Diverse Older Women: Narratives Negotiating Frailty

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Abstract

This study explores women's narratives from within and outside of the frail/non-frail binary of public home care services. It focuses on the stories that are commonly told about older women's needs and bodies and the regulatory potential of these accounts. Considering power, language, diversity and change, this study focuses on the way that twelve diverse older women at various social locations (e.g., ability, age, culture, ethnicity, 'race', sexual orientation, and socio-economic status) understand, make meaning, and negotiate the concept of frailty in relation to their everyday lives. The sample includes six women considered 'frail' in relation to service (i.e., according to clinical judgement & home care eligibility guidelines), as well as women not considered 'frail' (i.e., non-service recipients).

The twelve older women's storied responses, illustrations and experiences challenge the various stories that are told about them. Their complex accounts both reflect and reject dominant notions, blur the boundary between the frail and non-frail classifications, expose frailty as contextual, temporal and relative, as well as illustrate the connections between medical and social needs. Their individual accounts highlight how they make meaning of their life events in relation to their diverse experiences and identities, as well as how these identities and interpretations are key to their negotiations of life and needs. The variations between the imposed stories about frailty and women's self-perceptions highlight the research, policy and practice relevance of a narrative approach focused on in-depth local accounts, raise questions about the current priorities within home care services, as well as the future of social work practice with older women considered frail.

Résumé

Cette recherche explore les récits de vie de femmes âgées à l'intérieur et à l'extérieur du système binaire (fragile/non fragile), qui fait partie du système public de soins à domicile. Elle met l'accent sur les histoires dont on entend couramment parler au sujet des femmes et de leur corps, et sur les possibilités réglementaires de ces comptes-rendus. En tenant compte de la force, de la langue, de la diversité et du changement, cette étude se concentre sur la façon dont douze femmes âgées, de conditions sociales différentes (le potentiel, l'âge, la culture, l'origine ethnique, la nationalité, l'orientation sexuelle et le statut socio-économique) comprennent, mettent en pratique et gèrent le concept de fragilité dans leur vie quotidienne. On retrouve, dans l'échantillon, six femmes considérées fragiles (selon l'évaluation clinique et les conditions d'admissibilité des soins à domicile), tout comme des femmes considérées non fragiles (qui ne reçoivent aucun soin).

Les témoignages sous forme d'histoire, les illustrations et les expériences de ces femmes remettent en question ce dont on entend parler à leur sujet. Ces comptes-rendus complexes reflètent et rejettent les discours dominants, brouillent la démarcation qu'il y a entre fragile et non fragile et montrent que la fragilité est contextuelle, temporelle et a des liens avec la mort; de plus, ils montrent les liens entre les besoins médicaux et sociaux. Leur compte-rendu individuel met en évidence la façon dont elles donnent un sens aux événements de leur vie en relation avec leurs expériences et les différentes facettes de leur identité, de même que la façon dont ces différentes identités et interprétations deviennent la clé dans leur manière d'aborder la vie et leurs besoins. Les différences entre les discours dominants imposés au sujet de la fragilité et la perception que les femmes ont d'elle-même fait voir la pertinence de la recherche, de la politique et de la pratique d'une approche centrée sur les témoignages en profondeur, soulèvent des questions concernant les priorités du système public de soins à domicile et l'avenir de la pratique du travail social avec des femmes considérées fragiles.

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Act I
Tensions Between Lived Experience, Research & Practice

The Women	The Researcher	Policy & Practice
My life and experiences. Well, I'm not sure where to start. I suppose I would make a distinction before and after the event. Things haven't really been the same since. I can't do the things I used to do. I used to be quite active—I would go for walks, exercise, travel and volunteer. I'm getting used to it. Sure, it bothers me—but it's not so much about the body. It's more the adjustments that I've made in my life. Frail? I wouldn't consider myself frail. I think more of those little old ladies down at the club—they're frail. They don't each much, walk on their toes. They look as if you could break them—no, that wouldn't describe me. Me? Well, my health is generally good, but I'm making a number of changes in my life. I've learned that I can't do everything all the time. I'm trying to stay active, but at the same time, I'm taking things at a slower pace. Well maybe not slower, just different. I'm not giving in—I'm making adjustments—living differently. I realise that I'm not going to last forever. I may as well try to enjoy life while I still can. I know that things can change quickly and I suppose I am trying to anticipate and prepare for future changes. You're not as old as me—you'll see when you get to be my age.	My research and practice experiences exposed the way that policies define and impact on the lives of people receiving services. Language and classifications define experiences and set both the guidelines for practice and the requirements for people seeking service. Frailty is one such concept that has caught my attention. Journals, policies and services commonly speak about frailty. This is a concept that seems to have rapidly appeared on the scene and is connected with risk and eligibility. Frailty, which makes a binary distinction based on bodily injury, discriminates between the eligible and the non-eligible. As such, it is a powerful concept that seems to define and regulate older women's experiences based on their bodies and abilities. Use of this concept therefore plays a role in defining older women. Yet, as I write this piece critical of the power within the language of frailty, I am struck by the power I have in defining, collecting and writing this thesis. Frailty is a concept that struck me and has therefore become the object of my investigation. What do older women have to say? How do older women interpret and/or make- meanings of this concept? Do they have the same reactions that I do? What do they say about their lives and experiences?	"A large number of people with a temporary or permanent disability wish to remain at home in their community for as long as they can, leading as independent a life as possible and taking responsibilities for themselves". (p.1) Our intention is to provide services to: "Anyone, regardless of age, who presents one or more temporary or permanent disabilities, the cause of which is physical, social or psychological, and who should receive part of all of the services he requires in his own home" (p.6). This means that "services take into account the individual's situation as a whole and his needs at home and in his community. The choice of services should foster the individual's functional independence" (p.15). However, "In view of the limited resources and the magnitude of the needs to be covered, a system of priorities must be set up. This system must foster and support maintaining people who are most in need of services, in their home, under adequate health and social conditions" (p.19). These priorities will be established using "A …regional evaluation tool, [to] determine the individuals need for services" (Quebec, 1994, p.20).

Rhetorical Starting

Starting points are the symbolic launch of a tale—they are the so- called beginnings that define the context, content and structure of the story. They provide direction and shape both of what is to follow, and the way in which what follows will be interpreted. Where some dissertations would begin with a generalised statement, application of a theoretical perspective or hypothesis, this dissertation begins with a challenge to the traditional starting point. It begins with fragments of three accounts that negotiate, study and structure frailty. In a sense, it is similar to a journalistic exercise where the same story is told from three positions: that of the older women who told me their stories, myself as researcher and doctoral candidate, and home care policy/practice. This is not to say that these three accounts are mutually exclusive, nor are they the only accounts that exist within the discourse on older women's health. There are also the multiple accounts of Western society, the academic community and social theories about older persons. However, the three selected accounts interact most commonly within practice and therefore, were chosen as the focus for this dissertation. Yet, just as in any performance, the actors do not participate in all scenes, have varying levels of influence within the performance, and struggle amongst themselves for the recognition of their stories. Assigning each account a role, home care policy is both the scene and the director, diverse older women, the main characters (or at least I would like them to be), and myself the narrator. Supporting actors include societal expectations, various social theorists and past research and practice.

In every performance and every act within each performance there is an audience. In this dissertation, you are my audience. As I write, I picture you reading, anticipating, and waiting for the next turn. Just as the starting point shaped the story, you provide a context for interpretation, judgement and legitimisation. You use your experience and co-operation with standards and/or past practices to determine what counts as a legitimate account. Although the accounts of the twelve women, myself and home care policy are relevant accounts each with a valid claim to be heard, they have varying audiences and therefore varying levels of legitimacy. As recipients of care, older women have a right to be heard granted to them through notions of citizenship, policy as well as notions of autonomy and/or self-determination. Their audience however, is questionable—older women are often publicly invisible. As a doctoral candidate, I have the same rights granted as a citizen, but the additional privilege of being heard at discussion groups, conferences, teaching as well as most notably through this piece of written work for you. Health policy, through the voice of government, makes claims to the citizens or taxpayers to balance the social rights or moral obligations of providing care with the economic costs of such provision. Policy is heard officially through government, but is also given voice and power within services and its recipients. As such, the three accounts exist at varying locations and levels of power and influence within the health system. The contradiction however, is that the very power that assigns both policy and my account significance and legitimacy, sustains the invisibility and limited validity of the older woman. Starting with three accounts was intended to expose this contradiction and question the unbalanced power relation that exists between the accounts of diverse older women, myself as pseudo-expert and health and home care policy. Ultimately, it is up to you to determine whether this account is convincing in both the achievement of the standard requirements and the desired level of reflexiveness about my role within these circumstances.

A friend says to me- "I'm not really sure that I buy the column idea. I'm not sure that the columns really do anything- you can't pretend that the accounts are equal" I'm not trying to say that they are- I was trying to present them as such to challenge the very fact that they are not equal- like stories in a paper that can and are read differently-different perspective on the same account. I would like my readers to have the same reaction that you had- it is my reaction- it is what I work from- my starting point. I suppose I could just say that the accounts weren't equal, but somehow it isn't as powerful. But this power to choose is also the powerlessness of immediate defeat. I am limited by the medium of text. I have to choose which to present first. Ultimately I impose the structure on the document- I am telling the story- I have the power to choose. So I will begin with the power imbalance. And although in the columns I have started with the women's accounts, the way I see the current context forces me to invert this order- to begin with the way that the policy structures older women's accounts-leaving myself in the middle of course to negotiate and present the stories. In this account, I ultimately have a powerful position—I *get to pick and chose, organise, and reference whom I like, when I like. Overall, I guess I am trying to work within and between these three accounts of the twelve older women and policy and practice. It is for this reason that I have placed myself between them as ultimately, it is me who is interpreting based on my experience.*

The Policy Account

Constructing and Restricting Need on & through Bodies in Decline

The policy account is an account that directs and defines local practice and experience. It is a complex, multi-layered account knotted with discourses of care, objectivity, and risk. Located within the larger context of health and the welfare state, this account is intertwined with notions such as eligibility and need —distinctions imposed by the current context of cost restriction and targeting services. As such, it not only structures and defines the way services or practices should be carried out, but also structures the perceptions and experiences of older women receiving care. In this sense, binary distinctions made between healthy/unhealthy and frail/non-frail are interpretations of the powerful, which mark bodies according to medical criteria reinterpreted as social needs. Within these conditions, older women become highly visible as bodies in decline.

Binary Construction of Need

In public services, distinctions are made between the eligible and the non-eligible, acceptable or unacceptable criteria, recognised or unrecognised needs. Frailty is one such socially constructed classification used to define, assess, interpret and ultimately respond to the needs of older persons and persons with disabilities. While some health services within home care are universal (e.g., medical access), others (e.g., meal preparation or cleaning) are targeted to vulnerable or at-risk populations. Classifications are used to determine the level of risk, compare cases and distribute services. Frailty is used in policy, research and practice to define a population of vulnerable persons and exists within the context of services which the state has agreed to provide according to accepted or recognised needs. At the service level however, services are interpreted and implemented according to individual medical notion of risk. This level of risk is measured through clinical judgement and a standardised assessment tool focused on functional impairment (Regie Regionale Montreal-Centre, 1994). This tool allows practitioners to uniformly assess risk and classify the older person or person with a disability as frail or non-frail and determine their priority for service. Only those at risk are eligible for service. Under the current system, eligibility and need are then balanced with available services; priority is assigned to those persons with the highest level of need according to the standardised measures. Frailty therefore becomes one binary classification which is used to determine the level of risk and restrict eligibility within the current context of home care services. Under the current system however, being frail does not guarantee access to service—services are distributed to those with the highest level of need.

A Powerful Interpretation: Restricting Bodies in Decline

In this sense, professional classifications of frailty may be considered a construction or interpretation of the powerful. Frailty does not exist as an objective reality. Rather, it is socially constructed to make comparisons between situations, restrict recognition of need, and therefore, the spending of public health care dollars. In doing so, it is a dividing practice, which separates, objectifies, and categorises experiences in the name of risk and cost restriction. The concept of frailty is used to classify the abnormal (e.g., unhealthy) from the normal (e.g., healthy), to create disciplinary boundaries (e.g., gerontology), organise social response (i.e., need) and restrict services within the public home care system. As such, frailty is a form of coercive power whereby experience is defined in the interest of a more powerful force. In this case, the more powerful is the state, which has placed an emphasis on cost restriction and residual home care services as opposed to universal social notions of care. As such, frailty is inseparable from the larger movement to managed care, which includes notions of effectiveness, efficiency, objectivity, standardisation, and professional certainty. The power to interpret these needs however, is located within the everyday practices of health care workers (e.g., doctors, social workers, nurses, physiotherapists, etc) who assess and provide access to services. However, although workers have the power to interpret the needs, the extent to which workers may actually respond to service needs within and outside the recognised categories of risk or need is limited.

Frailty is also a culturally relative expression of power that has only recently emerged within home care services. That is, frailty is a Western concept that may only exist within the current context of residual home care services. In general, the concept of frailty refers to physical decline and weakness. In the Western context and specifically within home care services however, it is connected with medical practices, risk assessment and social control. While larger policies include both managed care notions such as risk assessment and the remnants of universal components of social care, the use of frailty in practice marks the implementation of residual based services based on risk. Frailty could and would not exist as such if public services were not restricted on the basis of medical needs, nor should age, decline and disability be universally accepted within society. Location within the Western context and the current focus on management means that understandings of frailty also operate in relation to dominant discourses and expectations of compliance, available kin, finances, as well as deservedness. Frailty is thus a culturally relative expression of power. It is a powerful term used to create divisions and restrict access (i.e., eligibility) within the current context of managed care and residual service provision.

