript shows, adjustments in the nurse's speech framed Mr Sigar as belonging to the unsuccessfully aged. This, however, was not Mr Sigar's perception, and he succeeded in making that known.

References

Antonsich, M. 2010. Searching for belonging: an analytical framework, *Geography Compass* 4/6, 644-659.

Auer, Peter 2007. The monolingual bias in bilingualism research, or: why bilingual talk is (still) a challenge for linguistics, in Monica Heller (ed.), *Bilingualism: a social approach*, London: Palgrave Macmillan UK.

Balsis, S., and B.D. Carpenter 2006. Evaluations of elderspeak in a caregiving context, *Clinical Gerontologist* 29/1, 79-96.

Bernard, H. Russel 2002. *Research methods in anthropology: qualitative and quantitative approaches*, Walnut Creek CA: Altamira Press.

Boelsma, F., V.E. Baur, S. Woelders and T.A. Abma 2014. 'Small' things matter: residents' involvement in practice improvements in long-term care facilities, *Journal of Ageing Studies* 31, 45-53.

Bucholtz, M. 2000. The politics of transcription, *Journal of Pragmatics* 32, 1454-1465.

Coupland, Nikolas, Justine Coupland and Howard Gilles 1991. *Language, society, and the elderly: discourse, identity and ageing,* Oxford: Wiley-Blackwell.

Cruikshank, M. 2008. Aging and identity politics, *Journal of Aging Studies* 22, 147-151.

De Bot, Kees, and Sinfree Makoni 2005. *Language and aging in a multilingual context,* Clevedon: Multilingual Matters.

Glaser, Barney G. and Anselm L. Strauss 1967. *The discovery of grounded theory: strategies for qualitative research,* Chicago: Aldine.

Gullette, Margaret Morganroth 2004. *Aged by culture,* Chicago: The University of Chicago Press.

Hammersley, Martyn, and Paul Atkinson 2007. *Ethnography: principles in practice,* New York: Routledge.

Jørgensen, J.N., M.S. Karrebaek, L.M. Madsen, and J.S. Møller2011. Polylanguaging in superdiversity, *Diversities* 13/2, 23-36.

Laceulle, H., and J. Baars 2014. Self-realization and cultural narratives about later life, *Journal of Ageing Studies* 31, 34-44.

Lagacé, M., A. Tanguay, M.L. Lavallee, J. Laplante and S. Robichaud 2012. The silent impact of ageist communication in long term care facilities: elders' perspective on quality of life and coping strategies, *Journal of Ageing Studies* 26, 335-342.

Lamb, S. 2014. Permanent personhood or meaningful decline? Toward a critical anthropology of successful ageing, *Journal of Ageing Studies* 29, 41-52.

McHugh, K.E. 2003. Three faces of ageism: society, image and place, *Ageing and Society* 23, 165-185.

Meinhof, Ulrike Hanna, and Dariusz Galasiński 2005. *The language of belonging,* New York: Palgrave Macmillan.

Padgett, Deborah K. 1998. *Qualitative methods in social work research: challenges and rewards,* Thousand Oaks CA: Sage Publications.

Rubinstein, R.L., and K. De Medeiros 2015. 'Successful ageing'. Gerontological theory and neoliberalism: a qualitative finding, *The Gerontologist* 55, 34-42.

Samuelsson, C., E. Adolfsson and H. Persson 2013. The use and characteristics of elderspeak in Swedish geriatric institutions, *Clinical Linguistics and Phonetics* 27/8, 616-631.

Sebba, Mark, and Tony Wootton 1998. We, they and identity: sequential versus identity related explanation in code-switching*,* In P. Auer (eds.), *Code-switching in conversation: language, interaction and identity,* New York: Routledge.

Sokolovsky, Jay 2009. *The cultural context of ageing: worldwide perspectives,* Westport: Praeger Publishers

Swinnen, A., and C. Port 2012. Ageing, narrative, and performance: essays from the humanities, *International Journal of Ageing and Later Life* 7/2, 9-15.

.

Williams, K., S. Kemper and M.L. Hummert 2003. Improving nursing home communication: an intervention to reduce elderspeak, *The Gerontologist* 43/2, 242-247.

Appendix

Context: 29 October 2015, 4.30 PM. Audio recording (1m.28s) with Mr. Sigar [SIG], 1st nurse [NUR1], 2nd nurse [NUR2] and researcher [RES]. [1]

