

► Frail elderly people: difficult questions and awkward answers

▷ Valerie Hey

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Defining the focus of the research

This chapter reflects on my experience of conducting a small qualitative study of community care, decision making and the frail elderly. It tries to capture how some frail elderly people live out their lives in the context of social divisions and their associated forms of social exclusion. The authorial voice assumes the impossibility of doing value-free social science investigation.¹ The chapter focuses on specific methodological issues in order to raise wider theoretical and sociopolitical questions common to all social policy investigations. The main intention is to trace how different 'stakeholders' come to define how people (in this case, the frail elderly) are positioned in terms of policy, practice and research accounts. A major concern is to promote an understanding of the impacts of policy, practice and representation on the frail elderly, who are so often made subject to the intentions of others.

The context of social policy: the 'new' community care, rights and the position of elderly people

During the 1980s and early 1990s, major policy changes in the field of the care of the frail elderly brought an enormous expansion in private sector care. During the 1980s, capacity in the private sector more than trebled and public sector investment virtually ceased. Current community care policies in the UK emphasize the importance of 'consumer' choice, and of professionals consulting fully with their clients. A great deal has been written about

the intentions of community care under the Griffiths reforms.² A main aim of the NHS and Community Care Act 1990 was the encouragement of the private sector as provider of 'customized' social services. Greater emphasis was placed on clients having a 'choice' within this newly invigorated private sector. Social Service departments (SSDs) were divested of much of their role as providers of services and seen instead as 'enabling authorities'. The main platform of the then Conservative government's reforms was a series of claims to:

- enable people to live as normal a life as possible in their own homes or in a 'homely' environment in the local community;
- provide the amount of care and support needed to achieve maximum independence;
- give people greater choice and independence

As Julian Le Grand has argued, the shift to marketization has meant the growth of a new managerialism within a culture of what can be termed 'quasi-markets'.³ The development of marketization raises fundamental issues to do with the exercise of choice.⁴ Since different consumers and 'stakeholders' hold different 'collaterals' as well as different interests, there is concern about the way in which these 'social markets' may intensify existing inequities and/or produce new ones.

Defining the 'frail' elderly in the literature

Age is an important defining characteristic in all human societies, but the statuses, rights and responsibilities associated with being both 'young' and 'old' differ considerably between different societies.⁵ One of the features of a culture that considers biological age important is 'age determinism' – the tendency to attribute to age itself a whole range of individual characteristics and personal problems. A popular cartoon in pensioners' publications is the one that shows a doctor bent over an elderly woman's leg and saying, 'It's your age'. Her reply is, 'But the other one is just as old, and it's alright!'⁶

This problem of definition extends to social research. In choosing to research the 'frail elderly', the researcher may be accused of ageism and thus of defining elderly people out of the 'normal' population of adults. Many of the difficulties older people experience are problems of the body and of dependency, and are assumed at the opposite end of the age scale. None the less, older people do commonly experience many different social circumstances, perceptions and experiences, which together provide a framework for research, professional practice and policy domains. Funders and social policy makers are properly interested in what will, after all, come to be an increasingly larger group of the population.⁷

Research traditions

There is an overwhelming tendency within academic and social policy literature to pathologize, stigmatize and marginalize the elderly. Old people are generally defined negatively as lacking physical, financial and mental resources, and as a 'liminal' group.⁸ The negative stereotype arises through the domination of gerontology in the literature, with its emphasis on normative psychological and medical models.⁹ This confluence of disciplines has worked to suppress the perspectives of older people themselves.¹⁰ However, there is a developing analytic literature, which studies elderly people's talk, in the context of intergenerational exchanges.¹¹ But there are significant gaps in what is known about the situation of elderly people with respect to their involvement in care decisions. The existing accounts tend to take the form of superficial 'customer satisfaction' surveys and hence lack the 'thick descriptions' that can offer important insights into the social processes of ageing. One irony is that although the literature includes many studies about the elderly body, they construct elderly bodies in disembodied ways separated from social accounts. In contrast, the fictional/semi-fictional literature with extreme old age as its theme – especially work by Margaret Forster and Michael Ignatieff¹² – provides this missing account of the social, psychological and material processes involved in becoming frail or elderly.