At the local level, frailty is also an example of an imposed culture—a culture of persons at risk within the larger culture of age, health and home care services. When implemented at the local level of service delivery, frailty extends beyond a divisive practice into a coercive construct, which assigns a personal and social identity based on age, disability and decline. Here, professionals are charged with assessing and inscribing accounts on and through the bodies of older women. Older women do not define their needs or experiences—only trained experts are permitted to assess and determine need using a standard endorsed assessment tool. The coercive power within policy and practice imposes and inscribes a frail identity on the older woman, and replaces her multiple stories, voices and/or experiences with an individual medical concept of frailty. In doing so, older women eligible for public services are represented by an imposed culture of frailty—they are the 'little old ladies'[1]. Although this understanding of frailty as a culture within a culture pushes the boundaries of what is normally considered a culture, it provides a location to understand practices at the local level. The culture of frailty for older women is defined by restrictions of persons older than 65, by levels of disability, risk, and service eligibility. This dissertation focuses on the older women potentially classified by the dividing practices—the women at the so-called margins. This purported power imbalance that exists between the accounts however, is at times fervent, elusive and contradictory. Although in one sense, older women are often excluded in the majority of societal discourses including the policy and expert account, the older women involved with public services becomes highly visible in relation to health. That is, her personal and social identities are now associated with her health status—she is only visible when regulated by health professionals and as such becomes hyper-visible as a body in decline.

Hyper-Visible: Older Women as Bodies in Decline

Older women's visibility in relation to receiving care presents a major contradiction. The object of the frail older woman is central to social policy decisions, operating discourses of health services, and assessing need. Yet, older women's subjective experiences are invisible within these relations of power. Recognition of older women's medical problems in home care means that the classification of normal/abnormal becomes taken for granted. Older women become partially located within the discourses of value, social cost and service restriction, medical intervention, as well as the remnants of burden and deservedness. Yet, at the same time as being located within the account, the subject of the older woman and multiple identities are located between or outside of these very discourses. Their visibility is not as a collective group but as the individual recipients of services, the users of health care dollars. They are assessed and either given or refused access to services; they are at times placed in competition with other deserving groups for their demands. At others, they are viewed as a politically powerful group. Older women are located within and between their diverse invisible experiences of mother, daughter, friend, neighbour and their hyper-visible health status. Hyper-visible frailty however, does not operate on its own, but is accompanied by a set of social expectations about passivity and compliance. Where frailty would be abnormal for the rest of the population, it has become normal for older persons receiving public services. It has become a normal way of talking about older women who represent the majority of service users. In this

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[1] Here, the concept of 'little old ladies' is placed in parenthesis to highlight both the socially constructed nature of the term and

sense, the body in decline is the only way of becoming visible. Frailty represents an economic rationale whereby costs are restricted only to those most in need. As such, it both justifies the social response and maintains the frail/non-frail binary. I would argue that health and the eligibility criteria of frailty create a situation of hyper-visibility where the woman may only be seen as a body in decline.

This is the point where I have to step in- like the narrator who tries to warn you that the story is about to take another turn. To interrupt and convince you—to make sure that you are following the story as I am presenting it—perhaps to try to clarify your interpretation. Being accounted for and the contradiction where older women are visible only in relation to health seems to present a gloomy one-sided portrait. In a sense it is the story of oppression. A story of power over in which the bodies of older women are inscribed in particular fashion. You may be saying "wait a minute- older women are more than this- they are not victims". If you are, this is the point where I would like to agree with you.

Where there is Power there is Resistance

Although it may seem that older women's experiences are removed from this process, older women's narratives exist both within and outside the margins of these powerful interpretations or discourses of care, objectivity and risk. The powerful classifications of risk, which are required for the purposes of residual service provision, portray the older woman as a body in decline. Within this location or imposed culture however, are examples of negotiation and resistance. Multiple forms of power circulate within and between older women's accounts and social locations. For example, while the frail/non-frail classification imposes an identity and limits what is recognised as need (i.e., risk), in doing so, it also provides access to a restricted service. Classifying older women who receive public services as frail is a strong form of coercive power. In this sense, power becomes more than imposed from the state level. Power operates within and between the various accounts and actors within home care policy. As such, it may be considered that where there is power there is resistance (Foucault, 1980b). As such, I wanted to understand how older women would negotiate this frailty that was both a social

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negative connotation of this label.

construction and representative of a reality of physical decline. In a sense I am looking for the complicated ways that older women define themselves, negotiate and resist health, aging and decline.

At this point I realise that I have jumped into theory- perhaps because it is safe- perhaps because it makes sense at this point of time. My thoughts about resistance however, remind me of my comprehensive exam where one of my committee members asked me whether her grandmother's jam making was an act of resistance. Although at the time I didn't have the language or theoretical position to back up my belief I laughed and said it could be- point well taken. Now however, I would say that depending on her interpretation of her experience it could be—that it would depend on the meaning that she associates with making jam. Considering Foucault's notion of where there is power there is resistance (Foucault, 1980b), combined with the making of self through narrative, her grandmother's reasons and meaning for making the jam would decipher whether or not it was an act of resistance. Was she making the jam because she enjoys the jam? Because she wants to share the jam with her family? Because she holds the tradition of jam making as an important role despite the time and effort involved? Is she making jam because she does not want to buy the jam that is mass-produced by companies? My answer now would depend on her answer, her experience, and her meanings. I would now look to question the very activities such as making jam that are taken for granted. The jam may be a meaningful activity that depending on the context, situation and interpretation may represent resistance for her. However, her concerns are valid—I will find resistance where I look for it. Research is informed and influenced by the person who collects, interprets and presents the account. At this point, I feel I have to justify my interest in older women's issues. To do so, I should provide a summary of who I am and why I am interested in older women's experiences, as well as the reason that I have chosen to present my story as such.

My Account

My life experiences and social locations impact the way that I understand and interpret older women's experiences. Similar to the women in this study, I have chosen to present varying locations at varying points in time. Like them, I have kept some facets of my life to myself. I have not revealed the parts of my life that did not seem to fit within the context. At the same time as I have imposed limits on myself, I am also constrained by the expectations of the academic institution, research and practice milieus, as well as tradition and structure of a doctoral dissertation. Just as the stories or accounts of the older women in my sample are performances told to a younger woman, this piece is a performance for you. It is a performance for the purposes of a doctoral degree in social work. It is an account that I have written for you—it is my interpretation. To contextualise my interpretation and analysis, here are the experiences, which I feel are relevant to my interpretations.

I am currently a doctoral candidate within the joint program between McGill and Université de Montréal. I am a young, white, now privileged woman. My life as a fully funded doctoral student at a prestigious university has given me first hand knowledge of how a change in social location such as income can change everyday experience (e.g., access). Living in Montreal has given me the opportunity to explore and understand my roots and connections as a French Canadian woman who grew up speaking English in Ontario. My life as I knew it prior to graduate studies at McGill and life in Montreal, and how I currently experience it, are very different. My former and current social location and the contradictions between the two have given me some insight to understand two very different locations as well as provided a personal example of both the shifting nature of identity, and the way location impacts on experience. And although I have the empathy to understand some of the experiences on the 'other side' or at the margins, there is no going back. I was raised in a small town, working class, and religious. Work ethic, volunteering and discipline are interwoven into my experiences of 'how things are'. I have worked since I was a child—on a farm, in restaurants, offices and now would say I am a researcher. To this day my family asks me "what do you really do"? In my current life, these social locations remain unknown. Instead, my identity is presented as student, researcher, or friend. My current identity is saturated with professional identities and responsibilities. Yet at times, they surface and become a part of not only who I was at one time, but how these experiences have shaped who I have become and will be, as well as the way I interpret and live my life. My personal experiences set in motion a keen interest in identity as storied, contextual and relational.

At the same time as I am currently recognised within my professional identity, internally, I struggle with how to create balance between my professional identity as an academic or intellectual, and the connection that I feel with my body. Growing up, I was a dancer. At an early age however, I had decided that I would not pursue dance as a career path—for me, I was uncomfortable with the emphasis on structure, beauty and aesthetics. Of course, this sentiment here is rationalised. At the same time, dance was expression—it was an escape, a release, and a reality. Yet, within classical ballet, I could never find the room I required for self-expression. Further, I felt constrained as a body. I stopped dancing for several years until I came to Montreal. Upon leaving dance, I decided to pursue university studies. Here, I focused on history, women's issues and body. Only recently, did I realise that I had created and lived a dichotomy between body and mind. I now realise that in my current work, my mind is often disembodied. I am currently struggling to incorporate these two and maintain a balance of intellect and body. When I came to do my Masters in Montreal, I took recreational classes in Modern dance. Although I have made a transition from Classical to Modern, I will always be a classical ballet dancer. In Montreal, I began to pursue my interest in studies related to care and the body. This balance of body and mind however, was not merely at an intellectual level. It was also influenced by a previous illness experience with meningitis that I would consider a major turning point in my life. As a result of this experience, I am constantly aware of my body. At times, my professional and personal choices are inseparable, at others overlapping. However, my own experience within and through my body has instilled a keen interest in the way that other people negotiate their bodies in everyday life.

My interest in older women however, is not merely at the level of the body and the way that they interpret and live through their bodies. I have always felt a connection with older women. Throughout my dissertation years, I have attempted to find a rational explanation for my interest in older women's issues. I have only found pieces that are tentative and partial at best. In part, this interest comes from my connection to the past—to history, styles, people, and clothing. I have always been interested in older women's stories. I'm not really sure that I knew it was their stories—I guess it comes from some value of history, perhaps similar to Mischler (1999) whose "romancing the crafts" led him to pursue research on the stories of craft artists. Perhaps like Mishler (1999), I am romancing the past, perhaps trying to discover it, perhaps looking at it as a way to confront my disillusion with present and future. At first, when asked 'why older women', I would respond that this is one feminist issue that has not received a lot of attention. True, but I have to admit that my interest in older women's issues goes way beyond an interest in women's issues or social justice. I feel very connected to older women in a way that I do not feel connected to other groups within society. Stories from older women hold wisdom accumulated over the years. There are many times in my life where I have been called an old soul—I feel honoured by this statement. In addition, I have always been fascinated with the time period between the 20s and the 40s. This interest may be understood as a fascination for a period of liberation despite financial restrictions or gender, a period of artistic and philosophic upsurge, or purely an aesthetic interest, yet it nonetheless it is there. Most importantly, all of my life I have been told that I resemble my grandmother in style, appearance, and most of all "Sa façon d'être". I never knew her. Perhaps my connection with older women is a search for my roots. Recently, I have also wondered if my connection to older women comes from a comfort level discovered long ago in my Catholic school years in small rural community. Several of my teachers were older nuns—in fact, my high school was attached to a convent and infirmary for older nuns. I admired the work of many of the sisters, whom to me were the activists, community organisers, and social workers of the past. I am comfortable in discussions with older women and could listen for hours to their stories, lives and experiences. Older women for me are teachers and role models—I believe they are the reason that I entered social work.

Professionally, my social work career began in 1994 when I secured a position as a disability service worker with the Essex County Association for Community Living in Ontario. Over the three years in this capacity, I began to question the impact of community care policy on service delivery for persons with disabilities and their families, compelling me to pursue graduate social work studies at McGill University. In my undergraduate degree, I worked within the independent living movement, mainly with persons with developmental disabilities who had recently been released from a local, and perhaps one of the largest, institutions. Here, I worked as part of the team of youth workers and developmental service workers. Although I was already a supporter of the independence movement in philosophy, this position with the association allowed me to see both the strengths and shortcomings of this policy initiative. For many, I saw how de-institutionalisation enabled an independent life in the community. For others, I saw how the lack of resources, planning, and follow-up restricted their ability to live in the community. This front-line position gave me a great deal of insight into the illusions and contradictions within the policy of community care. I would further take up to these interests in the Masters at McGill.

While conducting a dossier review of a local service centre for my Masters of Social Work, I became acutely aware of thematic ways in which older women of home care services were described in the files. These included powerless, non-compliant and being demanding. Examples ranged from discussions about older women who interrupted the flow of service provision (i.e., amount of service hours allotted) by asking too many questions, as well as those who were labelled for their failure to comply with service directives. I felt that in addition to a strained service environment, older women's services were affected by their compliance. On one hand, those with no active family member to advocate on their behalf were given services as a passive recipient, while those who had an advocate or were able to be the 'squeaky wheel' seemed to 'get the oil' (i.e., the service). However, there existed a fine line between asking for service and being seen as demanding. It seemed that gender and disability played central roles in assessing and determining eligibility for public service. Although older women's experiences in relation to frailty and service were not a focus of my past project, I reacted to the construction of older women within the files. I began to ask questions about defining need on the body, meeting need according to level of risk, as well as the ways that older women's negotiation was silenced. As a feminist, I disagreed with the pathology, victimisation, and ways that older women are portrayed, excluded, and devalued in general, academic, and service discourses. As a result, I began to question the assumptions underpinning frailty and discourse of and about being a frail older woman in relation to service eligibility, and continued my exploration through doctoral level studies. I felt that there had to be more to older women's experiences than what was set out on paper—I am a feminist—I did not want to see the older woman pathologized, nor portrayed as a victim. In this research, I am guided by the belief that 'things could be/are otherwise'. That is, I believe that older women's experiences may not be summarised by the 'little old lady' stereotype, but that older women's everyday lived experiences are more complex. For too long, researchers have ignored local and diverse experiences, and in some small way, I aim to understand and explicate these differences. As such, I am starting by exposing older women's voices and experiences and attempting to understand them in a larger social context. I anticipate that exposing older women's voices and experiences in relation to being frail, will demonstrate differences between the way older women are constructed and the ways in which they make meaning and negotiate experiences in relation to frailty.

Again, I have to interrupt both myself and your reading. As much as I have tried to be honest about my position, this account is not about me—it is about the twelve older women who told me their stories about their lives, themselves and their health. I have chosen to present their identities as summaries, which reflect both their identity and my interpretations. While I have attempted to maintain consistency between accounts, I have tried to organise them differently depending on the way each woman presented herself to me. I have described specific social locations and included verbatim sections from their accounts to give the summaries meaning. This presentation of individual summaries is intended to challenge the binary position that would classify the older women based only on their health status or absence of. It intends to create a balance between individual stories, overlapping experiences and the way similar experiences may be experienced differently. It intends to highlights the complex identities within each story, present their social locations and provide insight into common threads achieved only through a narrative method. Yet, I wonder if I can truly try to represent their identities and life experiences in a large paragraph—can I really attempt to summarise their situations? It makes me think that I couldn't tell anyone's story but my own. And even my own story would be told differently depending on the listener. In this sense, the summaries must be recognised as constructions that I have created for the purposes of presenting the older women in my sample and challenging the dominant understandings of women as frail bodies.

