

Sustaining the self in later life: supporting older people in the community

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ABSTRACT

This paper emanates from a small-scale qualitative study, currently in progress, looking at the implications for older people of decisions made by a social services department that they are ineligible for service provision. While the operation of eligibility criteria in the UK has been shown to exclude an increasing number of prospective users from receiving a service, little is known about how those refused a service contend with their difficulties or the implications these strategies have for them. The paper focuses on themes that have emerged during the first phases of the study in relation to how older people endeavour to manage their ‘unmet need’. It is suggested that a key integrative theme concerns their efforts to maintain a positive sense of self indicating, it is argued, the need for processes involved in the seeking, receiving and giving of help to be managed in a way that sustains the sense of self of the older person.

KEY WORDS – older people, community care, prevention, independence, self, identity.

Introduction

This paper is concerned with the broad subject of ‘prevention’ in relation to older people and community care or, more specifically, with factors significant in preventing loss of independence and deterioration in quality of life, as determined by older people themselves. It reports on a small-scale qualitative study involving older people who had been referred to a local authority social services department but who were refused a service on the grounds that the referred need did not meet prescribed ‘eligibility criteria’. Through in-depth interviews with the older people concerned, the study aimed to explore how older people perceive and manage their ‘unmet needs’, and the meanings these strategies and consequences have for them.

The paper begins with a brief review of the policy and practice

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context of prevention, followed by an outline of the methodological framework of the study. Some of the key findings in respect of participants' attempts to manage their difficulties are considered in relation to the theme of sustaining selfhood. The paper concludes with a discussion of the implications for the development of community-based support strategies.

Policy and practice context

Community care policy and practice in the UK have been characterised in recent years by financial stringency and service restrictions (Tanner 1998; McLeod and Bywaters 2000). As the resources of local authority social services departments have become increasingly constrained in the face of reduced budgets and escalating demand, so the significance of eligibility criteria as a mechanism for targeting services on those in greatest need has magnified (Mandelstam 1995). Despite the needs-led rhetoric of community care policy, it has been argued that it has 'been driven as much by the aim of targeting services as assessing need' (Lewis and Glennerster 1996: 163) and, moreover, that the requirement to contain resources has led to assessment and care management processes being dominated by managerial rather than professional concerns (1996: 143). Increasingly, services have focused on 'high level' need, leaving few resources for preventive and rehabilitative work (Audit Commission 1997). There has been a dramatic increase in the intensity of service provision, with a decreasing number of households receiving home care, for example, but a steady increase in the number of contact hours per household (Department of Health 1998a). While the effect of eligibility criteria is to direct relatively intensive resources at a narrow band of people identified as 'high risk' (Ellis 1993; Richardson and Pearson 1995; Hadley and Clough 1997; Stanley 1999), the consequences for those excluded by this same process are largely unknown.

Although, taken overall, research evidence on the effectiveness of low intensity support services is poorly developed (Quilgars 2000), such services appear to be highly valued by older people. Studies have found that maintaining 'home' and independence are highly significant for older people (Langan *et al.* 1996) and that they place a high value on 'low level' preventive services (Clark *et al.* 1998). Moreover, a range of benefits can accrue not only to service users but also to carers, the social services department, local community and partner agencies from a preventive strategy designed to meet lower level needs (Milne and

Morgan 1997). Health and social care policy statements (Department of Health 1997, 1998*b*, 1998*c*) are increasingly recognising the need for a shift in emphasis from services targeted exclusively at those defined as 'high risk' or 'in crisis' towards more preventive objectives (Fletcher 1998). However, a survey of the preventive activities of health and local authorities suggests that these are at present largely underdeveloped, patchy and unco-ordinated, and that some authorities are uncertain how to take their strategies forward. A range of factors affecting progress were identified, including concerns about the affordability of preventive services when set against the cost of meeting statutory responsibilities, organisational complexity and the need for strong leadership and/or dedicated budgets (Lewis *et al.* 1999). There is a distinction to be made between different 'levels' at which preventive efforts are directed. While the NHS Plan (Department of Health 2001) has prompted developments in 'intermediate care', this is defined in a way that will encourage alternative forms of provision for those already likely to meet eligibility criteria rather than support for those who could potentially benefit from 'lower level' provision.

Prevention, independence and identity

Two main strands within the definition of prevention in work with older people are first, services that prevent or delay the need to access more costly provision and secondly, strategies and approaches concerned with promoting quality of life and engagement with the community (Wistow and Lewis 1997). Fletcher (1998) identifies the former as the *cost-effectiveness* case for prevention and the latter as the *consumer* case. The focus of this paper is on the 'consumer case' since the concern is with the perspectives of older people themselves in relation to perceptions of 'need' and how it is managed.