In locating my self against the medical and social gerontological literature I also took a decision to break away from the practice of qualitative studies, which allow proxy respondents, frequently the 'carers' of older people, to speak on their behalf. I wanted to disrupt the 'Does s/he take sugar?' syndrome so resented and remarked upon by the elderly people I spoke with. As reported below, the challenges prompted in the process of face-to-face participant observation make up an important group of the research 'findings'; moreover they draw attention to what is at stake in the delicate (far from transparent) networks of meaning-making that underlie social research. More pragmatically, what I discovered about process powerfully reminded me of the need for generation-sensitive approaches and for theoretical attention to how the elderly are 'spoken' in our society.

The goals of the research

The Headley Trust, commissioners of the research reported on here, were rare in specifically wanting to discover the views of the frail elderly themselves. There has been an increasing emphasis on collecting recipients'/clients' views but overall it is still a minority position within social policy research and social work practice. On the basis of medicine and psychology and their associated professional ideologies and practices, those purchasing

services and providing them for elderly people continue to view clients in traditional ways as passive recipients of care. The study formed part of the move to new policy developments that welcomed people's engagement in community care decision making. But as I report below, even well intentioned initiatives and individual actors are themselves caught within configurations of power that they might simultaneously wish to change and challenge.

Certainly the group of people I interviewed and got to know included some of the most disadvantaged in our society. Several of the study participants had been diagnosed as having dementia, many were incontinent, most were physically disabled and the majority were extremely poor, including two who, prior to social services intervention, were defined as in a state of extreme self-neglect. This is a depressing and familiar but also a problematic representation of the frail elderly. They are neither a homogeneous nor a powerless group of victims.¹³ I specifically set my study in a more interactive tradition, one that recognizes respondents as more than the casualties of circumstance, however disadvantaged.¹⁴ My interpretation shows how respondents' tenacity, humour and occasional resistance worked to complicate and at times almost unravel my research agenda. I believe there are lessons here to be drawn about other information gathering practices, notably 'needs assessments'.

But I do not want to overstate the extent of individual agency. As I gathered stories from the people I interviewed, I became acutely aware of how our ageist and 'healthist' society structures the social experience of the frail elderly. Most frail elderly people have little 'physical capital',¹⁵ and one major effect is marked by their virtual social elimination from public view, designed-out of communities, homes and facilities that presume able-bodiedness. The frail elderly are one version of 'the disappeared'.

The research process

The study

The main aims of the study were to explore the social contexts of community care, and to understand how decisions about the care of elderly people were actually made, with a focus on the place of 'consumer choice' in community care outcomes. More specific objectives were:

- to explore the views and experiences of frail elderly people and those caring for them when making choices about their care;
- to look at relationships between mental competence and physical dependence, health, social support, and the social circumstances of frail elderly people;
- to make practical and policy recommendations about the involvement of frail elderly people in choices about their living circumstances.

The study was undertaken in two sites in London (Inner City and Riverside). These pseudonyms offer raw clues about their different socio-demographic profiles. However, getting access to the frail elderly was equally difficult in both sites. Indeed this difficulty is a marker of their lack of social and political power. For reasons of pragmatism, I relied upon sponsorship from their 'gatekeepers': care managers/social workers, since they were the first point of contact for this specific group of clients and their carers/families. The sample was recruited through the snowballing technique. As I wanted to learn about the social processes of decision making, I used a participant observation approach, seeking out occasions when professionals, family members and clients were involved in critical care decisions. In particular, I focused upon recording discussions between elderly people and their social workers/care managers. These sometimes took the form of a formal *community living assessment* – effectively risk assessments – when the care managers were appraising their clients' social, health and personal circumstances in order to obtain a picture of their care needs. I also attended *review* meetings; where care managers/social workers obtained feedback from elderly people and their carers about the current status of their pattern of care. In addition, I accompanied health and social work professionals on ward rounds in geriatric hospitals. I also visited several day centres.