Older Women's Accounts

Clara

Clara is a **'strong'** **'coloured'** **'woman'** originally from Nova Scotia. *" I can take anything, I'm a rough character, yeah, sturdy woman, strong woman all my life. (745-746).* She describes herself as a **loner**. *I'm just like a loner most of the time, I love being by myself, I guess that's why I'm here, that's the situation you're seeing. I love being by myself, doing my own thing, and I know enough, intelligent enough, to do things for myself that keep myself what I, very happy. Keep busy. (121-126).* Her narrative is organised mainly by strength, intersecting with her identity as a **'hard worker'** within a **'faith'** based perspective and is inseparable from her experiences as a **'coloured'** woman. Her identity as '**worker'** is threaded throughout her life. This worker identity starts as a child adopted into a 'poor' farming family. *God planted me in that house, yup, he knew I could do it, the good Lord, that's why I trust in God. He knew I could do that work and I could help them. I was planted there for a reason, believe me, good reason. Couldn't be a better reason in the world, even over money, money didn't, I had no money, 'til I came here to work. Money was nothing. (1013-1019).* Her identity as worker continues through her domestic work in the homes of wealthy women in Montreal, as a **worker** in a famous jazz night club, and throughout her **family responsibilities** of providing for her family. Family responsibilities were discussed as a struggle and overall achievement. *I had to go. [to work] They have to eat, they need clothing...(683-684) I had five children and it was a real struggle for me to bring them up, to bring 'em up properly and get 'em educated as you can say, that's work. (660-663).* She now describes herself as **retired.** She is 80 years old, a **widow** (since 1979), but never explicitly identifies as a **'widow'**; she never speaks of her husband. She lives alone. Clara **rents** her apartment- she has never had the financial means to purchase her own home. *Oh no, I never have, [had enough money] 'cause I woulda had a house long ago, it's quite obvious. I woulda had a house long ago with my children, when it was cheaper, that was the time. But now they're up so high you'll never get (1119-1123).* In recent years, Clara has experienced several health issues including difficulties breathing, heart problems and problems with her back. She was referred to me as **'frail'** by a community service, but does not consider herself to be **'frail'**. Her story reveals tensions between accepting and resisting decline. *You gotta be strong even if you know that you're not that strong, but you have to act strong anyway and I think it works very well for everyone [okay] that is not well.* (32-35). For her, her identity as a **'strong coloured woman'** is key to maintain a meaningful existence and resist a 'frail' identity.

Elizabeth

Elizabeth is an 80-year-old **academic** who describes herself as a **White Anglo-Saxon Protestant**—*a dying breed* (1060). She is proud of her age. *I feel that anybody can be young, I mean, we're born that way, but it takes a certain amount of stamina to get to be old* (109-110). Her identity is strongly connected with her profession—she continues to work and was one of the two women I **interviewed outside of her home** (in her office). *I have been working here for something like twenty-six years, um, I enjoy it, um, I greatly prefer this setting to belonging to bridge clubs and the heart clubs and things of that sort (laughs) and I think of where else for somebody my age, find a place they can sit and bright young people have to come in and be nice to me.* (8-13). She comes from a **privileged** background. She was born and raised in Montreal. She got her BSc in 1942, worked in three munitions plants, worked for the Federal Treasury Board, spending several years in Ottawa and Japan as the **wife of a diplomat**, had a family, and did **volunteer** and **board work**. *I got into volunteer work, boards and so on, and realised quite early that, um, the real action was with the professionals not for volunteers, at least for me. (51-53).* She describes her self as a **bureaucrat** by nature…a **civil servant** who prefers to **toil behind the scenes**. *(53-55).* She started her academic position in 1972 when her husband died, with a few years off to obtain her doctorate. She is a **widow** of twenty-one years, **mother** of two and regrettably no grandchildren. "*I don't know if my son is ever gonna come through, my daughter certainly won't* (15-17). She **lives alone** and has a housekeeper who was formerly the nanny of her children. *Well, I live alone so to speak socially but I have a housekeeper who I've had for, I think about twenty-three years, she entered my life when I still have a husband and children and I just never could bear to let her go.* (1031-1034). Elizabeth does not receive public services and was therefore considered non-frail. She recently underwent hip replacement surgery. She has **purchased** the **health services** she needs from a private rehabilitation clinic *I haven't needed [public services] yet so that, um...I'm fortunate that I can, up until now anyway, I've been able to afford the services I needed so it hasn't been a big issue* (836-839). She has also used her financial resources to **relocate** and **modify** the **condo**, making it accessible and appropriate for her needs. *I couldn't deal with stairs happily, [okay] so I moved from a house with a number of stairs, there was quite a lot of levels, moved into a condo, no stairs.* (1037-1040). She has also recently acquired a handicap parking sticker, which permits easier **access** to her work. She describes her health as excellent—she would not describe herself as frail. *My problem is clearly arthritis, quite boring to talk about…You don't usually die of arthritis, so it's, um, just extremely uncomfortable* (138-141).Her account is filled with the realities of decline, the way her financial resources have permitted her to make the necessary changes to maintain her professional role, and the way she adapts and negotiates the practical daily issues of access—housing, elevators, parking.

Alice

Alice is an **87-year-old woman** with **spirit** and good sense of **humour**. She is **married**, **cared** for her husband after his stroke; he is currently placed in residential care *But I looked after him for 13 years at home. By that time, they decided they better take him or else they would have to take me too you know. I was worn out from it all. (111-113).* She has several **health issues**, including arthritis, osteoporosis, fibromyalgia and incontinence. *I don't know what's gone wrong with me...It's this, that and the other thing. I said "You name it and you can have it". But no one has taken me up on that offer.* (528-530). Her major health struggle however, was a **difficult recovery** from hip replacement surgery. *Instead of being away from home for six weeks, I was away for five months. (132-133).* At this time, she is not able to leave her house very often. Her days are spent with the chores of **self-care**. *The cares of the day take over...I have quite a lot of activity, just walking around, and doing my self-care here in the house, which helps but it's not the specific exercise that I need (40-44).* She talks about the realities of **decline** *the body doesn't always want to do what my mind tells it..(16-24)*, **adaptation** *I never can adapt, entirely. Because my body isn't the same. At one time, I could do things...I went out with a cane, but I could go out. (855-857)* and **uncertainty** regarding her condition *Maybe I'll get better, maybe I won't. Time will tell. (94-97).* As a result of her involvement with service, much of her narrative is framed as her need to organise, schedule and manage her life. *I have to **readjust**, because my life now is tied to other people and schedules. I can't just make my own schedule. I have to do the adapting* (54-56). The biggest **loss** for Alice however, is not being able to garden. *So I was very heart broken that I couldn't get out in the garden anymore, because you see how nice it looks out that window? (210-211).* Despite the presence of illness and decline, her narrative focuses on her resilience and coping. She maintains contact with her neighbours and takes pride in doing small things such as baking bread to please others. *You know, a slice of bread was nothing at one time but we old folks, we like it ...that, saved the day, you know... Mission accomplished. (307-312;* 344-347). Her income is limited. *I know how to manage on a small amount (788-789).* She lives in the home that her **family has owned** for years and rents the upper duplex for limited income. *I could never live on that (750).* Although the housing may not suit her current needs, her home has a family history. *My grandmother died..in this room...My mother died in this room. My father was taken away from here to the hospital, where he died. My brother died in that room, so you see it's all tied up* (393-397). She was referred to me as **frail** as a result of her extreme arthritis. Sometimes she is involved with a day centre, she receives cleaning from the CLSC and several neighbours and previous care workers stop in to help her. Her narrative reflects the strategies she uses to negotiate and manage her self-care and life on a daily basis. *You live for day by day. And you have to make a certain, you make goals. You don't have any plans. (965-966).*

Maizie

Maizie is a **68-year-old Black woman** who identifies herself as a **senior**. Her identity is centrally connected with her **professional identity** and **community involvement** with the church and the Black Community. She was involved with the Black Nurses Association, fundraising for Senegal, with the seniors at the church, the Congress of Black Women and is currently involved with several organisations and fundraising efforts for the Black community, women and seniors (58-61). *I think that's why I'm still here. [Yes] Hello, can't look at it any different...There are too many things that I got to do, too many things I'm involved with* (53-55). She is also a **mother** and **grandmother**. Our interview took place in one of the organisations that she is involved with, making her the second woman that I **interviewed outside the home**. Her grandson was with her at the organisation during the interview. Although she is currently **retired,** she is a **nurse** by training. Prior to her retirement, she worked for several years in one of the hospitals in Montreal and **knows the system** of health care very well. Her narrative is organised as a lesson about making claims and the realities of both need and care. Her narrative includes various examples about these issues. *So you have to be strong (159)...you have to be able to stand up for yourself or have a relative that'll stand up for you* (182-183). She is **non-frail** and is in relatively good health—although she admits that everyone has their own health issues. *I think we all have health issues...I don't think there's one of us out there without. There's some that may be a little bit more severe than others* (12-15). She was born in Barbados and **immigrated** to Canada in 1958. Her social location as both an immigrant who has lived here most of her life and a Black woman contribute to her way of seeing the world and negotiating for herself and others. Her narrative is framed within a **rights-based perspective**. *I'm a senior. [Yeah] I'm a senior I want to live with dignitary and respect. I want all the dividends, that I helped build this country, whatever is mine...I came here as a young person...and I've always worked, haven't drawn, paid unemployment...never asked for anything...I helped build this country, and I need my dividend.* (301-307). Although she currently identifies as a **senior**, she doesn't see much difference between the way she has always lived and the way she lives now. Her identification as a senior is connected with **making claims** as opposed to slowing down—she was **busy** throughout her life and continues to be busy after her retirement. *Yeah. Even when I was working, people say, "how did you do it?" and now I'm not working, and they say, well I don't think I need to ask you how you're doing it. No. Because, when I was working, I was still doing it. So.* (63-66). Her strategy to negotiate and make meaning of her life is a combination of **motivating** herself "*I'm gonna start to move*" (27), "***prayer, faith and perseverance***" (30) and **doing things for others**.

Margaret

Margaret is a 90-year **'old woman'** *I'm an old woman, I'm a well-preserved old woman. (748).* She was **born in Wales** and immigrated to Canada at 52 to be closer to her daughter. Margaret' account begins as a life review *But I've enjoyed myself, I've had a good time. Good life. Yeah. (35-43).* Margaret describes herself as a **fighter.** She had a **very hard life** when she first started work as a **Skivy.** *When I was 14 my mother sent me to ..London...I used to have to work hard..they'd get me up in the morning at half past 5 and I worked until 11 o'clock at night...But I had a brain you see, and I thought to myself. They're not doing this to me..* (78-85). It was here that she learned to fight. *I hated it there...I'll never forget that..since then I've been able to fight for everything. Lots of things in my life that I've had to fight for. (190-194).* She talks about moving from job to job *...Run, and if that was a little better I'd stay a bit longer, and if I didn't like it I'd move to another one (76-91)* until at 22, she found a job **supervising** a restaurant—this was a major turning point for her. *'Cause you see, that's how I got on from there on. And from there on, everything went nice for me. (101-105).* She began opening factory canteens and continued this work in Canada. She was **married twice**, **widowed twice** (1948 and 1981), has one **daughter**, two **grandchildren** and eight **great grandchildren**. She worked as a supervisor until she was 69. Her life review however, is interrupted by a **bad accident**, which changed her life. *I have not felt healthy since (216)*—she describes **aging as tough**. *You see 4 years ago I had a very bad accident and I really, you know it's affected me...I've got backache and knee ache, and this happened four years ago through a fall. Just a fall. (17-20).* Prior to the accident, Margaret had never had health problems *I'd never been in a hospital before (30-31).* The accident meant that she could **no longer do the activities** she enjoys. *Let me tell you, I used to walk three and four miles, a day after my retirement...every morning. I exercised, I did aerobics...(215-225). Now I can't even go to that. That's too much for me you see. I can't get on the floor because I can't get up (241-245).* Sometimes she is able to do exercises with the seniors. *...the exercises we get, are now only just movements really. But they do something for you, you know...I'm so glad I can even do what I'm doing now (241-251).* She also has a **difficult time getting around** *I can't walk, what I do is I get a lift there. And everything, they send cars for us you know. Otherwise I couldn't go. (252-256).* She is **afraid** for her **security** as well as **falling** on the bus or in the metro. *I'm nervous. I'm nervous, going out and I was watching, if there's a man behind me or anything like that, because now I'm helpless, you see. (394-395).* At this point, she sums up her life as a lesson learned *I think of it all, it's all a good lesson you'll learn, you'll learn from uh, lots of things, yeah. (128-131)* and is concerned with **being** strong, resisting aging and fighting **decline**. *I'm not going to have a walker unless I have to have it (297-298).*

Martha

Martha describes herself as an active **volunteer.** *I did a lot of, uh, social action work, I picketed, I did many, many things, and I enjoyed every minute* (35-45). She is an 80-year-old **Canadian Jewish** woman born in Poland. *Well, uh, I came to Canada with my parents when I was six months old....difficult times but we were very fortunate...we started off better than a lot of other immigrants.* (15-19). She has strong **family connections:** She was **married** just before the war **and lives with her husband** in apartment that they have **rented** for several years. She had one child when her husband was overseas, one nine years later, and now has **four grandchildren**. She describes herself as middle class *we live, most of us, live on this fixed income of our pensions* (103-106). She speaks English, Yiddish and French. Looking back on her life, she has **worked hard**, **negotiated transitions** in life and **learned** a lot. *...looking back, it may have been hard at that time...but then I look back, it wasn't so terrible* (19-20)*...it's been a pretty good life, uh, not a life of plenty but, good things* (53-55). She is a **cancer survivor.** *Except for that session that I've had, I was pretty well* (32-35). She does discuss however, how during her illness she was weak and afraid of becoming a burden for her family. She began her current involvement with **volunteerism** about a year after adjusting to her **retirement**. *I stopped working, I was sixty-four years old, and I, even though I was looking forward to the day where I'd retire and not have to run for the bus early in the morning, what not, I was miserable after I finally did do it...then I decided that, uh, I'd do some volunteer work.* Martha stays young by **working with younger people** *the fact that I was working with young people was great. I was not allowed to get old (35-45).* While she talks about the need to **motivate** herself and **keep active**, she also describes how she has made the choice in the past years to **slow down**. *I don't force myself anymore to do anything...that's a privilege now, that's the bonus of not having to do things, I can do it when I want, if I want (249-251).. I don't wanna make big dinners anymore, but I am eighty.. so a lot of things is not because I was ill or I am ill, it's just time to slow down [okay].424-426).* In addition to **slowing down**, Martha has now accepted her identity as an **older woman**. *I'm old enough to be gray (903).* Referring to her mother, she highlights how age is relative. *Now, she as a mother never considered me as an old woman. You know, I was seventy, as I say to her, hundred, and, uh, uh, she was still trying to tell me what to do and I would tell her I'm grown up, and I, and I do it my way okay?* (845-849). Within my sample, Martha is **not frail.** Her narrative is about the tension between **staying active** and **youthful** by associating herself with youth, as well as her strategies to **slow down, accept** her age and limits, and **adapt** her life in a way that is meaningful. *So I have to learn all these things, I'm still learning, we learn 'til the day we depart.* (869-870).

