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Communication Accommodation Theory	Theory		Carma	2500	Nicola Sheeran, Ying Jin, Rachyl Pines, Liz Jones	1/31/2021

Communication Accommodation Theory

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Abstract

Communication accommodation theory (CAT) has been used in health contexts to explain and predict when, why, and how people adjust (or not) to other people's communication language and style. By considering a range of micro and macro level factors, CAT highlights the way that health systems, such as hospitals, prime a range of group identities, including roles (e.g., patient, clinician), professions (e.g., doctor, nurse) and/or specialties (surgical nurse, cardiologist). Communication encounters in healthcare settings are influenced by these group identities, whereby interactants use a range of strategies to either adjust their communication to be more like their communication partner (i.e., accommodation) or to be less similar (non-accommodation). Communication can be more interpersonal or intergroup depending on a range of factors, such as sociocultural norms, relationships between the groups, and the history between the interactants. CAT addresses a key criticism of communication research by highlighting the intergroup nature of health communication. The model lends itself to understanding patient-clinician communication interprofessional communication, and health communication interventions, which may improve health service delivery and patient safety.

Keywords

Communication Accommodation Theory, Intergroup communication, Interpersonal communication, Health communication

Main text

Communication Accommodation Theory (CAT) developed in the early 1970's after Howard Giles (CAT's originator) observed how people adjust their speech according to who they are talking to. Models of communication at the time ignored such variations, viewing it as "noise". Giles however, sought to understand this phenomenon, leading to the development of speech accommodation theory (SAT) and subsequently CAT. CAT is a psychosocial model explaining and predicting when, why, and how people accommodate (or not) to other people's communication style and language, their motivations for doing so, and the communicative, relational, and social consequences, including health outcomes. Ultimately, CAT explains how aspects of communication and language, such as accent, tone of voice, and word choice, move people closer together, enhancing perceptions of similarity, or move people apart, by highlighting perceptions of differences.

Early CAT research identified three ways people adjust their communicative behaviors to achieve their communication goals: convergence, divergence, and maintenance. Convergence involves adjusting all or part of one's communicative behaviors to be more similar to another's. Divergence involves adjusting one's communicative behaviors to be more dissimilar to another, and is especially common when interactants' different roles or group memberships (e.g., social identities) are primed, or intergroup relations are salient. Maintenance refers to maintaining one's 'default' communication behaviors without adjusting for others. Using a range of sociolinguistic strategies, people adjust their communication relative to the goals of the conversation or their partner's needs/characteristics. However, CAT theorizes a range of macro and micro level factors beyond the interaction itself, that shape communication before, during and after the encounter. Below we discuss the health context and how the roles of patients and clinicians shape communication encounters. We then provide an overview of the model before we outline how CAT has been applied to health contexts.

[A] Roles/Health Professions as social groups

A fundamental premise for CAT researchers is that interactions occurring in health care settings are interpersonal interactions that occur at an intergroup level (Watson, Hewett, Gallois, 2012). CAT draws on Social Identity theory to explain how individuals identify themselves and others as members of social groups (ingroups, which are groups a person is a member of, and outgroups, or groups a person does not belong to). Watson et al (2012) argue that clinicians and patients categorize themselves and others across a range of group identities that shape communication (e.g., roles such as doctor or patient; professions such as doctors or nurses; specialties such as surgeons or obstetricians). Group identities can be more or less salient, depending on the context, and the more a person focusses on the group membership of their communication partner rather than on their individual characteristics, the more likely the communication will be based on stereotypes.

Not only do clinicians communicate with their patients, but they also communicate with a diverse range of other clinicians, each from their own particular professional, specialty, and cultural background(s). This creates challenges, as each health profession has its own language, norms, and rules, that may not be shared across professions. Professions can also differ in status and power, creating an environment with a myriad of intergroup dynamics at play, that can lead to miscommunication and conflicts, that ultimately impact patient care and outcomes.

[A] An Overview of Communication Accommodation Theory

CAT proposes a range of antecedent conditions that influence communicative behaviors in an encounter, including one's *initial orientation,* or predisposition for how they perceive their communication partner and the interaction. Macro level factors influencing a person's initial orientation include their interpersonal history, sociocultural norms and values, and the current and past state of intergroup relations, which influence whether each interactant approaches the communication encounter with an interpersonal or intergroup orientation.

The *interpersonal history* between interactants can vary in duration and valence. For example, interactants may be communicating for the first time (e.g., an initial doctor/patient consultation) or may have a long-term relationship (e.g., a nurse and doctor who routinely work together), and that relationship may be negative or positive.