In total, I interviewed 17 elderly people, (many of them several times) five social workers involved in their care; and key people who were in the elderly person's social network. This group included two neighbours, four family carers, one unpaid non-family carer and two family members not involved in the practical care of the elderly person. I additionally interviewed one home care organizer and two senior nurses; one at a geriatric hospital and the other at a voluntary sector nursing home.

On the whole, the elderly people I spoke with were accustomed to being 'interviewed'; to people coming to do something 'to' them or 'for' them. They were not generally experienced at making 'choices' in the newly privatized marketplace of personal social services. Thus it was difficult to frame an ostensible research task designed to encourage reflexivity – that is to discover frail elderly people's views about their role in consultations concerning their care – since they seldom identified themselves as 'consumers', let alone 'consultees'. These contradictions emerged at their most intense within initial exchanges. This is because first meetings involve the negotiation of levels of trust, which orchestrate, often at an unconscious level, what is said in the immediate moment as well as set up the viability of longer term and repeat visits. At these times they confused me *with* a social worker. The use of the term 'social researcher' seemed to stimulate this innocent mistake and they then assumed that I could offer advice about services. Conversely, at other times, I was told that because I was unable to do anything about someone's situation there would be no point

in talking with me. Clearly these and other issues of power organize the negotiation of degrees of disclosure and continue to impact at all stages in the research process, none more so than in the production, interpretation and representation of others' voices. I turn to these concerns next.

Interpreting dissident discourses – means and ends

One major imperative for the funders and the researcher was to discover the prior, as well as current, circumstances of the elderly person in terms of housing, social relationships and health. It was evident that only those with sufficient amounts of 'capital' had managed to benefit from 'care in the community'.¹⁶ My requests for information were overlaid by the complexities of some elderly subjects' mental confusion, social isolation and relative powerlessness. But although power might appear to lie with me and my well intentioned quest to know, I was 'read' by interviewees and frequently resisted in terms of this power as the following two extracts show:

VH: Can you tell me how long you've lived here?

FB: Mmm.

VH: How long have you been here?

FB: Not really very long, about three weeks.

VH: About three weeks, and where were you living before?

FB: In my own home.

VH: Yes, was that a flat or...

FB: Yes, it was.

VH: Were you managing to live there on your own?

FB: Yes, I was, I don't want to be... about my business all the time.

VH: Don't you?

FB: [unclear]

VH: No, I remember you said last time, well the time I called in for the last visit you said... if you're a social worker I won't fill any forms in.

Yeah, what else do you like doing?

FB: I like that! There you go again you must ask questions...

Or again, in another example I am trying in this opening exchange to establish an acceptable territory of talk:

VH: I'm a social researcher from the University of London and I'm involved in some work on community care.

GR: Community what?

VH: Community care and what happens to older people in the community and...

GR: Well, I'll do my best.

VH: Yes.

GR: I don't suppose we're all the same.

VH: No . . . I've got some very different stories, from some . . . I'm interested in the sort of patterns of care and whether older people themselves feel they've been consulted about what happens to them.

GR: Well I think that's a mistake you know in the beginning.

VH: What . . . to consult with them?

GR: To ask them too many questions, and then to . . . you know with what they [unclear] and I've had to do so much in my life by myself . . . I don't know what I can do about that . . . go on, carry on and see what you can do.

These responses are not examples of elderly 'eccentricity' – although I think 'common-sense' often constructs this group as the originators of the bizarre. Instead I want to suggest that the 'failures' to comply shown by Miss Beech or the equally interesting reinterpretation proposed by Miss Rowan, offer opportunities to think aloud about the (taken for granted) social processes in play when researchers attempt to locate themselves in someone else's world. Inevitably, the work of location is easier to see when things *do not* go smoothly!