Ella

Ella is a former **singer** and **entertainer** with the U.S.O. *We went to New York City and, uh, we auditioned for them and they accepted us right away and said we'd like you to, uh, to work with the U.S.O. (217-218).* She takes pride in her professional identity and says that she *wouldn't have missed it for the world.* Born in the United States and raised in Montreal, her narrative, framed as a life review, began with the following: *I'm looking for the pictures of my father's restaurant down on St. James Street. Oh I found them, that's what I brought the whole thing out for—that starts the story of my life* (150-154). Her family's relocation to Montreal marks the beginning of life as she knew it—as a **privileged** black woman—a daughter of a US businessman at the turn of the century. *And, uh, so we were very lucky we had a nice home on Elm Avenue, that's where I was born ..then my father bought a home...near the Westmount Park.* (167-172). The importance of **family**, her role as a **daughter**, **wife** and **caregiver** for her parents and her sister's children are threaded throughout her narrative. She is 91 years old, has been widowed twice, and has no children of her own. Ella was also a **teacher** at the Negro Community Centre for 18 years. She speaks of the children there as 'her children'. She **lives alone** and **owns** a duplex with one rental unit, which provides her with her main source of income. However, she **now lives on restricted means**- most of her work was in the United States, and therefore she does not have a Canadian pension. *It's difficult because I do without things that I would like to do and I don't, you know, a lot of people, "oh, you got it made', they don't know, 'cause I don't say.* (579-581). She balances her story using a metaphor of luck—she has been both **lucky and unlucky** throughout her life. Her discussions of luck refer to life, loss, death, and **being alone**. *I had a lot of friends, one by one by one they've all passed away and I mean, I feel it* (272-274) *I was so unlucky I lost them one by one by one... I've been to so many funerals...I have to watch them all go, you know, and be here by myself.* (287-298). She has fallen twice the past year, is '**lame**' and walks with a cane. She is **hearing and visually impaired** and uses a white cane. She is a **spiritual** woman but, is only able to go to church when she feels strong enough. *I don't go every Sunday. Um, when I'm feeling good I go, when I don't, I just lie in bed...I put my collection with next week's, put a rubber around it..* (304-309). She was an active **volunteer**, but now relies on volunteers for her transportation. *I used to go and pick-up, I'd pick-up those seniors, oh I thought I was young, I picked up the seniors... that's the same place now where I am. And I get picked up.* (528-533). She was referred to me as a **physically frail** woman, but her identity varies depending on whom she is speaking with. She receives services from the Association for the Blind, a Community Centre and the CLSC. In the spirit of her life review she sums it all up as being good *I'm glad to be living these days... I guess that's the story of my life (871-872).*

Kumiko

Kumiko is a **busy** 73-year-old **retired** Japanese Canadian woman. *I don't consider myself a senior, but I guess you would! (4) I don't know, I don't think I've aged since I'm, ah, fifty. (45).* She was born in Victoria, British Columbia and came to Montreal after the war[i]. She describes herself as **a Jack of all Trades- Master of None**. (413). Her narrative is woven around her past and present roles and activities in relation to her **work within** the home, **work outside** the home, and **volunteer** work with the Japanese community and church. She has been married for 48 years, is the **mother** of four and was a **caregiver** for her mother-in-law and mother. *I brought up...three boys and one girl which we put through university - all of them are university grads - and then I had... my mother-in-law here for thirty-seven years, and she stayed with us...and the last year of my own mother's sickness...she stayed with me and I looked after her until she died. (96-102).* She lives with her husband in the home they have **owned** for 35 years. They rent their upper duplex to their daughter and her family—this gives them the chance to enjoy their granddaughter. After her children grew up she **worked outside** of the home. *And I was working; I was in the office, I must have worked about eighteen years outside of the home. (104-105).* Since her **retirement,** she has found the time to do things that she and her family enjoy, including travel. She has taken up the **hobbies** of Japanese doll making (Kimekomi) and Japanese embroidery (Bunka Shishu). *Well, they like the end product, they're saying,... "Well, when you're tired of them, ah"- she'll take them all! "When you don't need it, I'll take this, and I'll take that." (340-345). And, ah, since retirement, um, I took these hobbies. But I've still continued my voluntary work at the church. (109-110).* She likes to **cook**—part of her volunteer work is providing Japanese meals and deserts at various community events and at the seniors centre. Here, she makes interesting distinctions between herself and seniors. She considers herself **retired** but not senior—seniors are the persons that she provides assistance for. [At the centre] *they have music, singing, and, it could be a movie, ah exercise for the seniors. So we don't take part because we feel we're younger. (35-37).* Her **health** has been very good—she and her husband do everything themselves. *We have no health problems, so that's why I consider myself young! (194)... I always read the Gazette you know and it has all kind of health problems and what to do, and I don't have any of that. The only thing I have is my allergies. (997-999).* She has always been involved in many activities—now, she speaks of the need to **create balance** and let some things go. *So I says, "I think it's too much; I think I'll quit, so about two years ago I let it go. (119-120).* Her strategy is to take things **one step at a time** and enjoy life. *Our life is worthwhile living, y'know? (224).* Her aspiration is to learn to play the **piano**. *I'm too old for that, but I'd try (1026-1029).* Her narrative is about keeping busy by doing one thing at a time.

Dorris

Dorris is a **76-year-old woman** from Farnham, QC whom is just moving on from an **illness** contracted while in the hospital for a knee replacement. She is a **gardener** *I'm a gardener, I ... one of my favourite things to do is garden, create and garden* (11-13), a **mother** *I tried to teach myself to be a quiet mother, mind my own business and not give my opinion* (250-251) and a **widow** *it was very, it was very devastating when my husband died ...because I was ...58, too old to go to work* (145-147). She **lives alone** in an apartment that she **rents**, but talks about **moving** with her other daughter in BC. *I decided to sell my house three years ago...moved to an apartment for two or three years and then, the thought would be that I would have to go with my daughter* (22-25). In the past two years, Dorris had had a series of **health issues** including knee replacement surgery and illness. At this time, her account and identity are dominated by **interrupted narratives** *I thought I would sail in and have this knee replacement and sail out again and, do a bit of physio and everything would be okay, but it didn't work out that way.* (35-39). Her illness with the so-called **"hospital bugs"** left her very ill for a long period of time. *Um, I caught this bug, and um, I guess I wasn't as strong as I thought...I was because it really got me* (39-41). *I really felt, I knew I was frail...* (804-805). This illness had an extreme impact on her life. *I tried to tell people, that I'm weak...well, you know, perhaps there was a bit of depression too, because when you're sick and I thought the disease was killing me* (995-998). She now has **facial paralysis** and continues to be **weak.** She questions her abilities, is no longer able to do the things that she used to do such as **travelling, socialising and gardening,** and lives with uncertainty about her condition. *I don't know whether ... the freezing weather will affect my face or not so* (167-173). She refuses to have her second knee replaced as scheduled. *I'll never have the other one done, I don't have the courage [unintelligible]...to go back now* (549-558). She talks about her **negative experiences** in the hospital and the **isolation** felt within one's home when one is ill. *Um, it does get lonely when you don't have family close by, especially when you're sick* (33-35). *when you're ill and when you're frail...it's very lonely when you're not, when you don't know whether you're gonna wake up the next morning or not it's not nice to be in the house all by yourself.*.(48-53). She talks about how her sickness brought on her thoughts about losing her daughter to cancer. She is looking forward to moving beyond this illness narrative. *it's really just been, it's just been since about the 20th of May that I've been feeling fine, so it's been a long, long, uh, long winter and spring and then I developed uh,* (65-68). She was referred to me as **emotionally or psychologically frail**—a term she herself uses to describe herself during her illness. She cancelled her involvement with services because they didn't meet her needs. Her story is about the difficulty of **coping** with illness and decline *it'll either go away or I'll have it for the rest of my life I guess, huh, better have to get used to it* (82-83).

Annie

Annie is a **67 -year-old woman** born in **Australia.** *I was born in Australia and I lived there for the first twenty years of my life and then I left to do the big world tour...* (15-16). She was married in Canada and had two **children**. She **worked within the home** when her children were young. *I was a stay at home mother and uh, you know the help mate as we used to call it in those days um, and be painting...and the gardening...a lot of physical things (46-49).* When she did **work outside**, she worked and studied at night. *I would go in...at one o'clock or two o'clock in the morning and do the work and come home.. So it didn't interrupt, uh, like the family routine...today I would do it very differently...*(53-70). She **divorced** in 1981, after which she worked long hours **outside the home.** *I have been so concerned about making ends meet, all of those things that I had stopped doing a lot of things I used to do...I worked long hours so it didn't leave me much time (199-203).* Now that she is older she feels **'free'**. *I find now I'm sixty-seven. I'm so lucky...I have such freedom...freedom to try different things...I think I used to feel very responsible for people...this whole idea coming back from when you put your priorities....well they're the last ones (98-102) ...Now that I'm older..[cough]...I have never been so carefree in all my life (140-141).* She **owns her own home** and rents the lower duplex to her son, his partner and their daughter. One of her current identities is as **caregiver**—she retired to look after her 3-year-old grand daughter. *I retired to look after my granddaughter...from Monday to Friday... I used to work very long hours before...it would have to be ...for something like that that I'd retire (41-45).* Family is important to her. *I'm still very close to them,* ***very close*** *and ...I also have a family here... my family, and my friends are like a family (31-33).* She also describes herself as an **activist**. She is a **friendly, outgoing** woman involved in health on both an individual level and within her **social activism.** Her hobbies, which she calls her "recipe for happiness" is a combination of **weight- training, yoga, and salsa.** *Annie's recipe for having fun and it would be good if you started it earlier (495-496).* Annie believes that **activity** and **involvement** gives you a strength that may help to prevent frailty and would like to teach older women. *It's obviously one of my hobbies, yeah it's like um, it's exhilarating, it gives you this quiet power and that's the strength yeah.* (462-463*).* For her, it is important to have **good friends** who keep you **involved**—difficulties for older women come as a result of isolation. *I'm, I'm very fortunate to have friends and I think, um, I think ...that's crucial to have relationships, to have close relationships and also to have secondary. (571-574).* She is **not frail** and describes her health as good. However, she has experienced difficult times or "sorrow' in her life when her daughter died. *So it makes me feel apart from anything else a desire to, um...really make this life count! To appreciate, beauty and people...and do something about...what am I doing with my own life. (164-168).* Her narrative is one of a healthy lifestyle, health promotion, getting it right and enjoying life.

Carrie

Carrie is **a 95 year old coloured woman**. *Tell me I don't look 95. Well, I don't feel 95.* (549). Her narrative includes several key stories that give her life meaning. She loves to **travel**, and began her account with her plans for her last trip back to Halifax. For her, this trip is connected with her **readiness for death**. *Yeah so I was born in Halifax... I'm going back uh, in about a month's time ... because I imagine that will be my last time. (24-27)... I'm sure after that the angels will come and get me (53-54).* Carrie describes herself as a **trouble-maker.** *You see I said, they don't want me up there ... they got enough trouble up there so they let me live.* (406-409). She gives several examples of the way she has **fought racism** throughout her life. *So they found out they couldn't fight me* (1214)... *I didn't get the name of the sauciest girl in the school for nothing* (1226). Her identity is connected with her **family** and her **work** life. She was **married** in 1927, **widowed** in 1949 and has two children. She came from a **poor** family *we didn't in live in the rich district.* (814-815). She worked into her seventies in order to get a full **pension** in the needle trade in Montreal and also collects her husband's pension from the railroad. She **purchased** her home when her husband was alive and rents the lower unit to her son and daughter who are her **caregivers**. She is a modest woman who appreciates what others have taught her she said ... *we are all poor together if we have it and you need it, it's yours...those were words I never forgot.* 141-142). She prefers to talk about the accomplishments of others. Through her stories of a woman at work, Carrie's respect for **hard work** and **determination** shine through. *One woman told me that when she came to Canada she had $8 in her purse, a sick husband and a baby. When I met her, she owned her own house.* (504-506). She is a strong, independent woman who **supports** the accomplishments of other women. ...*The women stuck together* (1151) and is active in the Coloured Women's Association of Montreal. Her narrative is threaded by a motto that reveals her philosophy on life. She says: *There is a destiny that makes us brothers no one goes his way alone what we send into the lives of others comes back into our own* (205-207; 366-368). She **discusses death** openly and feels that everyone has their time to die. *This is how I feel... when we're born, we're allotted a certain time space* (827)...*we're born to live and we're born to die, but I do feel that our days are numbered for us.* (865-866). According to her daughter in law and her social worker, Carrie is beginning to develop a **mild cognitive impairment**—she repeats some of her stories. Yet these seem to be the stories that have the greatest importance for her life. She was referred to me as a **frail** woman who is at-risk as a result of her developing impairment. She is involved with public services for Alzheimer's support and receives services from a local day centre. Her account is about sharing the lessons she has learned and preparation or acceptance of her time (i.e., death).