1. NUR1: (Deur gaat open)
2. SIG: Daar komen ze, daar komen ze.
3. RES: HALL::O
4. SIG: =°Hallo °=
5. NUR1: =°Hallo °=
6. NUR1: MENEER?
7. SIG: *Jao*
8. NUR1: BOUILLON?
9. SIG: Ja. (.1) *Wee ˙kump m'n bèd opmaken?*
10. NUR1: *Weet 'k neet joong.*
11. SIG: ( )
12. NUR1: {*IECH NEET*} in ieder geval, *ich {bin D'N PILLEN} aon 't doen.*
13. SIG: *Wa blief?*
14. NUR1: ° Ik zeg° {IK *BIN D'N* PILLEN *AON 'T* DOEN} HE?
15. SIG: Oh
16. NUR1: {*DAAN* KOM *ICH* STRAKS *eve*} trök, {*MER NOE NEET, NOE RED ICH DA NEE:T*}
17. SIG: Oh
18. NUR1: Ja:aa?
19. SIG: *Höbste zoe drök, joh?*
20. NUR1: {*JAO,* IK *BIN ALLEIN* HE *MÈT D'N PILLEN* HE}.
21. SIG: Oh
22. NUR1: {IK *HÖB GEIN HÖLP NOE*}.
23. SIG: O, jee
24. SIG: (.3) Ik *höb bezeuk.*
25. NUR1: *Jao, DAT ZEEN 'K, GEZÈLLEG*
26. SIG: =*Jao*=
27. RES: =Lacht=
28. NUR1: En *NOG ME:R KIAOGE* he, *ZEEN 'S IEMAND* he?

1. NUR1: (Door opens)
2. SIG: Here they come, here they come.
3. RES: HELL::O
4. SIG: =°Hello °=
5. NUR1: =°Hello °=
6. NUR1: MISTER?
7. SIG: *Yes*
8. NUR1: BROTH?
9. SIG: Yes. (.1) *Who will make my bed?*
10. NUR1: *I do not know, honey.*
11. SIG: ( )
12. NUR1: {*I'M NOT*} anyway, I {*am*} doing {*THE* PILLS}.
13. SIG: *What do you say?*
14. NUR1: °I say° {I *AM DOING THE* PILLS} HUH?
15. SIG: Oh
16. NUR1: {*THEN I* COME SOON *shortly*}, back {*BUT NOT NOW, NOW I CAN NOO:T MAKE IT*}.
17. SIG: Oh
18. NUR1: Ye:es?
19. SIG: *Are you busy,* huh?
20. NUR1: {*YES, I AM ALONE* HUH *WITH THE* PILLS, HUH}
21. SIG: Oh
22. NUR1: { I *HAVE NO HELP NOW*}
23. SIG: O, yeah
24. SIG: (.3) I *have a visitor*
25. NUR1: *Yes, I SEE THAT, COZY.*
26. SIG: =*Yes*=
27. RES: =Laughs=
28. NUR1: And *YET BU:T COMPLAINING* huh, *SEE ONCE SOMEBODY,* huh?

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[1] Transcription conventions are as follows:
WORD: Loud voice, relative to surrounding
°word°: soft voice, relative to surrounding talk
=word=: simultaneous speech
word: in dialect
{word}: words for which decelerated slower speech applies
word: stress on (part of) word
wo:rd: prolonged vowels
wor/: interruption
(.1): pause in seconds
( ): transcriber could not hear what was said

29. RES: =Lacht=
30. SIG: =Ja= (.1)
31. SIG: *Klaoge* dat ze /
32. NUR1: {JA JA}
33. SIG: Ja ( ) *vemurge*, wee *weetsje* hoe laat ze me *woue koume wasse* ,*tien eur*. *Woue* ze me *koume wasse* (.1) Heb 'k ze *weggesjikt*.

34. NUR1: (.1) Ja:a
35. SIG: Ja
36. NUR2: (2e verzorgende loopt binnen) Hall:o
37. SIG: Hallo
38. NUR2: Hai
39. NUR2: {*IECH* KOM U BOUILLON *MAKE MER*} /
40. NUR1: Maar dat *hub* ik al *gedoon wienie kriege veer*de waterkoker *joong*?
41. SIG: *Wa blief?*
42. NUR1: *Wienie kriege veer*de waterkoker?
43. SIG: Nee, ik *hub gein* cent *joong*.
44. NUR1: *Blijf GIJ* dat *ZOE DA:ON?*

45. SIG: 'T is toch *werm genög* 'k *moot da* toch *laote afkeule*.
46. NUR1: (.2) °Ja°. Tot straks he, *joong*.
47. SIG: Oke, he.
48. NUR1: HAI.
49. SIG: Hai.

29. RES: =Laughs=
30. SIG: =Yes= (.1)
31. SIG: *Complaining* that they /
32. NUR1: {YES YES}
33. SIG: Yes ( ) *this morning* kno *do you know* what time they *wanted to wash* me, *ten o clock* they *wanted to wash* me. (.1) I have them *arranged away*.

34. NUR1: (.1) Ye:es
35. SIG: Yes
36. NUR2: (2nd nurse walks in) Hell:o
37. SIG: Hello
38. NUR2: Hi
39. NUR2: {*I* COME TO *MAKE* YOUR BROTH *BUT*} /
40. NUR1: But i *have* already *done that when do we get* the kettle *honey*?
41. SIG: *What do you say?*
42. NUR1: *When do we get* the kettle?
43. SIG: No, I *do not have* pennies *honey*
44. NUR1: Keep <u>*YOU*</u> it <u>*DO:ING*</u> it *THIS WAY?*

45. SIG: It is *hot enough I have to cool it* anyway.
46. NUR1: (.2) °Yes°. See you later huh, *honey*.
47. SIG: Okay, huh.
48. NUR1: HI.
49. SIG: Hi.