Evidence suggests that as far as older people are concerned, a key state to be prevented is dependence. This in turn is represented by situations such as reluctant relinquishment of home, forced reliance on other people, inability to participate in activities and social networks and loss of maintenance of usual routines (Langan *et al.* 1996). Fisk and Abbot (1998) uncovered a wide range of views about the meaning of independence, but common themes included the importance of deciding things for oneself; the importance of financial resources; the limitations brought about by illness and frailty; the desire to receive necessary help without becoming a burden on others; and the development of strategies for reducing the impact of loss and decline.

For many older people, perceptions of independence appear to be closely linked with maintaining a positive sense of identity. A longitudinal study by Coleman *et al.* (1998) found that continuous themes in the life stories of older people were the preservation of independence and maintenance of home, and that these themes were significant in maintaining identity. This was defined as ‘that aspect of self and personality which expresses the overall unity and purpose of the individual’s life’ (1998: 391).

Postmodern perspectives emphasise the fractured and diverse nature of identity rather than its stability and continuity. Gilleard (1996), for example, sees the dislocation of previous social identities as liberating for older people in that they are afforded wider opportunities to construct identities of their choosing. Phillipson takes a less optimistic view and argues that changing social and economic conditions have led to older people being located in a new ‘zone of indeterminacy’ such that:

Achieving a secure sense of self has become one of the biggest challenges in later life: the postmodern self is one riven by insecurity and this is especially the case in the period defined as older age. (1998: 51)

He views old age simultaneously as a time of ‘risk’ as well as ‘potential liberation’ (1998: 125). Biggs also highlights threats to self posed by the social context. He refers to identity as ‘a concept at the cross-roads of the personal and the social’ (1999: 3), involving a counterbalancing of hidden aspects of self and those which can be safely expressed. This is seen as managed by a ‘performance of masquerade’ (1999: 131) in which functions are negotiated that are both protective (against assaults to the self) and connective (to the core sense of self). These distinctions between both the ‘personal’ and ‘social’ components and protective and connective functions of identity management, provide a useful context for considering the implications of ‘unmet need’ for older people’s sense of self.

Research design and methodology

Where the concern of gerontological research is with broader objectives than cost-effectiveness, approaches that facilitate understanding of people’s lived realities have much to offer (Lewis *et al.* 1999). This study is informed by the theoretical framework of symbolic interactionism, the basic premises of which may be summarised as follows:

- human beings behave towards other people, situations and actions, on the basis of the meanings that those communications and events hold for them;
- these meanings emanate from social interaction;
- meanings are channelled and modified through an interpretive process (Blumer 1969).

The aim of my study is to develop ‘thick’ description, incorporating information about the context of action, the intentions and meanings underlying it and the processes in which action takes place and unfolds (Denzin 1978). The relationship between the individual and society is seen as mutually interdependent; individuals both construct their reality and are influenced and constrained by it.

The concern of the study is not with reporting the ‘facts’, but with developing ‘deep, authentic understanding’ (Denzin 1989: 33). Specifically, it aims to develop understanding of the subjective meanings that particular events and processes have for older people, namely, meanings in relation to:

- need(s) they were experiencing at the point of the referral to social services;
- the significance of the decision made by social services not to meet the need;
- the implications of this for their ongoing day-to-day lives;
- self-perceived outcomes ensuing during a follow-up period (initially five months, but with further periodic follow-up interviews over a three-year period).

Focusing on how older people experience and respond to difficulties does not imply a ‘deficit’ or problem-focused view of old age, rather the opportunity is released to learn about positive strategies employed to manage changes occurring in later life.

The study adopts a multiple case study approach (Stake 1998), with the boundaries of the case delineated as follows:

- referral was made to one of three office bases of the participating Social Services Team;
- the potential service user was over the age of 65 at the time of the referral;
- the potential service user either expressed or agreed the need identified at referral;
- a decision was made by the Social Services Team that the referred need fell outside the agency’s eligibility criteria;
- the referral was made within the specified time frame (selected to ensure a maximum time of three months between referral decision and first research contact).

From agency-held computer records, letters were sent to potential respondents who fulfilled the requirements of 'the case', inviting their participation. Letters continued to be sent over a four-month period until 12 participants had been elicited. They cannot be seen to be representative since a range of factors is likely to have influenced positive replies. Also, no attempt was made to seek a balanced sample in terms of factors such as gender or ethnicity. It has, however, been argued that in qualitative studies of this nature, the most useful generalisations are analytic (to existing or new theories) rather than 'from sample to population' (Miles and Huberman 1994).