Katherine

Katherine is a **71-year-old full-time activist** for nuclear disarmament, peace, and social issues. *Um, I identify myself as a full-time activist. This is what I do. (468).* She describes herself as a **shy** person. She was **born in the United States** raised in **Montreal**. She was **married** and had three **children**. *I was...in a marriage, with a very powerful personality/partner...which certainly was...pretty hard for a shy person to deal with (250-252).* She is now **divorced** and **lives alone** in her **rented** apartment. She makes the distinction between her **old life** and her **new life**, marked by the turning point of divorce. *Once I found myself on my own I began the change (19-20).* Just prior to her divorce she became an **artist**, a **writer** and a **social activist**. *I branched into... a craft group...... it was my first venture out, which is, uh, appalling. My goodness, most women don't live like that anymore. (258-265).* A major turning point in her life was her involvement with the **peace movement** *So I went down without knowing anyone there (76)* and from that point on became a full-time activist. *I just plunged right in, partly because I was free to do so. I suddenly had nobody at home that needed my full-time attention and, uh, I guess, my youngest son was in CEGEP or university by that time, so I was quite a free agent* (86-90). She is the **founder of a local older women's activist group** which uses the image of older women as social protest, in addition to her ongoing work on nuclear disarmament *it's, uh, always surprises me how, a lot of people have, think that the nuclear issue has gone away, and it hasn't. I mean, it's still very critical* (95-97). Some identities such as **shyness** however, carry over into her new life. For Katherine, her frailties are the limits that she places on herself. She is in **good health** and is not frail. She talks about her '**strong constitution**', but feels that sometimes she has less energy than she used to. *Last year, when I turned 70 I, I said, I'm beginning to see that little dotted line behind my heels, I suddenly felt not quite so full of energy...sometimes I can't keep going as long as I expect to. But very often I'm, sort of, able to go at a better pace than much younger people.* (486-496). She talks about **moving** close to her children but is not sure that she can give up the social and activist roots she has established in Montreal. *I have three, three kids, they're all on the West Coast. And I'm trying to uproot myself. And I find it very hard, because I'm very plugged into Montreal, and I would like to be out there, closer to them, see a little more of them. But I don't know exactly how I'm going to do it. (286-290).* Her narrative is threaded by the **struggle to move beyond her limitations**—as she says it is **not a rehearsal**. *I guess at one point I just thought, well, you know, yeah, this is not a rehearsal, you've gotta shake that off. And, uh, it's just, it's not easy, and I'm still shy in many situations but, uh, I think you have to, make a decision to, uh, this has got to, this has to change.* (254-256)

My Interruptions

Presenting the three accounts has raised several challenging decisions. I was torn between allowing the women I interviewed to play the lead in the performance and balancing the three accounts. But as I said before, it is difficult to present the accounts when they have remained invisible within texts, policy and research. Challenges from my supervisor, rooted in women's standpoint, have both challenged me and assisted me to clarify my position. Originally, this first section began with the context of the older women's stories within managed care, review of the problems, and theoretical position. In the first version, the connections between older women's accounts and managed care were not evident—the older women seemed to be positioned outside of the debate. Even though I felt that older women's stories had everything to do with policy, I was struggling to convey this in my account. I then went back, and restructured the piece to explicitly confront these tensions between the three accounts. My intention as you will see later, was not merely to expose their voices—but to expose the voices and meanings in relation to a frail identity and experience—to show the contrast between the situations as well as the links between accounts. As such, my choice to place the strongest voice of policy first, is meant to reflect the way that policy imposes an experience on older women. Just as policy in part imposes an experience on older women in public care, the dominant account is imposed on this inquiry and presentation.

Aims of the Dissertation

Until now, frailty has escaped the lens of critique. Considering the movement toward managed care and residual services, as well as the proliferation of the use of this concept within research, policy and practice, a focus on frailty questions what has remained unquestionable. By looking at the frail/non-frail binary, this dissertation is a deconstruction of the foundational beliefs within frailty. It deconstructs these beliefs through a focus on the local experiences of older women positioned within and outside this category. In this case, the everyday practices of the local provide insight into the values and assumptions that operate within the larger concept of frailty. It focuses on diverse social locations to question the classification of experience, needs and imposition of an individualised medical notion. The intent is to explore the relationships and/or gaps between local meanings and the socially constructed concept of frailty. As such, it is an alternative reading at the local level—it is similar to Hall's (1998) classification of an exploration of the social construction of the policy experience. It differs somewhat however, as it focuses on the local experience of the persons classified as frail, rather than the policy texts which construct them. As such, it not only questions what is taken for granted, but the legitimacy of this position. It questions what counts as knowledge and attempts to present a different way of thinking. It positions older women's stories as examples of the negotiation, resistance and adaptation that are possible at the local level.

Considering that the accounts of policy, research and diverse older women are unbalanced in relation to power, I will explore how the three accounts (i.e., policy, older women's stories and research) interact to produce a dominant account of frailty as an individual and medical construct, challenge the imbalance that exists between this account and older women's accounts, and attempt to locate a more acceptable balance. Balance however, is misleading. My proposal is more what I would call a trialectic, which represents the tensions between three voices of policy, researcher and the older women that I spoke with. The tensions are more like several elastic bands that are pulling in varying directions than a balance between one heavier and one lighter object. Yet, the account of policy often has a stronger pull. This trialectical approach will highlight the tensions between accounts, voices and experiences of older women, critical analysis and reflection of the researcher, and health policy in relation to the receiving care. Doing so however is precarious. To deconstruct the power that is within the account also means deconstructing my power as the teller of this account. I am trying through reflexive pieces to be aware of my own rhetorical structure and critical of the choices made to create a balance of the accounts. It is structured as a performance and narrated by myself through my experience and reflection—it is self-conscious about its own rhetorical structure. Here however, I realise two major contradictions within the choice of myself as narrator. First, my account structures and defines experience in a similar fashion as the major accounts. Second, the choice of a narrator who guides the story—provides the turns and structures interpretation from a voice above or somewhere behind the scenes—seems to reaffirm the objectivity that is maintained within a traditional account or the voice of the professional expert. Despite trying to move from the limits of a traditional thesis, my presentation choices limits my real potential to have the older women speak for themselves. Perhaps however, it represents the way older women are not permitted to speak in certain circles—what counts as a legitimate voice. Taking into account twelve diverse older women's narratives and experiences, this dissertation intends to accomplish the following interconnected aims:

I. **To Explore and Understand Women's Lived Experiences Within & Outside Frailty.** That is, this project positions older women as the knowers or experts of their experiences. It aims to understand the daily and often taken-for-granted experiences of older women at the margins, as well as how older women negotiate both their identity and daily lives in relation to health and frailty.

II. **To Explore the Local Stories (Petits Recits) of Social Policy.** That is, it explores the local experiences that exist within generalisations and assumptions of social policy and practice. It aims to explore the smaller experiences within the larger stories of classification and need within the health care system. It focuses on the stories that exist behind the statistics and exposes the similarities, gaps and disjuncture between larger other-imposed stories and older women's self-created stories.

III. **To Explore the Issues and Merits of taking an approach focused on Language, Power, Diversity and Change.** That is, it aims to question various assumptions that exist in relation to frailty and home care. It is a critical appraisal of the common term frail, the power that exists within this construction, the way difference is and may be both excluded and accommodated (between dominant and experiences), as well as change that may make the accounts more relevant and useful to older women, policy, and research.

IV. **To Engage in Reflexive Research Conscious of its own Rhetorical Structure.** That is, it is written in a reflexive manner that is conscious of the way older women's accounts are told, the way the account is structured to persuade and influence, as well as reveal how the telling of the account is an exercise in power. Responding to Hall's (1998) statement: "By considering the constructedness of social reality we accept the constructedness of all claims including our own", I intend to write an account that is aware of my voice and role within the trialectic. (p.240).

V. **To Develop and Apply a Narrative Methodology Relevant at both the Micro & Macro level**. That is, it aims to create a storied approach to research that combines our current understandings of narrative. By doing so it aims to expand current knowledge and methods in research. It aims to expose the meanings older women associate with the construct of frailty, and recognise that other's stories may not represent older women's experiences. In this sense, narrative moves beyond a research method into a way of conducting practice.

VI. **To Present Alternatives and/or Change in Policy, Research and Practice**. It aims to move the voices and experiences of diverse older women from the margins to the centre, highlight resistance, and present alternative stories or accounts. That is, these older women's stories are meant to inform research, practice and policy. Understanding older women's stories questions current methods of service, recognise differences in older women's experiences, shift their conceptions of frailty and decline, and develop more relevant, policies and practice. These stories may provide insights about key policy issues such as language choice, recognition, as well as choices between targeted and universal services.

This dissertation is organised as a performance with varying acts. It is both limited by the expectations of what a dissertation should look like and at the same time is not limited by the structure of a traditional performance. Act II reviews the stories told on and about older women. It provides the context for the current dissertation focus on older women's narratives about frailty. It explores the way older women have until recently, remained invisible within research and theory, the evolution of medical response and social need, as well as how the older woman has become defined and regulated as a little old lady. It reviews the standard stories told by managed care, and how these have defined the professional criteria for assessing need and regulating services at the local level. It reviews the stories that are currently told about frailty as well as general stories of older women's resistance that exist within and outside of dominant accounts. Overall, this section reviews the existing account and presents both the challenges and questions that led me to my approach and topic.

Act III, is organised according to language, power, diversity and change. This act is structured as a dialogue reflecting my challenges to develop a relevant theoretical approach and the anticipation of your questions. The act is organised according to key questions, how I would respond at this point, and which authors I would use to legitimate my claims. Instead of an application of one theory which may not be as relevant to older women's experiences, this approach draws on various theoretical perspectives including cultural studies, literary theory, feminism, and postmodernism where relevant. Actors include Bourdieu, Bakhtin, Foucault, Fraser, Nicholson, and Leonard among others. As such, older women's stories may become examples of the biggish theory that exists within local accounts, opening the possibility for both new understandings as well as connections between the local stories and policy accounts.

Act IV is an intermission performance that allows you to go behind the scenes—to discover how I came to collect and understand diverse older women's stories about frailty. It is the story of a narrative methodology which outlines the roots of this approach, the transitions that I experienced moving from a more structured to a more open-ended approach, the sample and ethical concerns, as well as the structural elements that helped me to understand the meaning of older women's stories. It provides both a map for understanding this project, highlights the way the pieces of the stories became key analytic pieces, as well as insight into how this approach may be used within future research and practice.

Act V discusses how twelve diverse older women's storied responses, illustrations and experiences challenge key stories about older women, especially the individual medical construct of frailty. It presents the complex ways that older women's responses reflect and reject dominant notions, how their illustrations expose frailty as contextual, relative and temporal, as well as how physical or medical needs are interconnected with social experiences and social location. Their accounts show how older women's understandings of the concept and experiences associated with frailty are complex and shifting, how their experiences blur the boundaries of the common construction, how their accounts expose the power within the construct of frailty, as well as the gaps between services and older women's conceptions.

Maintaining distinctions between the stories, Act VI focuses on the way each woman constructs her identity and makes meaning of her past and present experiences. In each account, material is presented which demonstrates older women's multiple identities and the way in which older women negotiate their lives in relation to health. At the same time, it focuses on the language, experience and strategies that older women use to negotiate meaningful identities, reflect their needs, and negotiate the perceptions of others. It presents the various combinations of resistance, acceptance and change that are used to negotiate their lives, health and/or decline, as well as the way accounts differ as a result of social location.

Act VII places the understandings and negotiations of frailty within the context of health care services. It makes connections between the local accounts, the stories told about frailty, and their relevance in relation to research, policy and practice. It shows how older women's local accounts may become a site to understand and implement change, presents alternatives for policy and practice with diverse older women, as well as recommends an expansion of what is currently considered health and a return to a social model of care.

Act II
Stories told on and about Older Women

The literature provides glimpses of the various stories told on and about older women. Organised according to eight main stories, this section will examine the various discourses surrounding and representing older women. To do so, in each case I will provide a brief story plot or purpose of the story, the tellers or location of the story, the characters represented in each account, as well as reference literature which supports and/or resists the account. Although the stories are presented as separate accounts, they are actually overlapping—developed only in relation to each other. At times, it is difficult to separate them even for the purposes of discussion. Further, although these stories seem flat and/or equal on paper, they are actually very uneven and porous. The stories told about older women exist within a complicated system where claims have various levels of power. These stories compete and overlap to produce an account where frailty becomes an individual medical construct in relation to public services. As such, they provide the rationale for my attempt to create balance the policy, research and experiential accounts. The eight story lines include:

I. What Story? Older Women's Invisibility within Research and Theory.
II. Stories on and About the Body- Developing a Medical Response.
III. Social Stories of Persons in Need.
IV. Defined & Regulated: The Social Story of the Little Old Lady.
V. Standard Stories: Managing Care in a Business World.
VI. Stories of Professional Response.
VII. The Frailty Story (Defining Frailty & Frailty Defining Older Women).
VIII. Stories of Resistance.

I. What Story? : Older Women's Invisibility within Research & Theory

Storyline one recounts the tale of older women's invisibility (i.e., voices and experiences) within the fields of aging and feminism. This is a linear story, which documents major developments within feminism and gerontology that until recently, excluded older women from dominant accounts, and denied differences amongst older women's situations. Yet, at the same time, as a general review of past and present, it includes key turning points or transitions in thought and representation. The characters are the older person and at selected times, the older woman. Although I have re-shaped this story for you, my account provides glimpses of the various stories hidden within the accounts of researchers, theorists, and academics. As such, this story provides the context to understand how diverse older women are approached today within research and theory, and provides the impetus for attention to diverse older women's voices and experiences.

The Invisible Woman?