Although it is important to acknowledge the specific challenges of gathering data within the context of elderly frailty, these should not be conflated in (paternalistic) notions that inevitably presume elderly people's bodily and mental *incapacities*. Respect for the integrity of elderly people was the basis of my approach – indeed it was this assumption that was most often undermined by staff in the social settings in which the research discussions took place. These occurrences put me, like the people interviewed, under pressure to comply – whereas I was a guest, they were residents (see later). However, and paradoxically, some of the most 'vulnerable' people in the study proved to be the most resourceful in resisting my attempts to consult them. Why do my opening questions lead Miss Beech and Miss Rowan in their opposing ways to variously sabotage or reposition my agenda? They had, after all, both agreed to 'be interviewed' but then both question my questioning. Each woman has different concerns but both review my intentions. Miss Beech is more worried about 'ends'; where is her information going? ('I don't want to be . . . about my business all the time.'). Miss Rowan is also dubious about 'ask(ing) them too many questions' and declares her independence from notions of 'community' by insisting 'well I don't suppose we're all the same' and declaring 'I've had to do so much . . . by myself'. These small phrases are telling, even in their incompleteness. They are not 'answers' to my questions and yet they signal a set of values and social histories that are neither accidental nor random but are best seen as traces of alternative discourses that I needed to explore in order to throw light upon the substantive topic of my study.

The provisional power of refusal and re/wording

All elderly people in my study had to make sense of why I wanted to talk with them. They constructed me in terms of previous experiences of interviews (real, televisual and fictional). In the first case it is clear that Miss Beech constructs me as part of the problem rather than as a solution. I presented both women with a particular form of social power; my urgent professional need to know. It was *my* work that was at stake and *my* need to satisfy funders and superiors.¹⁷ They had every right to be circumspect about this educated 'stranger' parachuting into their lives, especially since I had the luxury of escape. Very few of them could remove themselves from their circumstances. Indeed the ideology of 'choice' was so far removed from the realities of their lives, their being literally and metaphorically 'pushed around', that at times this dissonance threatened to stall the research itself. This power imbalance was frequently dramatized in the research encounter for example, when Miss Beech was summarily wheeled out from watching television when I arrived at the appointed time. And yet the extracts show respondents 'answering back' in far from straightforward ways.

Both of the above fragments show two elderly women intent on exercising (in however unstable a mode) a form of provisional personal power – the power of refusal or reinterpretation. In the first extract, Miss Beech is very clear that I pose something of a threat: 'I like that! There you go again you must ask questions'. It is possibly the first time ever for me that having agreed to an interview an interviewee tells me that I can't ask questions. I discovered later, that there were sound reasons for this response. Miss Beech was suspicious of all 'officials', that is social workers and other 'related' 'nosey parkers' because 'these people' were intent on getting her to make a practical decision about giving up her tenancy on a housing association flat.¹⁸ However, to do this would have made her financially liable for contributing to the cost of her place at the nursing home. Ironically, she talks later in the interview of 'never having a crust of bread off the council'. Miss Beech was not the only subject who used the power of *not* making a decision to sustain what she took to be her best interests.¹⁹

My initial attempt to interview Miss Rowan similarly faltered until we agreed a way to talk. My opening remarks strike me as clumsy. In print it reads like a somewhat instrumental bid for a subject's attention that arises perhaps from doing too many research projects in too short a time. Yet Miss Rowan persevered in talking to me for two hours. It is clearly impossible to display all of this – the transcript runs to 35 pages. In short, she interpreted the research interview as an opportunity to do a life-history review, in the course of which she rehearsed her most troubling and pleasurable stories. The impact of these and other stories will be discussed in the next section.

Miss Rowan had little narrative 'grip' on the sequential history of her life because of impaired memory, yet her reconstructions of specific childhood scenarios was cinematic. She was completely uninterested in the present, and appeared to prefer her past, even though it contained difficult, unresolved experiences. Other researchers have suggested that institutional life is invariably accomplished by routinization and subsequent depersonalization.²⁰ It seemed to me that conversations about the past were seen by some elderly people as a rare opportunity to reclaim the 'self'. This same impulse may have inspired Miss Rowan's complex attempt to produce a life story that she was often compelled to replay to herself in silence. My questions about 'how she ended up' in the home, which I intended as an invitation to explain her recent circumstances, stimulated a series of flashbacks to childhood, young adulthood and middle age although not necessarily in that order. 'Interviewing' Miss Rowan was a very postmodern experience. In response, I felt driven to cling even more desperately to the 'here and now' of the social policy agenda:

VH: Were you a housekeeper?

GR: No, nothing like . . . oh, I wouldn't be in charge of anybody not even now . . . no it wasn't that sort of service but ahem . . . oh, hell, what can I do? . . . I was 14 . . . I was . . . I left school there's a lot to remember you know.