The study takes a 'grounded theory' approach to the data collection and analysis (Glaser and Strauss 1967: 1). Conceptual categories are found that are 'grounded' in the data, establishing relationships between these categories, and conceptualising and accounting for these relationships at a higher level of abstraction. There is an inherent obligation within this approach to give the actors studied a voice so that interpretations include the perspectives of those being studied (Strauss and Corbin 1998). This implies a more participatory model of research *with* participants rather than *on* research subjects, reflecting efforts to achieve more equitable relationships between service users and providers (Beresford 1992). Data secured for analysis are not regarded as 'objective' but rather a product of subjective and interpretive processes in which both researcher and participant are enmeshed. The research participant is not seen as a 'vessel of answers', but as 'an active maker of meaning' (Holstein and Gubrium 1997: 117).

Face-to-face, in-depth, loosely structured interviews were held with the participants in their own homes, with the majority of interviews being taped and fully transcribed. Two interviews, approximately five months apart, were held with nine participants. In the intervening period, there had been one death, one withdrawal and one house move. A biographical questionnaire was completed with each participant, also a social network map. This is a more participatory method than questions and answers and has the added advantage of providing a visible record that can be reviewed and amended in subsequent interviews (Hughes 1993). Participants were also left a diary at the first interview in which to record their perceptions of their needs and the strategies they used to address them. Subsequent phases of the study will comprise three further interviews with participants over a further two year period, focusing on perceptions of changing need, new or changed strategies adopted to address needs, and subjective meanings attached to both needs and strategies. Data analysis follows the

inductive coding techniques described by Strauss and Corbin (1990) in which concepts are identified, refined and formulated into categories, with this process being completed to higher levels of abstraction until a core category is selected.

Findings from the study and related literature

The participants included seven women and five men. Their ages ranged from 70 to 92 and seven were over the age of 80. In terms of ethnicity, all were White UK, which reflects the local population of the mainly rural area in which the study took place. One person lived with a marital partner, the other participants lived alone. The issues are discussed in terms of three related categories that emerged in the process of data analysis: self-reliance; maintaining control in help-seeking and receiving; and maintaining boundaries in helping relationships. These are related to a core category of ‘sustaining the self’.

Self-reliance

A recurrent theme within the interviews was that of ‘keeping going’. This was reflected in numerous creative strategies that the participants deployed to manage their difficulties in their own ways, relying on their own resources:

There are things like that I do find very difficult but I do cope ... I am so used to doing things on my hands and knees, like dusting or anything at floor level, that I just do it, so it means doing things one-handed. Quite often I've cut the edges of the lawn with a pair of scissors because I can't cope with shears you see. (Mrs Manders)

This picture of resourcefulness in the face of difficulties is supported by a number of other studies (Wenger 1984; Thompson *et al.* 1990; Richards 2000; Pound *et al.* 1999). Langan *et al.* (1996) identify themes of ‘making an effort’ and ‘making the best of things’ amongst the older people they interviewed. In the current study, the number of references to ‘being lucky’ or ‘being well-off compared to some’ were striking in view of the apparent difficulties inherent in these people's situations.

Although certain tasks were accomplished with considerable difficulty, ‘struggle’ was itself viewed as having positive value:

I realise now that those sort of jobs are very difficult for me ... If I'm feeling OK, I shall still (do them) because ... if you give up doing these things then you lose your independence entirely. (Mrs Manders)

Sidell (1995) found that older people equated 'health' with carrying on with normal living, and believed that this would hold in abeyance or minimise illness. Minichiello *et al.* (2000) report that older people in their study endeavoured to be perceived as 'still trying' and sought to distance themselves from its ill-favoured alternative: 'no longer trying'. This was echoed in my study by one participant who talked disapprovingly of her sister 'taking to her armchair' for the last few years of her life:

I think a lot of trouble is that people give up ... it's no good giving in, it really is no good giving in. (Mrs Forrester)

It seems that the greatest 'struggle' may be with those tasks most closely linked with identity (Sinclair and Williams 1990). Mrs Anderson, for example, had always taken care of her appearance and made considerable efforts to manage her own personal care even though, because of difficulties associated with osteo-arthritis and incontinence, getting washed and dressed in the morning could take up to two hours.