Until recently, the story of older women within aging and feminism could be characterised as an invisible or non-existent story. Many authors have challenged the invisibility of older women's voices and experiences within these fields (Copper, 1988; DeBeauvoir, 1972; Ginn & Arber, 1995; MacDonald & Rich, 1983; Myerhoff, 1979; Woodward, 1999). Older women's voices and experiences were either hidden within categories such as *the elderly* or positioned outside, external or peripheral to dominant stories or accounts. Within gerontology, gender was both invisible and actively suppressed in the field of aging. Sociogerontological efforts focused on role in relation to wage labour (e.g., role loss and disengagement) (Passuth & Bengston, 1988); women within the private sphere were classified as role-less and devalued for their unpaid caring efforts (Minkler, 1996). Early feminist movements focused on documenting the seriousness of women's oppression, establishing or rejecting connections between gender and Marxist philosophy, and focusing on differentiation based on gender (Nicholson, 1997). Overall, priority was given to younger women's issues. Minkler & Estes (1984), discuss MS magazine's rejection of the 1979 article "*Why is women's lib ignoring older women?*" (Lewis & Butler, 1984) as an example of feminism's failure to confront its own ageism, while Woodward focuses on the lack of attention until recently, given to Simone DeBeauvoir's subjective account "*On Aging*" (Woodward, 1999). When older women did become visible within research, aging was classified as a "woman's issue" (Hartman, 1990) and efforts focused on the problematic incidence of poverty. For example, through the "feminisation of poverty" thesis (Minkler & Stone, 1985), older women were considered an at-risk population in need of a social response. Early texts on women and aging focus on demographics, health, and poverty to demonstrate the extent of women's need (Gee & Kimball, 1987). Until only recently, this tendency to document the oppression of older women has continued (Allen, 1993; Barusch, 1994).

Invisible Older Women and the Essential Woman?

As older women's needs became recognised however, diverse voices and experiences remained invisible within the category of the older woman. Feminism was criticised for its false universality which represented white middleclass experience as womanhood (Riley, 1988) and failure to consider the differences that transcend commonness (Mama, 1995; Nicholson, 1997). Feminism became sensitive to the charges of exclusion that lesbians (Rich, 1986), women of colour (hooks, 1984; Lorde, 1984) working class women and older women (DeBeauvoir, 1972; MacDonald & Rich, 1983) were making. The personal explorations of Cooper (1988) and MacDonald (1983) challenged the invisibility and exclusion of older women within aging and feminism. Cooper (1988) writes specifically on the collision of ageism with her experience as an older woman, while MacDonald (1983) positions her work as essays on growing old, focusing on difference, and otherness. Similar to Lorde's (1984) critique of racism within sisterhood, MacDonald focused on the exclusion of older women within the claims of sisterhood:

> Ageism was branded onto the women's movement with the word *sisterhood*. When we accepted sisterhood we accepted that class system, with all of the mistrust and division the master had installed between younger and older women (MacDonald & Rich, 1983, p.104).

Similar to MacDonald's account which began with her own experience, the subjective account of Simone DeBeauvoir *La Vieillesse (1970)- The Coming Age (1972)* addressed the "neglect and disenfranchisement of the old" (Kuhn, Long, & Quinn, 1991 7; Woodward, 1999) and opened the door for older women's voices and subjective experiences related to aging.

Reflective of the approaches within feminism, the inclusion of diverse older women's voices and experiences focused on documenting the seriousness of women's oppression. When diverse identities such as ability, ethnicity, class, 'race' or sexual orientation were mentioned, they were classified as further at-risk victims of multiple oppressions. Take for example the focus on "double jeopardy" (Chappell & Havens, 1990; Posner, 1977), "triple jeopardy" (Havens & Chappell, 1983) and "multiple jeopardy" (Ovrebo & Minkler, 1993), where women of colour, for example, were seen as poorer as a result of their 'race' and class status. In the 1990s however, influenced by the post-modern turn, feminism began to address its own knowledge claims, objectivity, universal tendencies, imbedded assumptions and the value-laden position of the academy (Butler, 1990; Fraser & Nicholson, 1990; Stacey & Thorne, 1985; Weeden, 1987). In this final transition, feminism shifted from a focus on gender difference, to differences among women, to multiple and intersecting differences (Nicholson, 1997); identities and differences were seen as multiple and constructed in and through relationships with others (Burt, Code, & Dorney, 1988; Fraser, 1997b; Lather, 1991). Despite the transitions within feminism, tendencies toward including diversity and difference often remain additive (Ginn & Arber, 1995). Although the story of the invisible and essential woman have received challenges from within and outside of research, theory and practice, the actual integration of diversity and difference continue to challenge the accounts told about diverse older women's voices and experiences.

II. Stories on and About the Body- Developing a Medical Response.

Storyline two explains how medicine defined and gained professional control of gerontology, as well as how the past and present responses are located on older women's bodies. Stories told on and about older women provide the context for the current approach, which defines aging and frailty as an individual medical concept, and views older women as bodies in decline. The characters in this account are medical researchers, medical professionals such as doctors, as well as older women's bodies. The older women themselves are not depicted as characters, but their bodies are the characters upon which the story is inscribed. Through these developments it shows how older women's bodies were and remain central to the problematic status and responses. The story is a serious story of professional status, aging as a medical problem and the required medical response.

Disciplinarity: The Problem of Aging Bodies

The development of the gerontological discipline created a story of aging bodies as problematic. Gerontology—the study of aging— is firmly rooted in the medical profession. The 19th century hospital studies of Metchnikoff and Nasher established the terms "gerontology" (Metchnikoff, 1903) and "geriatrics" (Nascher, 1909; Freeman, 1979) while Charcot's work at the Salpêtrière Hospital in Paris is widely recognised as the first gerontological study (Achenbaum, 1995). As a discipline, gerontology focused on the individual biological, clinical and medical notions of aging (Achenbaum, 1995; Katz, 1999). Using Foucault's concepts of the *clinical gaze*[2], *biopower*[3], *power/knowledge(Foucault, 1980b, 1994, 1995)*, Illich's (1976) *iatrogenesis*[4] and Zola's (1972) *medicalization*[5], authors have demonstrated how aging became controlled and regulated by science and medicine (Achenbaum, 1995; Illich, 1976; Katz, 1999; Lock, 1993; Zola, 1972). For Foucault (1973), the regulation of bodies was central to the creation of subjects and the development and maintenance of the power/knowledge regime—in this case gerontology. Using their power and knowledge, medical professionals created dichotomies of normal/pathological which were used to classify and control the aging body (Achenbaum, 1995). In the article '*Charcot's bodies*', Katz (1999) explores the way Charcot used his clinical gaze to observe, classify and generalise between the behaviours and symptoms of a younger female population afflicted with chronic disease and healthy female public aid recipients over seventy, both of which were hospital confined. Charcot's study characterised healthy older women's bodies as ill, disabled and pathological to develop and legitimise the field; once classified by medicine, these dichotomies created an individual problem or need for which medicine became the

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[2] Foucault's concept of "the gaze" refers to the process by which patients bodies became to be viewed through professional eyes (e.g., diagnosis and classification) as opposed to the verbal descriptions of the patients. The gaze is a powerful process whereby the "observer develops both an expertise, and a control over those s/he observes" (Foucault, 1994)p.24Through the gaze, personal issues became classified as social problems with inherent symptoms and pathologies.

[3] Foucault's concept of "biopower" described the process of creating an expert domain, characterizing symptoms and responding. (Foucault, 1980b)

[4] Illich's concept of 'iatrogenesis' described the medical appropriation of health as a physician-induced disease. He argued that the medical profession was responsible for the creation of illness and injury due to side effects of medicines, and technology such as unnecessary surgery (Illich, 1976). The results of iatrogenesis are medical, state and social oppression and marginalization of sick, old and disabled persons. He argued that the state "sponsored sickness by re-enforcing a morbid society that encourages people to become consumers of curative preventative, industrial and environmental medicine and over-medicalization".

[5] According to Zola, the process of medicalization includes: classification of conditions as medical or 'biological' problems and diseases; the creation of professional control through services (e.g., surgery, prescriptions, referrals); the establishment of an exclusive professional domain; and securing social problems as medical problems (e.g., control of normal body processes such as aging, alcoholism, pregnancy) (Zola, 1972)

integral component of managing these unproductive or problematic bodies (Katz, 1996). Once defined in medical terms, the management and control of the disease or problem was legitimised through professional intervention (Kohler Riessman, 1983; Nancarrow Clarke, 1996). The stories told by the discipline of gerontology created accounts of older persons as deficient or diseased, established the need for response, and control of the profession. To this day, the concept of the "biomedicalization of aging" (Estes & Binney, 1989) creates an association between older persons and illness/decline (Achenbaum, 1995; Estes, 1991; Katz, 1996), positions aging as an individual medical issue, and favours disease models and biological reductionism (Moody, 1993).

On and About the Body

In addition to establishing medical control and defining a professional response based on the aging body as a problem, the body is also connected to social perceptions and social response. Considered a text or location for representation—a political surface for health-talk (Fox, 1993; Öberg, 1996)—"the body...has become along with its health or illness a text to be read, written and re-written by body experts be they doctors, beauticians, sports instructors or lovers" (Fox, 1993). Focus on the body as a political surface highlights both the way that social messages may be inscribed on the body, as well as the body as a site of resistance. Influenced by social constructionism, authors have highlighted the connections between the medical control and social value (Wendell, 1996) as well as how the body displays health, ideology and moral evaluation (Lock, 1988). In this sense, the body displays the connections between social representations available through discourse, and the way that social meanings and cultural representations are written on and experienced through the body.

Several authors have discussed the way that older bodies are positioned as intolerable (Gadow, 1991) or disconnected from social experiences through the focus on disease and/or the physical body (e.g., bones- fractures). Featherstone & Hepworth's (1991) notion of the 'aging mask' reveals the harmful cultural and societal representation, and Woodward (1991) talks about "checking ourselves" in the mirror for imperfection and concealing these signs of aging. For older women, discourse on menopause constructs and regulates social experience according to social attitudes and/or manifestation of cultural beliefs (Chornesky, 1998; Kaufert, 1988; Kohler Riessman, 1983; Lock, 1993; Nancarrow Clarke, 1996; Riley, 1988).

Connections between age and death have also been explored. Gadow's (1996) notion of "death rehearsal" and the "age/death connection" refer to the assumption in Western societies that aging should be accompanied by a decrease in quality of life, passive decline until death, and a merciful release from life (Gadow, 1996). This discourse on death "dictated the meaning of aging and thereby controls the experience of aging" (Gadow, 1996, p. 38). According to Wendell (1996) it is this refusal to accept bodily life which perpetuates the "myth of control", the inherent desire to avoid illness, disability, and death, decreases social value, and the normalisation of separation. Stories on or about the body therefore contain social messages about expectations and value. Critical social research on perceptions of mortality which express readiness for death (Howarth, 1998), resisting through the body (Wendell, 1996), as well as lived experiences of the body (Featherstone & Wernick, 1995; Oberg, 1996) challenge these individual medical stories written on and about the body. Stories on and about the body provide a context for how older women have come under the control of medical and professional disciplines. These storylines provide the context to explore the contradictions between these claims and how older women experience and live within their bodies.

III. Social Stories of Persons in Need

Balanced between the medical concerns of disease and decline and the social concerns of poverty, storyline three addresses how aging was interpreted into a social need requiring state intervention. It highlights how older persons were first considered dependent persons, then as a target population requiring public care[6], the shifts in the delivery of this care, and the ideology that accompanied the social response to dependent persons in need. It is the story of a professional response told in hindsight by researchers. It is available through historical documents, reviews of trends in welfare state and care

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[6] Public care refers to recognized or formal care of professionals in home care, day centres, hospitals and nursing homes. In general, formal or public care refers to the care activities that occur within state institutions and are paid by the state. However, the boundaries of public and private are tenous and shifting. Private care refers to any care received outside of publicly funded services. This includes both services that are paid for 'out of pocket' through private companies, as well as private care (i.e., within the private realm of home) provided by family, friends or community, and may also include unavailable public services which must be purchased from the market (e.g., transportation).

for dependent persons. The characters include the welfare state, policies abut care and dependent older persons. In a sense, this story provides a context or guide to understanding the current issues and organisation of services as well as older women's position within the service system.

Dependent Persons: A Focus on Poverty

Prior to the establishment of the welfare state (1940) and recognition of older persons as a target group, older persons in need were classified as dependent and cared for within the charity model by family, parish[7] and poorhouses (Armitage, 1976). In this model, older persons and persons with disabilities were categorised as the deserving poor in contrast to non-deserving (e.g., able-bodied) persons requiring assistance. From 1940 onward, the response to dependent persons became public/state responsibility; Canada, along with the United States and Britain addressed the problem of unequal resource distribution by setting up comprehensive welfare states (Chricton, 1998). The welfare state was established as provider of aid for dependent persons and protector from the social repercussions of a capitalist system (i.e., poverty). As such, the early welfare state balanced moral notions of protection from harm with social concepts of re-distribution, both of which were balanced with an economic policy (i.e., taxation system) whereby means of production offset social repercussions. The establishment of state responsibility for the welfare state meant that dependent persons were segregated into public institutions; older persons were cared for in hospitals, institutions and homes for the aged. This trend moved service delivery of care of those labelled poor and sick into institutions, where the issues of income and health could be addressed simultaneously. Take for example La Salpétrière, which housed both the chronically ill and public aid recipients. Recognition of need by the welfare state represented the transition toward consideration of aging as a medical and social issue.

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[7] Parish-based services were the main service providers in Quebec. As such, the response to dependent persons in Quebec has specificity, which is beyond the scope of this paper. The role of church involvement adds another level of discourse and means that the transitions in response to dependent persons were experienced slightly different in Quebec. Notably, Quebec's involvement in formal response to dependent persons came later, but led the way in community cased services. For a discussion of the emergence of social services in Quebec (Mayer, 1988)

Extension into the Social: The Making of a Target Population

Established as a medical profession, gerontology soon shifted into the social domain[8]-- sociogerontology became recognised as a discipline and older persons as a target population. Theories, explanations and interventions reflected both the social roots concerning poverty and medically defined need. The "first generation theories" (1949-1969)[9] and sociogerontological research reflected explanatory, medically influenced thought focused on observation, classification of disease and pathology (Bengston et al., 1997). The story of aging was established as an individual problem (Minkler & Estes, 1991) that required both professional and social explanations. Strategies to address individual social issues of aging included withdrawing from society, adjusting to the aging process and/or decreasing the level of activity (Bengston et al., 1997). As sociogerontology developed, aging shifted from descriptions of problems, to explanations, to social problems requiring government intervention (Katz, 1996). In order to demonstrate need, research focused on compassionate stereotypes (Minkler & Estes, 1991) such as increasing numbers of persons who will require services (i.e., demographics) and poverty (Katz, 1996). However, targeting services required discrimination between the eligible and the non-eligible. As such, medical discourse became combined with social components focused on measurement, assessment and the distribution of resources based on need. Once older persons became a target population, services were organised according to medical needs and social issue of poverty. Policies reflected a balance between social ideas of care and the cost of providing these services—need thus became central to the distribution of social resources (Featherstone & Wernick, 1995). Measuring this need in relation to older persons became the responsibility of home care professionals. This will be discussed in the section on professional response.