VH: There is a lot to remember – you needn't remember it all for me at once. [giggles]

GR: [unclear] well I often think about it 'cos they were happy times really.

VH: When you were . . . [puzzled]?

GR: 14 . . . till I left the potteries in '37 that's what you want me to get at don't you?

VH: Well partly that, but I'm also interested in how you lived . . .

GR: . . . before.

VH: If you're not too tired, tell me how you lived in London before you came into this home.

GR: Oh, this home ah . . . I mean this is . . . I've only been here a few months give me a chance.

VH: I know . . . well you have a view about it do you [slight exasperation]?

GR: Well its not me . . . I . . . like freedom.

VH: I know most people would prefer . . .

GR: They're not bad to me but . . . then I'm not as strong as I was at 60. How old am I?

VH: 90.

GR: 90 and I can't do the things I used to do.

VH: Well you can tell me what . . . you can tell me why you ended up here?

GR: You want me to come to London?

VH: Yes [increasing exasperation]. Tell me why you ended up in Hanover [the old peoples residential home].

Although I eventually 'got Miss Rowan to London' and I hoped somewhere nearer to the research agenda, she suddenly shifted both topic and 'discursive register':²¹

GR: Oh this doesn't count at all.

VH: This doesn't count?

GR: No this doesn't count at all. I'm ready to die, I really am.

In the context of a first and only interview such disclosures secured closure. Whatever else our exchange produced it was *not* a neutral consumer review about current social arrangements. Yet it said everything about people coming to their own conclusions above and beyond a concern with 'better social services'. Paradoxically, it would seem that one unpalatable consequence of surviving self-starvation through 'community care' was, for some elderly people, an extenuation rather than an elimination of their difficulties.

Theorizing discourses of elderly frailty: the unspoken, spoken and different

Even fragments of personal narratives can suggest what is involved in the processes of 'ideological becoming'.²² In this study, frail elderly talk was framed by a moral discourse that seeks to establish the superiority of health and physical robustness. The discourse of 'healthism' works to contain, constrain and filter out frailer voices. At the same time, it carries forward forms of thought associated with possessive individualism – a mindset endorsed by the move to import 'marketization' into ever increasing aspects of civil society.²³ We therefore need to read elderly people's responses carefully as much for what they *do not say* as for what they do.

In this light we can note how the moral discourse of 'healthism' resonates and can be said to articulate with powerful values already offered within the social biographies of some frail elderly people. (Indeed these same Victorian values were actively invoked by the Thatcher government in opposition to the 'nanny' state.) As we have found, two frail elderly women insisted on the values of self-sufficiency to the point that their misplaced independence resulted in their self-starvation. Their removal to institutions – effectively a form of protective custody – meant a loss of personal autonomy that chimed not only against their personal values but also against the philosophy of 'choice' and self-determination. How else did the elderly people in the study respond to being positioned as frail, elderly and marginal?

It was possible to identify several general discursive features in elderly people's accounts. These precepts were co-constructed and can be summed up as follows:

- minimal expectations of the local community and the state;
- maximal aspirations of 'coping' – 'The Life of Brian Syndrome' – accompanied by a compliant tendency to non-complaint about services they were in receipt of

Occasionally elderly people resisted in the form of a refusal or a deferment of decisions. It was extremely rare for them to adopt the 'consumer' role of demanding their 'rights'. Recall that I was actually trying to elicit their *demands*, in the context of a project about their *needs*. These 'conservative' responses are inextricably bound in with each other and taken together they determined how elderly people responded to questions about their care. Their answers carried assumptions that in competing and contradictory ways constituted reactions both to their immediate circumstances and to the wider forces of ageism/healthism. I have shown how I was also caught up within these power relays – forced to negotiate different forms of minimal expectations. A different (but equally inhibiting) response was that of relentless cheerfulness – what I have termed colloquially as 'The Life of Brian Syndrome'. This position implied a refusal to acknowledge a stigmatizing definition, in this case the degree of physical frailty, a process that has been called 'dis/identification'.²⁴ In my study dis/identification was frequently constructed through a willingness to convert impossible situations into 'opportunities'. This was a feature that was far more prevalent in elderly women than in men. Miss Andrews in Riverside noted that there were other people much worse off than herself. She re-interpreted her being 'put to bed' at 5 o'clock in the evening (to conform with the scheduled 'home care') as an opportunity to read. She also refused to wear her mobile alarm because it reminded her of another fall(!), eventually compromising on this by attaching it to her Zimmer frame.