Struggling to maintain routines encompasses 'social' as well as 'personal' components of identity, acting as a mechanism for preserving reputations of independence and continuing ability (Wenger 1984; Seale 1996). Interviews in the current study were littered with statements such as 'I'm independent', 'I've always coped' and 'I put on a brave face'. The latter, in particular, suggests a 'performance' for the benefit of others. Such statements have to be considered in the light of the 'ideologically induced illusion' of independence (Leonard 1997: 54). It is worth noting that in an interview, as much as any other situation, participant responses are only partial revelations (Kaufman 1994) and all that may be available to the researcher are 'the contours of the masquerade' (Biggs 1999: 172).

Maintaining control

It was possible to identify a number of themes within the interview data related to attempts to maintain control in the process of help-seeking and receiving. This can itself be seen as related to efforts to preserve a positive sense of self.

Defining need

Maintaining control is related to defining need and to decision-making about eligibility. Unsurprisingly, the study found a discrepancy between 'need' as defined from an agency or professional perspective based on eligibility criteria and 'need' as perceived by the participants. As Blackman and Atkinson argue, 'in public policy terms, needs are essentially what the state decides to recognise and provide resources to meet' (1997: 131).

Despite the needs-led rhetoric of community care policy, there is a yawning chasm between need felt and expressed by potential service users, and normative need operationalised by professionals (Caldock 1994; Sheppard 1995; Lewis and Glennerster 1996; Tanner 1998). In common with many local authorities, bathing was not regarded by the Social Services Team, who had assessed the study participants, as 'necessary' unless there were specific hygiene or medical reasons dictating otherwise. This was at variance with the perspective of the older people who had been referred or had referred themselves for help with getting in or out of the bath. Mrs. Forrester, for example, expressed her incomprehension and dismay at being refused help with the installation of a shower:

I do not understand it ... Normally I like to bath every morning, now I can't and I feel dirty. (Mrs Forrester)

Twigg (1997) highlights the wider social significance of bathing and Tulle-Winton (1999) points out the link between individual 'government' of the body and notions of 'successful ageing'. Similar points can be made about the emotional and symbolic significance of other seemingly 'functional' tasks: eating 'proper meals' (Howarth 1993), shopping, cooking and gardening (Glass *et al.* 1999) and, particularly for women, maintaining household standards (Clark *et al.* 1998).

When interviewed, Mrs Anderson was appalled at being told she would be eligible to receive help with personal care but not with cleaning because 'no-one's ever died of a dirty floor'. Mrs Manders, when reading this in a summary of the preliminary findings of the study, commented on this 'crass statement':

... a dirty floor is an absolute hazard for an elderly person ... you fall over so easily, I've fallen over any number of times just putting my foot in a drop of water ... and how many elderly people have fallen trying to do things, you know, to keep things clean, fallen off chairs and stools and steps? (Mrs Manders)

Other participants felt that those involved in making these decisions

had failed to understand the significance for them of these routine tasks:

They should get down to basics, they're so high up they forget what's underneath. (Mrs Everson)

This 'failure to understand' could also apply to informal 'helpers'. Mr Jarman said that he could not 'let the garden go', as his daughter suggested, but protested 'it's part of my life'.

The process of how decisions about 'need' are made is clearly crucial. Mr Jarman was told that Social Services could not provide help to carry in his coal, yet this meant that he had no source of heating or hot water. It is possible that the implications of his service request were not revealed or understood at the referral stage. In the same way, the standard form that Mrs Forrester was sent to list her medical needs, did not prompt her to reveal the gynaecological problem that necessitated her to take daily baths. Professional 'screening' and assessment processes often operate in such a way that meanings for service users (or potential service users) are overruled by professional perspectives (Rodger 1991; Leonard 1997; Richards 2000). Only two of the study participants had received a 'face-to-face' assessment interview. The other referrals had been processed by telephone, in some instances with no direct contact between the assessing professional and the potential service user.

'Consuming' services

Maintaining control in help seeking and receiving also concerned the degree of control that could be exercised over the terms under which help was provided. Some participants had experienced Social Services providing 'help' but of a nature discordant with their view of their requirements. There was a common perception, based either on past experience or on the experiences of acquaintances, that statutory help was heavily restricted and inflexible. As Mrs King said of the local authority home care service:

They're not allowed to do this, they're not allowed to do that, so what's the good of paying them to do something you can do yourself. You want them to do the things you can't do ... which will probably be things they aren't allowed to do ... why bother with it? (Mrs King)

The private sector was seen by some as enabling them to exercise a greater degree of choice over care arrangements:

I would rather have someone privately if I can, who would do what I want, even if I said take me into (town) for a couple of hours, you know ... I would

like someone that could do what I would, what I need help with, and not just what they are allowed to do sort of thing ... I'm willing to pay for it if I can get it. (Mrs Manders)

This view would seem to vindicate the community care policy reforms of the 1990s that reframed service users as 'consumers', able to exercise choice in the welfare market (Walker 1997; Harris 1999). However, it has been argued that there are fundamental weaknesses in the construction of service users as 'consumers'; for example, that consumer choice is in practice only available to those who have the resources – such as a powerful voice, high expectations and information – to enter the market place and articulate their needs (Stanley 1999).