Sociocultural norms and values specify appropriate behaviors in the given context. For example, in hospitals, it would be counter-normative for junior nurses to challenge doctors' medical directives, especially in front of a patient.

Intergroup relations refers to the current and past relationships between the groups. When interactants belong to groups that have a history of conflict, they are more likely to view the communication encounter in intergroup terms and communicate in ways that emphasize the differences between groups.

CAT also outlines a range of factors that dynamically shape communication *during* the interaction, including motivations, ability, norms, and accommodation strategies. We focus here primarily on accommodation and the strategies CAT theorizes that interactants employ, as these have received the most attention by researchers. However, we also note that the motivation and ability of the interactant, and the norms for the specific encounter, influence the use of different strategies.

[A] Accommodation as core of the theory

Central to CAT is the notion that people adjust, or "accommodate", their communicative behaviors to one another during a communication encounter. This can include adjusting speech patterns, language use, accent, dialects, communication styles, and other verbal and non-verbal behaviors. Additionally, there are two types of non-accommodation, where people, either consciously or unconsciously, do not adjust their behaviors appropriately. *Under*accommodation occurs when a communication partner does not adjust at all, or does not adjust enough, to meet the needs of their communication partner (e.g., a doctor uses an excessive amount of technical medical jargon when talking to a patient). *Overaccommodation* occurs when people adjust their communication too much, beyond what is reasonably considered appropriate (e.g., speaking in a patronizing manner, or speaking more loudly and/or slowly than is appropriate to an elderly patient). Accommodation is typically viewed more favorably than non-accommodation.

CAT also posits that people use a range of sociolinguistic strategies to attune to their conversational partner. To date, there are at least five sociolinguistic strategies articulated in the model: Approximation, Interpretability, Discourse Management, Emotional Expression, and Interpersonal Control.

Approximation involves making one's language and communication similar (convergence) or dissimilar (divergence) from another. For example, a doctor slows down their speech rate to match the patient's rate of speaking.

Interpretability involves adapting communication to help comprehension of the message. For example, a clinician may use less technical medical terms in a conversation with a patient who has less health literacy than with a patient who is highly educated and has medical knowledge.

Discourse Management focuses on managing the interaction, such as regulating turn-taking and topic selection to ensure that each speaker is listened to and engaged in the conversation, such as a nurse asking for a patient's opinion.
Interpersonal Control involves interactants focusing on role relationships within an interaction and may keep people in a particular role or, conversely, establish a common role. For example, using honorifics, such as calling a medical professional "Doctor" and a nurse by their first name highlights the roles and establishes status in the interaction.
Emotional Expression involves attending to the emotional or relational needs of one's communication partner. For example, addressing the concerns or providing reassurance to an anxious patient.
Face management strategies are less well researched strategies that may be particularly important in intercultural communication encounters, as they concern the public self-image of people. *Positive face* involves managing a person's need to be liked and respected and have their wishes appreciated, while *negative face* involves managing a person's need to be independent, free of demands, or impositions, for example where a doctor adjusts the timing of a ward visit to accommodate a nurse's meal break.

In conversation these strategies overlap and may be used consciously or unconsciously. Each strategy may heighten or reduce intergroup differences. As such, CAT helps us to explain how interpersonal and intergroup dimensions of a conversation shape the interaction through accommodative and nonaccommodative communicative behavior(s).

The final stage of the CAT model addresses evaluations of the interaction and interactants' future intentions. Here interactants make judgements about the effectiveness of the communication encounter and whether their goals were met. Their experiences of the communication encounter then shape how they intend to speak with similar individuals in the future.

One criticism of CAT is that it is a particularly complex model. However, the complexity and range of factors accounted for in the model are also seen as its strength. The model and its propositions are continually being refined, with recent work by Dragojevic, et al., (2015) proposing the most parsimonious propositions to date. Research using CAT to explain the nuances of talk in interactions, particularly in health, is in its infancy. However, below we review a selection of studies that highlight CAT's major contributions to understanding communication in health contexts.

[A] CAT in the Health context.

To date, CAT has been applied to health communication in three ways: patient-clinician communication, interprofessional communication, and health communication interventions.