Complaints about care were especially noteworthy because they were so rare. Critical comments about services and their delivery were more in evidence when I talked with the elderly people's advocates – family, neighbours or friends. Those without these forms of social support seldom voiced reservations about their care regimes or the decisions affecting their care.

As noted, some people held out against making decisions as they were influenced by fears about people who asked questions. One source of this reluctance to talk to 'officials' related to personal pride; many subjects stressed that they had managed previously without help. My data clearly provided evidence of a specific ethic that equated help from others with 'charity' and thus saw it as a sign of personal failure. Indeed one way to read the cases of self-neglect (Miss Rowan and Miss Beech) is to reinterpret

their withdrawal as a fear of loss of control, which calling in the 'social' might mean.

As an earlier much larger study also found, few elderly people were familiar with the vocabulary of 'consumer choice'.²⁵ Few took up the decisive role of an active 'consumer'.²⁶ Since most were either poor or destitute and unused to manipulating 'choices', few had ideas about what 'community care' might mean, and only one of them saw himself as a consumer of 'services'.²⁷

Emotional hard labour

Dealing in the above processes was emotionally demanding for both researcher and participants.²⁸ But as so little is written about the difficulties and demands of researching the frail elderly,²⁹ it is important to stimulate further discussion about some of the ramifications of interviewing frail elderly people in particular and the elderly in general. The ensuing commentary arises not from any claim to inherent social sensitivity, but because I was not prepared for talking with this group. I suggest that some of these difficulties are practical (about how best to communicate) and some are emotional and social and involve the challenges of listening to harrowing stories and yet being able to 'detach' and 'walk away'. Despite working to a research brief designed to evaluate the workings of social policy, the actual research process meant I must negotiate an entry into people's lives and their prevailing concerns. These tended to be about highly charged events: stories of the tragic deaths of children, of illnesses and deaths of family members. I heard also of family betrayals and neglect.

Feminist researchers have paid detailed attention to the interpersonal nature of research.³⁰ However, even this literature offers little about researching within the context of extreme old age: it reflects daughters' rather than mothers' stories. Nor is there much about the practical problems of communicating with and understanding people who may have lost the powers of full speech or memory and who are also unable to control their bodily or emotional states. But 'misunderstandings' were also essential clues about why their talk was (as I have shown) frequently wildly dissonant from my fixation with getting them to focus upon 'community care' or to comment upon what they wanted. Moreover, the accumulated effects of listening to highly charged, and apparently off-task topics meant that I created my own coping tactics. These, ironically, mimicked survival strategies used by the people I studied. My interview approach at times consisted of my own resistance to their answers as well as embracing a counselling or caring rather than a 'pure' interviewer role.

My first response to reinterpret stories emerged out of listening to difficult retributive narratives. Part of me wished for more optimistic accounts and

in this way I could be said to have incited the 'Life of Brian Syndrome'. For example, I found one elderly woman's insistence that her daughter-in-law 'hated her' so upsetting that I began to gloss her daughter-in-law's actions in positive ways. More generally, I found myself pulled into a counselling role, advising elderly subjects to give people more chances, and even more crassly to keep their proverbial spirits up. More urgently, I found myself chivvying elderly people to eat, or to attend their home's social events, especially in the case of one elderly woman who was so depressed that I was concerned she might just 'give up'.

Intriguingly in view of the above, several of the social workers I interviewed felt that the counselling and mediating aspects of their work were being squeezed out by the demands for practical action stressed in the mechanics of community care.³¹

Conclusion

In conclusion I want to draw out some of the implications of researching questions about decision making in the context of the social divisions of age. All of these bear upon the struggle to understand and represent the complex social realities of any 'minority' or marginalized group. I want to arrange these implications at different levels – the practical, personal, theoretical, political and professional – even if in reality these levels are lived each within the other.