This scepticism is supported by the experiences of participants in this study. In practice there were a number of limitations in the extent to which the private sector increased consumer control over support arrangements. Those participants who were equipped with the financial resources to use the market to purchase 'care', were thwarted both by a lack of information and by the lack of available provision. The paucity of information about both statutory and independent sector services was a significant theme throughout these interviews and is corroborated by other studies (Davis *et al.* 1997; Clark *et al.* 1998; Richards 2000). Even participants who were confident about purchasing from the private sector encountered difficulties when the service they knew they wanted could not be found:

It's not paying that is a problem, it's finding the help. I've tried for ages to get help in the village but I can't find anyone. (Mrs Forrester)

As Barnes states, 'a major problem for many users of social care services is still finding any available services, rather than making difficult decisions about whether alternative services would meet need more effectively'. (1997: 34)

Five of the participants were totally reliant on state benefits for their income and they felt unable to afford private care. Social class and poverty are intrinsically related to the creation of dependency and loss of autonomy (Arber and Ginn 1993). Thompson *et al.* (1990: 244) point out that inequality is 'one of the fundamental continuities of later life', and widening economic inequalities mean that inequitable access to private sources of care in later life is likely to increase. As Baldock states,

To extol the virtues of choice and competition in the face of sustained evidence that a not insignificant portion of Britain's disabled older citizens and their carers do not have ... the incomes necessary to be independent purchasers in a social care market is just plain insensitive. (1998: 179)

In addition to financial resources, participation in the care market is also dependent on attitudes and values conducive to consumerism. Mrs King indicated that she 'would not know where to start' looking for help outside the statutory sector since she had 'always kept herself to herself' and 'lived a quiet life'. Some participants had purchased goods they needed; for example, Mr Norris had purchased a scooter and various disability aids privately. Even they, however, did not necessarily feel equipped to purchase services via the market. Baldock and Ungerson (1994) show that obstacles to market use may be 'habits of the heart', a matter of values and culture rather than facts and information. Illness and frailty also inhibit proactive consumerism. Mr Williams, for example, had a serious heart condition and was largely confined to the house; even making telephone calls demanded a great deal of effort. This illustrates the central contradiction between being 'in need' and functioning as an autonomous, articulate and solvent consumer (Biggs 2000).

Maintaining equilibrium in helping relationships

Respecting boundaries

Participants also sought to preserve a positive identity by maintaining what they perceived to be acceptable boundaries in their helping relationships. Older people's concerns about receiving help from their families have been noted in a number of studies (Wenger 1984; Clark *et al.* 1998; Tulle-Winton 1999). Without exception, the participants who received support from family and friends in this study perceived helping-seeking boundaries and expressed concern about transgressing these. There were a number of relevant factors. First, participants were aware that some potential helpers were contending with their own problems and they were wary of adding to this 'load'. Mrs Thomas, for example, was concerned that her husband's health might be adversely affected if he were to take on what she perceived to be her tasks within the household. Mrs King described how she tried to conceal her physical pain and worries from friends by presenting a jovial facade:

Well, they've got their own worries and troubles, you know. They know my situation, and they're there if I want them, but they've got their own families, worries and troubles, so why should I put it onto them?

For some, asking for help transgressed implicit expectations underpinning the relationship. Mrs Manders, for example, saw being

independent as ‘not needing to call on anyone, other than paid help’, and she described her difficulty in asking for help:

... it’s very hard for me, very hard. I feel a nuisance. I feel like I’m eternally apologising for being a nuisance, for saying can you do this for me, will you do that.

Asking for or accepting help also carried implications for their self-perception as ‘independent’. Mr Norris, who had two daughters living nearby, said:

I’m independent. I do lots of things myself. Although I’m a bit slow getting up to the door, I’m independent and I don’t want to bother people ... My daughters, they only live up the road, but my daughters are not my slaves. I don’t want them to be, let me do this, let me do that ... no, I don’t want it.