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[8] Gerontology's shift into the social sciences was officially marked by the 1946 Journal of Gerontology's expansion into the social sciences. (Bengston, Burgess, & Parrott, 1997)

[9] According to Bengston et al, 1997, the first generation of socio-gerontological theory (1949-1969) includes: activity theory (Havinghurst & Albrecht, 1953; Havingurst, 1963), disengagement theory (Cumming, 1963; Cumming, 1975; Cumming & Henry, 1961), subculture theory of aging (Rose & Peterson, 1965) and role theory (Burgess, 1960; Cottrell, 1942).

Resistance from Within and Below: Calling Need and Care into Question

At the same time, theorists and activists began to question the accounts and practices of care. “Second generation” theorists (1970-1985),[10] (Bengston et al., 1997) began to resist notions of problematized age through a positive presentation of older people as healthy, sexually active, productive and self-reliant (Cole, 1992), while others examined the structural causes and implications of problematic constructions based on age (Walker, 1990) and inequalities (Estes, Swan, & Gerard, 1984; Minkler & Estes, 1991). Practices of care were also called into question. Fighting against abuses and the institutional model, activists within the independent living movement called into question the construction of disability as dependence, revealed the structural oppression of disabled persons, and proposed a new model based on rights (Morris, 1997; Sarage, 1998). These rights-based movements resulted in the recognised need for community care and initiated the general de-institutionalization movement of all persons identified as dependent. Shifts in service provision began in the 1960s, and by the 1980s there was a major transition from institutional to community care. Care shifted to public responsibility within institutions to the community and into the home[11]. Although the ideal of community care meant that there would be greater access to services under less stigmatising conditions this policy was poorly implemented, and notions of dependency and need were retained. Movement to community care however, was accompanied by the problematic assumptions inherent within discussions of need.

The Ideology of Need

Distinctions between the needy and the non-needy were accompanied by an ideology of need—“needs talk”—which through its connections between the claims-making process and the response of redistribution, impacts on perception of the person in need (Fraser & Gordon, 1994). Sociogerontological research based on gaining problem

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[10] According to Bengston et al, 1997, the second generation of socio-gerontology includes: continuity theory (Atchley, 1989; Havingurst, 1963; Neugarten, Havinghurst, & Tobin, 1968), exchange theory (Dowd, 1975), age stratification (Foner, 1974, 1975; Riley, 1971; Riley, Johnson, & Foner, 1972) and political economy (Estes, 1979, 1991; Minkler & Estes, 1984; Quadagno, 1988; Walker, 1981).

[11] The two terms home care and community care are often used inter-changeably. My distinction however, uses community care to represent the larger or macro policy issue (e.g., a commitment to rights) while home care refers to the concept implemented at the program level.

recognition resulted in constructions based on the older person as poor, dependent, and burdensome (Minkler & Estes, 1984; Phillipson, 1991; Walker, 1980). The ideology of dependence, which is socially defined and created, serves to regulate resources from a scarcity mentality, where resources are only given to individuals with the highest level of need (Walker, 1982). The ideology surrounding dependency is wrapped within notions of individual characteristics, independence, and non-productivity (Fraser & Gordon, 1994). Residual services for older persons therefore, grew out of a punitive and moralistic philosophy (Dunkle, 1984), where social meanings of disease and pathology defined and enforced control of deviance (Miller, 1987). The stigma, which emerges from receiving scarce resources or services, maintains ageism (Gee & McDaniel, 1994; Qureshi & Walker, 1986). Dependency in youth is regarded as normal, in age, it is seen as deviant. Further, the context of cost restriction however, resulted in a crisis rhetoric ideology which paired the increasing numbers of older persons with social problems and the drain of public resources also developed (Minkler & Estes, 1991). This "overselling of demographic crisis" (Gee & Gutman, 2000), resulted in public debate about the burden of non-productive persons[12] which included older persons and persons with disabilities. In this context, stories about older persons shifted from deserving to non-deserving. These stories of need highlight the politics of need which are written on the body as well as open the debates, that exist between the social, medical, financial accounts and older women's stories. Accounts about older persons in need represented the tensions and contradictions between care and control. Challenging the ideology of need, several authors suggest a focus on the "discourses about needs" (Fraser, 1989a). This focus may allow contradictions between expert and lay needs (Aronson, 1992), or opposition discourse surface (Fraser, 1989a). In this sense, the definition of need (i.e., "needs-talk"), is central to the construction, frailty and response to older women.

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[12] Within this discourse and debate on cost and burden, early notions of deservedness were questioned; older persons privileged status gained through labour contributions shifted to status of non-productive and therefore undeserving.

IV. Defined & Regulated: The Social Story of the Little Old Lady

Storyline four of the "little old lady"[13] is a social construction that includes notions of decline, social exclusion or withdrawal based on age, and ideas about gender. This story is told by the discourse and perceptions surrounding older women. It is captured best by the character of the little old lady represented as a petite, fragile or breakable woman who usually carries a cane or uses a walker. On the surface, the character is a small and cute, passive and harmless woman. When combined with assumptions about ability, age, and power, however, this story is a purposeful account that regulates a compliant response, excludes older women from participation, and assigns a low social value. Although the character and expectations within this story are shifting, the two main locations include the marginal, cute, dainty and compliant woman and the frail, dependent social burden. The first leaves no room for sexuality, power or resistance, while the second, is packed with individual blame and social stigma. This story is available through discourse, perceptions and representations of older women, as well as by the critiques presented by older women themselves.

Little:

Reference to size trivialises and stigmatises the older women's experience. In her writings, Maggie Kuhn (1991) challenged the way being 'little' was used to render a woman childlike and/or remove her credibility. Reflecting on the powerless status assigned to being cute she writes:

> "I am often portrayed as a cute old lady by the press. They love to describe my ninety-five pound physique, my half-moon bifocals, and my wispy bun. It is much harder for people to see the determination that lies beneath my sense of fun" (Kuhn et al., 1991, p.145).

This example demonstrates how the portrayal of the older woman as cute served to trivialise the successful Grey Panthers movement. In addition to the portrayal of older women as powerless and non-threatening, reference to size and status includes associations with dependence, and earlier charity-based sentiments of deservedness,

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[13] The term "Little old lady" was first used by MacDonald and has since been used as resistance against a defined or imposed social experience. (MacDonald, 1983)

burden and stigma (Harbison & Morrow, 1998). Although both possibilities that exist within the construction of the little old lady assign a powerless position, the social response is quite different; being little and therefore cute is the socially accepted and nice to grow older, while being little and frail or dependent is stigmatised as awkward and burdensome.

Old:

Reference to being old regulates and excludes older women's experiences. Several older women writers challenge the invisible and marginal social experience of aging. Gullette (1997) challenges the imposed markers of age which define, exclude and regulate older women's experience, Woodward (1999) challenges the youth oriented society and the stigma associated with age, while McDonald (1983) challenged the social exclusion and lack of available role models from her position as an older lesbian. Older women may be marked as old according to appearance (e.g., grey hair), biology (e.g., menopause) or age-based criteria (e.g., 65) (Matthews, 1979; Morganroth Gullette, 1997). According to older women, these age markers are purposeful—they serve to regulate, exclude and exercise control over women's bodies. For example, the visible markers based on external appearance may serve to increase the consumption of age defying products (Woodward, 1999), markers based on menopause to devalue and/or control older women's sexuality apart from reproduction (Morganroth Gullette, 1995b), and age-based categories regulate dependence on the state. McDonald (1983) writes about the impact of this exclusion where older women must negotiate aging on their own. She says in frustration & disappointment:

> Again I lived with the never-knowing when people would turn away from me, not because they had identified me as lesbian, since I was no longer thought of as a sexual being, but because they had identified me as old. I had lived my life without novels, movies, radio, or television telling me that lesbians existed or that it was possible to be glad to be a lesbian. Now nothing told me that old women existed, or that it was possible to be glad to be an old woman. Again the silence held powerful and repressive messages. Again I had to chart my own course, this time into growing old (MacDonald, 1983, p.5)

Lady:

Several older women have challenged the societal expectations of behaviour, image and grace that accompany the class connotation within the notion lady (Joseph, 1987; Kerner Furman, 1997). The most popular example of this challenge comes from Joseph's (1987) Poem *Warning* from the collection *When I am an Older Woman I shall Wear Purple*. The following is the first stanza of the poem:

> When I am an old woman I shall wear purple
> With a red hat which doesn't go, and doesn't suit me.
> And I shall spend my pension on brandy and summer gloves
> And satin sandals, and say we've no money for butter.
> I shall sit down on the pavement when I'm tired
> And gobble up samples in shops and press alarm bells
> And run my stick along the public railings
> And make up for the sobriety of youth.
> I shall go out in slippers in the rain
> And pick the flowers in other people's gardens
> And learn to spit.
> (Joseph, 1987, p.1)

Joseph's poem resists the class expectations of being proper, growing old gracefully, and not "letting herself go". She defiantly pushes against the expectations to act her age and/or act in an appropriate manner. Acting appropriate complies with the notions of powerlessness, segregation and/or exclusion on the basis of age markers discussed by Gullete (1995a), Woodward (1999) and MacDonald. Herein lies the tension of the construct of the *little old lady*. If the woman follows the expectations she is seen as unproblematic and therefore invisible, yet breaking from these she is non-compliant, deviant or out of control. Joseph (1991) articulates a similar conflict that inspired her to write the poem:

> It also came, I suppose, from two conflicting strands in my upbringing...the long attempt by elders to get the child to become a clean, competent, acceptable member of society- someone not a failure, someone not smelly, not a slut; and the inculcation of charitable attitudes that said you don't show distaste for the dirty, the shabby; you pretend not to notice the smell, you do not judge people by appearances, you do not mock the unfortunate. However...you must make sure that you are not a laughingstock, too noticeable, a show-off, and above all, you mustn't be "silly" (Joseph, 1991)

The story of the *little old lady* contains both strong social messages which define, regulate, and exclude the social experiences of older women based on the body, as well as opportunities for resistance and subjective experiences. When considered within the context of cost restriction however, the meanings and assumptions within the notion the *little old lady* have implications for the older woman in receipt of public services. Messages of social burden may be exacerbated within the context of managed care.

V. Standard Stories: Managing Care in a Business World

Storyline five presents the new business rhetoric that exists within health and home care—managed care. It is the story that defines and establishes the larger organisation and delivery of services, a system of accountability, and a major contributor to public perception. In this story, health care is depicted as a business that requires effective and efficient management of resources, services are placed under the audit of effectiveness and efficiency, workers are charged with management tasks (e.g., objective and standard assessment of risk) and older women in need of public services are storied as consumers of a costly health care system. This story is told mainly by government, public policy, and managers. The characters are political leaders, media, texts on health reform as well as case managers and clients involved at the implementation level. The stories of managed care highlight debates central to public and political party platforms, what is often labelled as the health care crisis. It is available both through new procedures of services as well as authors who are critical of its intentions and implications. Placing care within cost concerns, it is a story that retreats from social welfare and universal health coverage, where the social aspects related to income and need have gradually faded from the picture. It exists in relation to the current service delivery model where access to home care services is only available through individual medical notions of need. In the story of managed care, care shifts from a balance of social, moral and economic balance toward a more financial rationale for care, and the ways in which service providers determine or judge need through objective, standardised measures of risk, such as frailty.

Managed Care: Existence within a Mixed Economy of Welfare

The shift to managed care is part of a larger global transition amongst welfare states toward what has been labelled the "mixed economy of welfare" (Neysmith, 1999). From 1980 onward, several welfare states including Canada, began to question their social organisation and financial commitments and retreat from the provision of universal formal services (i.e., retreat from the welfare state) (Chricton, 1998). In this retreat, the welfare state was reorganised according to commercial principles; the state moved from enabler to partner, shifted toward a model of individual responsibility, and took on the rhetoric of management and cost control. In this shift, previous concerns with universality, integration and income distribution have shifted to the assessment of risk, connection with market services, and residual based services (Dean & Ellis, 2000; Leonard, 1997). Dean comments on the shift of the welfare state:

> It has been argued that we now live in a 'risk society' (Beck 1992) in which the function of the welfare state is merely to manage the risks to which we are individually subject (Giddens, 1994) and not, as Titmuss (1963) had argued to provide collectively for states of dependency...The state is concerned less with the provision of care than with the management of provision (Taylor-Goodby and Lawson, 1993) (in H. Dean, 2000, xvii).

Although the shift to market principles is noticeable on a global context and especially in the UK where "Best Value" policy (UK Department of the Environment, 1999) has been introduced to regulate all public services, the trend toward market and management principles is particularly strong within home care. This is likely a reflection of the interdisciplinary nature of service delivery, gerontology's medical roots, as well as larger notions of business rhetoric in relation to health and social service administration. In Quebec home care, rationales of increasing costs, emergency room overcrowding, and criticisms of a poorly implemented community care (Joubert, 1991) have resulted in a shift to managed care. In the current system of managed care, case managers administer standard services. Emphasis is placed on standardisation, cost restriction, and effectiveness. In this new model of service delivery, the rights of the client have become overshadowed by obligations of the independent consumer and terminology such as partnership has emerged (Joubert, 1991). In addition to regulation according to market principles, managed care also emphasises decreased state involvement and reliance on family, neighbour and community responsibility.

Changing the Nature of Service Provision

Several authors have focused on the way that the shift toward managed care has changed service provision. In general, managed care represents a major move away from the social and moral ideas of care espoused within universal services to a focus on the costs of providing such care (Armstrong, 2001). As such, managed care represents a shift from a service based model funded through taxation, such as the Canadian Model, to an individual model based on individual eligibility and managed risk, such as the American Model, which is inconsistent with the principles within the Canada Health Act. In this system, efforts within care have shifted from providing care (i.e., service provision) to managing this provision (i.e., service management). This is evident at all levels including the discourse at the micro level; social workers are referred to as case managers as opposed to social workers, or caseworkers (Chambon, 1994) and discussions focus more on performance indicators (e.g., effectiveness and efficiency), record keeping, and partnered services than quality of care. The shift is also present within the type of service provided. The role of service providers is being altered from in-depth interviews and experiences to evidence-based practices of assessing and managing cases within the market.