Practical

Interviewing and negotiating meaning-making in the context of extreme old age calls for methodological adaptability. This can start with recognizing and accommodating people's physical disabilities – speaking louder, sitting within very close proximity, sometimes using improvised sign language, seeking out validation about timings and sequencing from others because of memory loss. Old people are frequently ill and can reasonably change their minds about obliging interviewers. Sometimes they forget that they had agreed earlier. Close contact with them via wardens, neighbours and friends is advisable. Indeed I felt it necessary to meet with such 'gatekeepers' as existed, especially neighbours, in case they thought that the elderly person was 'at risk'.

Personal

This concerns the emotional impact of eliciting life histories. We need to bear in mind our own responsibilities here and the effects on the interviewee as well as on the interviewer. This is because such intensity of

disclosure is frequently unwarranted in terms of the elderly person's familiarity with the researcher. Loneliness may well propel the elderly to disclose information in order to retain the company of the researcher. Subsequently, they may regret engaging in too much personal talk. We need to be aware of the power we hold as interested strangers who, having established trust and encouraged disclosure, can then move on. Leaving 'the field' may well mean consigning elderly people back to a heightened awareness of their social isolation.

Theoretical

There is a broader, interrelated and more theoretical question that relates to how we think through social divisions and their consequences. As a social policy researcher I am sometimes compelled to act as if the 'client group' under consideration is subjected to one dimension of social disadvantage, and this is particularly true of the 'frail elderly'. I certainly do not want to add to this age essentialism here. Yet it would be specious to discount either the materiality of bodily frailty, or the power of the discourse of 'frailty' and its associated material practices. At the same time I am aware that not all people identified with the category of 'frailty'; frailty was gendered. As I have argued elsewhere, the identification was performed by some elderly men as a tactic of power, in order to extract 'community care' resources from women professionals.³² In contrast, most women *dis*-identified with the term, precisely because it was in contradiction with the feminine subject position of *care-giving*.³³ This suggests that 'frailty' is not a transparent term.

This chapter has also sought to show how the force of hegemonic discourses about 'proper' bodies has influenced what the frail elderly feel entitled to and thus entitled to say. As I have discussed elsewhere, access to different discourses is not equally available to all.³⁴ Importantly, whereas traditionally social analysis has always paid attention to the said, the 'not-said' is also crucial.³⁵ Moreover, identifying 'structured absences', in this case why so few frail elderly identify themselves as 'consumers' (at least in this research), indicates the conditions of knowledge production: who or what is made into the subject and object of knowledge. Here resonates the full force of elderly people's minimal expectations and 'refusal' to complain.

Political

By investigating 'community care' and its derivative professional health and social welfare actions, I too became inextricably part of an apparatus of power that bears down even within that apparently 'private' encounter known as an interview. In concentrating upon methodological complications I do not wish to claim that these are unique to studying the frail

Physical frailty intensifies the inherent difficulties of understanding 'her' in research (as in life) and the delicate interpretive manoeuvres in meaning-making (and thus of sustaining an interaction) are on to *all* interview exchanges.³⁶

sional

Since 'needs assessment' is the principal means for making claims 'community care' resources, care in its design and administration is al. Social workers, like social researchers, stand in an (unwanted) iral relationship to frail elderly subjects. This has a number of consequences, some of which I have outlined above. Care management within contexts requires the sort of attention to detail and the sort of time investment of professional labour that are simply not being made ble; the cost in terms of the dilution of care for elderly people has yet properly recognized. Paradoxically, elderly people are frequently ewed (by medical staff, by social services staff and occasionally by researchers).³⁷ Self-evidently, asking questions is not the same as ig to often uncomfortable answers. Autobiographical talk constit- potentially rich source of material and ought to form the ground- or understanding how the elderly person is coping with their current on, but it makes numerous demands on the listener – to listen to the and for the silenced. The implications of my own engagement with frail people are clear: practitioners too need to recognize that com- social forces configure elderly people's responses. We will be in a er position to understand elderly people's needs if we recognize the complexities of asking as well as answering questions.

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