Seeking help may be perceived as more or less acceptable, depending on the current and historical culture of the relationship as well as individual personality and attitudes of those in the caring network. In many instances older people prefer the state rather than the family to meet their financial, health and social needs (Bowling *et al.* 1997; Wenger 1999). Phillipson (1998) argues that policy chooses to ignore this aversion of older people to any dependence on their children.

Reciprocity

One way in which attempts are made to maintain acceptable boundaries in helping relationships is through reciprocity. Study participants stressed the reciprocal nature of their helping relationships. The ‘giving’ by participants took different forms, including the direct giving of practical help, such as baby-sitting for grandchildren, making jam, doing simple DIY jobs; offering emotional support to family or friends facing difficulties; and ‘indirect’ help given to the community at large, such as by making craft items for charity coffee mornings, or knitting baby clothes for a premature baby unit. Mrs Manders reported that:

they’re all for good causes, the coffee mornings, you know. I take some of the work I’ve been doing for the bring and buy so, you know, I try and put a little bit back into the community. Well, now that I can’t actively help anyone physically, you know.

A number of studies confirm the significance of perceptions of equity and reciprocity for feelings of self-esteem and independence (Finch and Mason 1993; Pratt and Norris 1994; Langan *et al.* 1996). Conversely, self-perceptions of dependency appear to be related to feelings of

having nothing of value to exchange in relationships (Wilkin 1990), with the result that those most needing 'care' may be least likely to be able to reciprocate (Wilson 1993). However, it is important to note that reciprocity can be sustained even in objectively adverse circumstances (Nolan *et al.* 1996), also that it may, as noted earlier, be expressive rather than instrumental. Mrs Anderson, for example, telephoned her daughter every day to offer emotional support as her son-in-law had a debilitating illness. The perception of reciprocity would seem to be more important than the 'facts' of helping, and there was evidence in this study that reciprocity has to be carefully managed to preserve the self-esteem of all parties. Mr Williams referred to the help he gave to some of his older neighbours living within the housing complex, where helping relationships appeared to feature 'covert' reciprocity:

Some of the widows here ask me if they need anything doing, like if they want a light bulb changed or the sink is blocked ... There is one lady who can't read English well and she asks me to come over if she has any correspondence she can't understand and I explain it to her. Then, a day or two later, she will phone and ask me to go over and she will say 'I was cooking and had some left over, here you are', and I say 'right, thank you'. She always has some left over! Another one, I helped her when the water was overflowing and she was flooded. She came round the next day with something she had bought too many of and would I like one.

The construction of certain groups as 'recipients of care' tends to obscure the multiplicity and reciprocal nature of caring relationships (Barnes 1997; Bytheway and Johnson 1998) and, in so doing, fails to acknowledge the significance of maintaining reciprocity for sustaining selfhood.

Sustaining the self: implications for community-based support

Personal strategies to 'keep going', attempts to find support which allowed the retention of some measure of control within helping relationships, and efforts to maintain acceptable boundaries in those relationships can all be seen as related to struggle, in the face of inimical forces, to preserve continuity with existing concepts of the 'self' and, at the same time, to preserve an acceptable social façade. Phillipson and Biggs argue that a secure foundation for a mature identity is through:

the creation of a protected inner core and an external environment that provides both an adequate material base while remaining sufficiently indeterminate to allow experiments with social identity. (1998: 20)

Protecting the core self

Preserving continuity

While identity in the postmodern world is seen as fluid and indeterminate (Gilleard 1996), there is evidence from this and other studies (Coleman *et al.* 1998) of the significance of continuous life themes for older people. Andrews notes that the lives of the older people she interviewed were ‘a direct outgrowth of the whole of their lives leading up to that point’ (1999: 313). For the participants in my study, significant factors for sustaining the self related to the continuing importance of earlier life themes whether this was maintaining a well-groomed physical appearance, keeping socially active, maintaining domestic standards or keeping a well-tended garden. Acknowledging first, the diversity of sources in which a positive identity is rooted and secondly, the importance of preserving continuity with these sources, highlights a number of implications for support services. The diversity of user-perceived needs suggests that preventive strategies need to be directed at developing a correspondingly wide range of responses. There is mounting evidence on which to draw; for example, the significance of help with cleaning, shopping, gardening and home maintenance (Walker and Warren 1996; Bowling *et al.* 1997; Clark *et al.* 1998; Bartlett 1999); accessible transport to enable community participation (Cope and Palfrey 1997); opportunities to engage in valued social activities and hobbies (Andrews 1999; Glass *et al.* 1999; Tulle-Winton 1999); and, cutting across each of these, adequate financial resources (Langan *et al.* 1996; Parker 2000).