A key way CAT has increased our understanding of communication in the health context has been through examining how patients and clinicians accommodate (or not), and the implications this has for patients. For example, research exploring the relationship between CAT strategies and patient satisfaction demonstrated that using a blend of interpersonal control, discourse management and emotional expression strategies predicted patient satisfaction (Watson & Gallois, 1999). Both patients and clinicians tend to accommodate on interpretability and typically account for the other's knowledge and disposition when communicating. Conversely, there is often a struggle for control, primarily by the clinicians, who may underaccommodate on interpersonal control (Farzadnia & Giles, 2015). Clinicians typically manage the discourse better than patients, by enabling patients to contribute to discussions (Farzadnia & Giles, 2015), which parents who have infants hospitalized in a neonatal care unit perceived as a particularly effective communication strategy (Jones, Rowe, & Woodhouse, 2007). In this context, accommodative emotional expression is also perceived as effective, while under-accommodative interpretability (i.e., did not explain

enough), interpersonal control (i.e., treated as just another parent) and face (i.e., being scalded and talked down to) were ineffective. There are also gender differences in parents' perceptions of communication, with mothers most often describing face and interpersonal control and fathers describing interpretability as ineffective (Jones, et al., 2007).

CAT is particularly useful for considering intersectionality (i.e., the ways that different identities intersect), with researchers examining perceptions of communication for people with intersecting group memberships or identities such as age, ethnicity, and roles. For example, Jones, Sheeran, Lanyon, Evans, and Martincovic (2018) found that nurses used different communication strategies with minority social groups (i.e., teenage mothers and mothers from culturally and linguistically diverse backgrounds) compared to parents from the majority group. Interactions with majority group parents were described in more interpersonal terms and interactions with parents from minority groups were more intergroup, with less accommodation on discourse management and emotional expression and over accommodation on interpretability and face.

CAT is also a useful framework for exploring communication between different clinicians, including the implications for patient safety. Watson, et al., (2012) review several studies investigating communication between different clinicians, including doctors from different specialties. They report accommodation was generally the stance taken when other specialists were required to aid patient care. However, non-accommodation was common when intergroup conflict was present and was, for example, used by doctors to deflect responsibility for patient care and distance themselves and their specialty from other doctors. Interpersonal control strategies were employed to emphasize status and role, and under-accommodation was prevalent (e.g., not responding to written requests for assistance). They also found medical records written by one specialty used highly abbreviated language that was open to misinterpretation by doctors not from that specialty, and medical notes were signed using collective names rather than personal names (e.g., *Surg reg* [surgical registrar] and no name of doctor). Thus, communication, particularly by the higher status specialist doctors, sought to emphasize the differences between the professions with a range of implications for patient safety (Hewett, Watson, Gallois, Ward, & Leggett, 2009).

CAT also informs training and interventions to improve communication in health settings. A recent study by Chevalier, Watson, Falconer, and Cottrell (2017) demonstrated that training pharmacy students in CAT accommodation strategies resulted in improved knowledge about the importance of communicating with patients, and improved students' communication. Pines, Giles, and Watson (2019) developed a training program to prevent patient-perpetrated workplace violence. The CAT-based intervention highlighted the role of attitudes and organizational norms in how clinicians were responding to aggressive behaviors.

Together, these studies highlight the utility of CAT as a framework to examine how intergroup identities influence interpersonal communication in the health context. Interventions using a CAT framework have the potential to improve patient outcomes, including safety, by improving communication between both patients and clinicians, and the different clinicians involved in a patient's care.

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Further Reading/Resources

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Contributor Bio

Nicola Sheeran is a Lecturer in the School of Applied Psychologist at Griffith University. Her research interests sit generally in the social health psychology field and she has a particular interest in communication in health contexts, the role of culture in patient preferences for health communication, and interpreter use for culturally and linguistically diverse people, and unplanned pregnancy, domestic violence, and reproductive coercion. Nicola serves as a regional representative for the International Association of Language and Social Psychology and has recent publications in *Health Communication* and *Patient Education and Counselling*.

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Rachyl Pines is a Research Scientist at Santa Barbara Cottage Hospital. After completing her PhD in Communication from University of California, Santa Barbara, she completed a postdoctoral research fellowship with the Terasaki Institute for Biomedical Innovation and University of California, Los Angeles. Rachyl conducts research in behavioral health, population health, and intergroup communication topic areas to improve patient education and care. Rachyl serves as an executive officer for the Intergroup Communication Interest Group for the International Communication Association, and for the International Association of Language and Social Psychology.

Professor Liz Jones is Head of Department of Psychology at Monash University Malaysia and President of International Association of Language and Social Psychology. Her research interests are in an intergroup approach to health and organisational communication, and its impact on the quality of patient care. She is interested in both health practitioner-patient communication and interprofessional practice. She has particular expertise in communication and quality of patient and family care in neonatal nurseries. Her intergroup approach considers the intersection between multiple identities in health communication, with recent publications in Patient Education and Counseling and Health Communication.

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