Responding to threats

Charmaz (1983) sees illness as an ‘assault upon the self’ conducted through various impositions: a restricted lifestyle; social isolation; discrediting definitions of self; and becoming a burden on others. She sees one of the most significant sources of suffering from loss of self as ‘the inability to control one’s self and life in ways that had been hoped for, anticipated and assumed’ (1983: 187). My study similarly has shown how difficulties brought about by illness and disability pose threats to the ‘core self’.

Shifts in identity may be entailed in the required adaptation to changing circumstances, and frequently this is not a matter of individual choice. Mrs King’s view of herself as independent, for example, was jeopardised by the lack of alternative sources of support, compelling her to rely more on her daughter. Similarly, Mrs Manders,

who had always received help 'on a paying basis', could not now obtain this and had to resort to asking 'favours' from friends. It follows that a focus for preventive activity should be to support older people's abilities to control their lives. 'Liberation', in the construction of ageing identities, is dependent on both a power to choose and the resources to realise that choice.

Engaging with individual meanings

To maintain coherence and continuity of the 'core self' requires the 'gatekeepers' of support services to engage with individual 'stories' and meanings (Rodger 1991). Blaug (1995) argues that in social work communicative practices are distorted by structural constraints and power imbalances. He describes the 'toxic brew' of the professional dilemma between 'the progressive colonisation of communicative practices on the one hand, and the denial of resources necessary to meet client need on the other' (1995: 435).

Screening and assessment practices would seem to be cases in point (Stainton 1998; Baldwin 2000; Richards 2000). Smale and Tuson (1993) advocate the 'exchange' model of assessment, which recognises the user as expert in his or her own problem solving, in contrast to the 'procedural' or 'questioning' models, which are rooted in bureaucratic and professional power respectively. While translating the exchange model into the realities of current assessment and care management practice presents its own difficulties, even more of a challenge is applying this in crucial telephone contacts on which access to later stages of the process may depend.

Ensuring 'helping' is 'helpful'

As well as engaging with and responding to individually-defined 'need', what is also necessary for protecting the core self is greater sensitivity to the process through which 'help' is given. 'Help', referring to informal as well as formal support, can be provided in a way that either sustains or diminishes the sense of self. There is a potential disjunction between action strategies and psychological coping (Bury 1991). Seeking help from family, for example, may address the practical consequences of illness and disability but, in so doing, undermine the individual's ability to cope. This appeared to apply to Mr Ross whose family had arranged for him to move from Scotland to live in a sheltered flat near them. The family were very attentive and catered for many of his physical needs. He talked graphically, however, of feeling stifled and 'hemmed in', not only

emotionally cosseted but also physically ‘caged’ since he was now living in a block of flats in a town centre, when what he wanted was to be able ‘to look out of the window and see the sky’.

Lack of attention to ‘coping’ threatens to undermine the effectiveness of preventive strategies. Coleman *et al.* (1993) found an increase in depressive symptoms and a lowered self-esteem in those receiving help with household tasks. They see this as indicating that the provision of support can be demeaning rather than protective of self-esteem. George (1998), however, suggests that perceived quality of life can remain high even in adverse environments, and he highlights the impact of social psychological resources such as self-esteem and autonomy on perceptions of wellbeing: ‘increasing the degree to which clinicians and service providers treat their patients with dignity and respect is potentially an extraordinarily inexpensive way of bolstering life quality’ (1998: 48). Similarly, Clark *et al.* (1998: 18) found that help from others could support the ‘core self’ of older people. This, however, ‘was acceptable so long as it supported the core identity of independence and did not incur a shift from having to depend on others for help to a total identity of dependency’. Important issues in terms of the process by which help is provided include the quality of the relationship with workers, the reliability, continuity and flexibility of help provided (Harding and Beresford 1996; Langan *et al.* 1996; Henwood *et al.* 1998), and, encompassing all these aspects, services that reinforce feelings of independence and autonomy (Wilson 1993).

Creating a supportive social space

There is evidence that when people produce ‘public’ accounts of their health, complex social processes prompt positive representations of the self (Bywaters 2000). Biggs (1999) highlights the significance of the social space in which ‘self’ meets ‘other’. A hostile social environment will bring to the fore the protective functions of the ‘mask’ while a benign environment will allow greater scope for connective functions and reduce the need for masquerade. Thompson *et al.* (1990) conclude that the construction of meanings is constrained by material restrictions and by negative public attitudes. Both aspects require attention if older people’s efforts to sustain selfhood are to be supported.

Access to resources

In terms of material constraints on identity, the older people interviewed in the study had a clear perception of their difficulties, and

also of the support they needed to address these. However, unlike the 'self-active' strategies they employed, their efforts to pursue strategies based on seeking external sources of help were thwarted. There were a number of reasons for this: lack of information; unavailability of the desired service (whether through 'ineligibility' or it simply not existing); lack of financial resources to purchase the service; illness and frailty; and 'habits of the heart' alien to the specific nature of the help-seeking requirement. These individual meanings 'are themselves embedded in wider layers of meaning, these emerging from social and economic practices at large within society' (Phillipson 1998: 108).

Changing attitudes

User-focused research leads to questioning of accepted notions of independence, and acknowledgement that this 'ideal' is socially constructed and not necessarily either desirable or attainable (Biehal 1993; Morris 1993). Leonard (1997) points out that while dependence on the state is stigmatised and condemned, dependence on the market is promoted and reframed as 'independence'. He suggests that the possibilities for autonomy might be more realistically sought within the notion of mutual interdependence. Similarly, the concept of 'care' is problematic. It implies paternalism and dependency (Seale 1996; Priestley 1999); it is in practice bound up with notions of control, supervision and protection (Johnson 1998); and it fails to reflect the realities of lives based on reciprocity (Nolan *et al.* 1996; Barnes 1997). Given the importance of perceptions of reciprocity for the maintenance of a positive identity (Pratt and Norris 1994), an effective community-based support strategy would be to create and maximise opportunities for older people to engage in reciprocal help. In this way, facilitating independence is about promoting networks of support rather than self-sufficiency (Thornton and Tozer 1994; Beresford and Trevillion 1995).

A further challenge in terms of fostering a supportive social space relates to notions of ageism. While it is important to eschew ageist assumptions, denial of the realities of ageing may perpetuate ageism rather than challenge it (Andrews 1999), increasing the necessity for a 'masquerade'. Minichiello *et al.* (2000) show how the lived realities of older people are shaped by their internalisation of ageist attitudes and there is a range of other evidence attesting to older people's dissociation from ageist stereotypes (Thompson *et al.* 1990; Titley and Chasey 1996; Tulle-Winton 1999). While negative social attitudes impel people to dissociate themselves from 'old age', social movements depend on feelings of alienation and an awareness of collective disadvantage. In

terms of developing user empowerment and 'resistance' by older people, the challenge is to acknowledge diversity while at the same time developing the basis for collective action (Beresford and Trevillion 1995). Political strength, then, may be gained by embracing and reconstructing an 'aged' identity (Ward 1993). In this sense, a more supportive social space is seen as produced by, as much as producing, positive assertions of ageing identities.

Conclusion

The findings of this study, considered in this paper, suggest that the efforts of older people to manage 'need' are directed at maintaining a positive identity. Older people's resourcefulness in trying to address their difficulties and their efforts to maintain independence, autonomy and reciprocity can be seen as related to efforts to sustain selfhood. It follows that community-based support strategies need to be directed at supporting these efforts. Many aspects of policy and practice appear to diminish the sense of self. The challenge is to develop strategies that sustain the self by supporting both continuity with key components of positive identity and a facilitative social space (Biggs 1999). Since identity itself is fluid and diverse, so too must be the range of support options on offer. There is however an ambiguity in trying to apply this to services designed to meet universal needs (Orme 2001). Williams advocates 'the politics of a differentiated universalism' (2000: 350), combining a commitment to the social inclusion and equal moral worth of all with a respect for individual diversities. Such an approach offers the potential to support both the 'core self' and foster a benign social environment.

Finally, implicit in the discussion and increasingly apparent as this study has unfolded, is the extent to which older people find ways to 'resist' threats to identity. As Biggs (1999) points out, masquerade is itself an adaptive response to threats contained in the social context. While ageing may entail threats and losses, it also has at its disposal an increased ability to deploy protective strategies to preserve the integrity of the core self (Phillipson and Biggs 1998). Perhaps a fitting conclusion, then, is to see ageing identity as primarily concerned with, 'sites of struggle rather than scenes of defeat' (Hockey and James 1993: 175). It is apparent that while the situation of some participants whose needs have remained unmet has deteriorated physically and/or psychologically, others have managed to 'resist' threats to selfhood by finding alternative 'strategies' in practical terms or new ways of 'coping' in

terms of psychological readjustment. A focus for further and more extensive research should be the conditions which favour such resistance.

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