Social work within managed care is increasingly involved with the bureaucratic and technocratic practices of assessing need according to risk instead of direct work with clients (Parton & O'Byrne, 2000). Although it is assumed that the risk for older persons is risk of poor health and poor quality of life, within the context of cost restriction, risk could also be interpreted as the risk of increasing costs. At the service level, risk within managed care is about worker surveillance, restricting access and providing the least possible care. As such, managed care moves toward the American model where public care is accompanied by the assumption that dependent persons will abuse the system if given the chance, and subsequently provides minimal levels of care to only the weakest citizens (Armstrong, 2001). At the same time as altering perceptions of the persons receiving care, these assumptions of abuse and compelling discourses of blame, burden serve to undermine public support for services (Armstrong, 2001). It was during this final shift to managed care, where current conceptions of risk and frailty emerged. Although managed care presents a fairly strong unified story of managing care in a business world, it presents major contradictions between cost and care, distracts focus from social and emotional needs, and silences client needs or replaces them with standard objective results based on risk.

VI. Stories of Professional Response

The stories of professional response are accounts about how storyline six of medical/social needs and managed care are interpreted within home care practice[14]. These stories show how professional case managers assess, interpret and respond to needs. Service directives and case managers tell professional stories for clients to interpret and negotiate. These stories are mainly available through the language of practice, expectations, as well as authors critical of the professional account. The characters include policy documents, service mandates and expectations. This story outlines the required practices of standardised assessment of risk that restricts the costs of the services, as well as the technocratic procedures of this new professional response. Drawing on the local story of service provision in Quebec as an example, these stories outline the professional stories as a representation of power where the professionals become the gatekeepers of services, standard practices re-story experiences and impose a professional based identity on the client. The story is a serious story of professional practice and accountability about the clients risk and potential eligibility for services. It is a story where medical notions of need and assessment of functional decline provide access to service and construct the woman as frail.

Eligibility for public service is dependent on expert/professional classifications of need (Lock & Kaufert, 1998). In this sense, the professional is a gatekeeper who distinguishes between normal and pathological states (Katz, 1996). In current services, eligibility is marked by medical notions of decline or disability and measured by a standardised instruments focused on functional measurements of need or risk. Current

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[14] Formal home care services within Quebec are provided within the Maintien à Domicile programme implemented through CLSCs (Local Community Service Centres). In general home care includes personal care (e.g., bathing), environmental care (e.g., home making), and health care (e.g., bloodwork).

eligibility requirements for receiving home care services in Quebec include: Anyone regardless of age, who presents one or more temporary disabilities, the cause of which is physical, social or psychological, and who should receive part or all of the services he requires in his own home (Quebec, 1994, p.6). Intake and assessment tools are then used to create evidence based on medical and functional criteria to legitimate needs and/or demands for services. The use of a standardised assessment tool (i.e. multi-clientele) to determine risk (i.e., frailty), level of need, and restrict number of eligible persons in Quebec's Maintien à Domicile Programme[15] is a key example of the professional classification of need. Upon referral from health care professionals, neighbours, family or self, the intake worker (usually a nurse) completes the intake form (i.e., prise de contact) which focuses on the presenting problem, medical information including physicians name, nature of the demand, identification of risk and priority for evaluation, reason for referral and social supports. The intake form includes designated blanks for standard contact information, pre-determined risk and priority categories. Using this form based mainly on medical criteria, the intake worker determines whether this case is eligible for the next stage of assessment, assesses the level of risk and assigns a priority for evaluation.

At assessment, a member of the Evaluation team (e.g. Social worker or Nurse) completes the assessment tool (i.e., Multiclientele). This tool assesses the degree to which the person is at risk[16] or has a loss of autonomy from a bio-psychosocial perspective. However, authors have found that within the current context, actual service provision focuses on intensive services as opposed to the social and preventative services (i.e., bio-psychosocial) outlined in home care policy (Levesque, 1993). The professional on the evaluation team marks a dichotomous response (i.e., yes/no) to standard questions related to health, living habits, psychosocial situation, and economic conditions. Additionally, the tool also requires a priority for services based on the level of severity (i.e., o least severe, 3 most severe) and available support (e.g., user, family, neighbour, homemaker, nurse, volunteer and other).

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[15] The MAD home care program has standard goals and objectives for service as outlines in the home care policy. However, the services may be organized an implemented differently according to community needs and each CLSC

[16] While all clients are screened for their risk at intake, a special target population (Guichet Unique) exists within the health care continuum. This special category includes elderly persons (80+males or 85+females) or those with a geriatric profile, are at risk or have lost their autonomy. These clients have multiple incapacities, or are experiencing deterioration and their social and psychological state does not favour their stabilization or recuperation.

In the process, clients needs are re-defined or reshaped according to eligibility criteria of frailty, available interventions (e.g., nursing care, adaptation consultations, cleaning, etc), and the context of ambulatory care where high level medical needs are given priority over the social[17]. As such, need is standardised—those that fall outside of recognised needs are excluded from consideration and/or rendered less important (Aronson, 1993). For example, despite need, grocery shopping and transportation fall outside the provided services and therefore, cannot be recognised as needs within the current context of home care. In the context where the demand exceeds the supply, clients may also be excluded if they have alternate supports (e.g., family) and/or financial means to purchase services. In addition, this expert redefinition of need, objectifies and depersonalises the story into an individual, problematised case (Clark, 1996, p.751), and may normalise and/or depoliticise the woman's reason for seeking service (Aronson, 1992), or neutralise those persons who contest (Dannefer, 1988).

Professional gatekeeping practices of assessing and restricting eligibility are also accompanied by expectations in relation to public services. For the most part, professionals expect that clients will follow the required steps and suggestions of the expert—that is, they will comply. Non-compliance—"the neglect or failure to comply" (Simpson & Weiner, 1989c)— rooted in the medical model and extended into other professions however, is usually seen as negative, or deviant (Foucault, 1994). Clinically, non-compliance is defined as "the extent to which patient's behaviours deviate from expectations of appropriate, proper and reasonable patient behaviour" (Fineman, 1991, p.219). In gerontology, professional literature focuses on decreasing the levels of non-compliance and improving client participation in treatment. In this literal sense, non-compliance extends non-conformity into the social realm of sanctions or control, thereby associating non-compliance with deviance. In addition, non-compliance in the medical and professional sense fails to include diverse experiences or reasons for rejecting a particular therapeutic regime (e.g., culture), thereby establishing individual responsibility

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[17] The MAD program focuses on health and social services collectively, considering both prevention and social aspects of health (Lesseman, 1993). However, influenced by the larger trends of managed care, there are inconsistencies between the policy aim of maintaining clients and actual provisions which provide services to those with the highest level of need/risk. Quebec, like other providers of home care is caught within cost related concerns for the provision of home care, standardizing service and restricting access.

for blame (Wuest, 1993). As a result, ethnic and racial minority elders are likely to be identified as non-compliant and stigmatised for cultural differences (Fineman, 1991).

Non-compliance is rarely seen as a positive tool of resistance and strength. Authors, especially feminists have challenged the dominant notion of non-compliance. Following this, non-compliance has alternatively been defined as "a persons informed decision not to adhere to a therapeutic regimen" (Wuest, 1993, p.217) making reference to a choice or informed decision. Another suggested definition, which is consistent with a feminist analysis, is: "compliance occurs when one person carries out the directives of another more powerful person" (Wuest, 1993, p.217). Notions of compliance represent re-storying of clients' needs, situations and responses. Older women seeking public services are judged according to their level of decline and services are provided to the most urgent needs. Stories of professional response highlight how professional stories create expectations for the client. Although opportunities exist within professional account to bend or shape the boundaries, the current context places heavy professional requirements of management upon service providers. The story of professional response provides insight into the way that language is embedded in material practice, and not only represents a particular perception, but comes to define and regulate a world or situation. This leads to questions about the language and story of frailty that exists in relation to public services.

VII. The Frailty Story (Defining Frailty & Frailty Defining Older Women)

Storyline seven focuses on the language that defines older women within and outside of the public home care system as bodies in decline and the interactions with stories of need, risk and managed care. The frailty story reflects individual medical notions told to sort the eligible from the ineligible, draws the lines of social exclusion, and imposes a social experience based on judgements about older women's bodies. Eligibility criteria of services clinically embody the older woman as frail. The characters within the frailty story are the medical and interdisciplinary service providers as well as the older women in need of public services. It is a serious story about medical and social risk. Although there is no one accepted definition of frailty, there are several indications and interpretations, which guide professional judgement. The frailty story within the literature may be characterised as a search for defining frailty, while in services it is a definition and experience imposed on the home care recipient.

Defining Frailty

The term frailty is used frequently within gerontological research, policy and practice to describe a person who is at risk (i.e., loss of autonomy). Research indicates that frail individuals are more likely than non-frail persons to experience increased levels of hospitalisation, falls, and a general decline in ability to perform the activities of daily living (Fried & al., 2001). Cited consequences of frailty include increased care demand and overuse of health services (Hamerman, 1999). However, although there seems to be a general acceptance of the usage of this term to distinguish between conditions which require service interventions (e.g., need, eligibility), the term has not been explicitly defined. In some cases frailty has been used simply to refer to persons who are 85 years of age—the 'old old' (i.e., 85+), while at other times, it is used in relation to a loss of function. Discussions of frailty, including the risks and consequences, connect frailty with an individual medical concept, discourse about the body, and the costs of service provision.

Recent medical (Michel, 2001) and gerontological research has turned focus toward defining frailty. In medical research, frailty has been referred to as an age-related inability to respond adequately to stress (Rockwood, Fox, Stolee, Robertson, & Beattie, 1994), classified into signs and symptoms (Fried & al., 2001) and defined by the presence of two or more of the following nutritional, physical, affective, cognitive, and sensory related issues (Stawbridge, 1998). While many medical studies have focused on the individual and medical elements of frailty, Michel (2001) has expanded the focus beyond the physical (e.g., nutrition, mobility) and mental components (e.g., personality, affective) to include the social (e.g., family support, income, education). Michel (2001) makes a distinction between frailty as a dynamic process and the status of being frail. He also differentiates frailty from disability, yet links it with the aging process. He concludes, "the frailty process corresponds to an insidious and late phase of the normal aging process", stating that "like the ageing process the frailty process is irreversible- it can not be stopped but it can be slowed or delayed" (Michel, 2001). This definition works within the individual medical boundaries and provides the incentive for medical intervention, yet, it also stretches these boundaries through reference to the social, distinctions between the process and status of being frail, and the connections with a natural process prior to death. As such, this definition also leaves room for the possibility of preventative efforts on a social scale. While the studies to define frailty remain in progress, three major sources tell the story of frailty in relation to service: the dictionary, clinical judgements and standardised risk assessments.

Literal Frailty

Moving outside the medical definitions of frailty, the literal definition provides some insight into the way that the term frailty is understood within daily use. The literal definition of frailty focuses on physical weakness and powerlessness. This definition includes notions about the body as well as the social qualities that are assumed by someone who is classified as frail. Frailty in the literal sense is negative. Consider the following definitions:

> FRAIL, a.
>
> *1. Liable to break or be broken; easily crushed or destroyed.*
> *b. Of immaterial things, sometimes with conscious metaphor: Subject to casualties, liable to be suddenly shattered, transient.*
> *2. Weak, subject to infirmities; wanting in power, easily overcome.*
> *b. dial. (See quot.)*
> *3. Morally weak; unable to resist temptation; habitually falling into transgression. Now sometimes applied as a half-jocular euphemism, to a woman who lives unchastely or has fallen from virtue.*
> *4. Tender. Obs.*
> *5. Comb., as frail-bodied, -floreted, -lived, -strung, -witted.*
> *Hence frailful a. [+ -FUL], extremely frail. frailish a. [+ -ISH], somewhat frail, feeble. frailly adv., in a frail manner.(Simpson & Weiner, 1989a)*
>
> FRAILTY
>
> *1. Liability to be crushed or to decay, either in a material or immaterial sense; perishableness, weakness; an instance of this; also, a frail feature or spot, a flaw. Now rare.*
> *2. Moral weakness; instability of mind; liability to err or yield to temptation.*
> *b. A fault arising from infirmity; a 'weakness'. (Simpson & Weiner, 1989b)*

Clinical Frailty: Judgement and Risk Assessment

At the clinical or service level, professionals define frailty through their judgements about ability, functional impairment and risk. Although unspecified, there seems to be a difference between a frail and non-frail person in relation to services. In medical research, clinicians state that they can easily distinguish a frail older person from a non-frail older person (Fried & al., 2001). In the medical field, markers which classify the clinical syndrome of frailty include three or more of the following: unintentional weight loss, self reported exhaustion, weakness (e.g., grip strength), slow walking speed, and low physical activity (Fried & al., 2001). Frailty is also discussed as the precarious balance between the ability to maintain health and function and the multiple impairments and deficits that threaten the balance (McDouglas, 1998). Medical gerontologists speak about the concept of total recovery—the ability of an individual to withstand illness without a loss of function (Carlson, 1998). For frail persons, this recovery may be slow and incomplete, meaning that the person may not regain all of their functional ability. Influenced by the medical profession, these clinical indicators are also present within the social sciences.

Within home care, frailty is integrated into clinical judgements about the overall level of risk and/or threat to safety for the person to remain at home or in relation to services. Frailty is assessed through the use of a standardised risk assessment tool. Judging by the elements within the assessment and screening tools, frailty seems to involve a combination of mobility problems, which receives the most attention on the screening instrument, advanced age, incapacities with personal care, daily living, as well as falls, hospitalisation, unstable medical condition, medication and malnutrition, cognitive level, family or social situation and financial situation. While workers within the system discuss frailty as a combination of medical issues which impact mobility, psychological issues such as depression and/or fears, as well as physical weakness and isolation are also included. Although the assessment tools include several medical, affective and social components, a great deal of emphasis is also placed on cognitive impairment. Workers connect the presence of cognitive impairment with increased risk.

Together, the social and the medical stories about frailty define older women's experiences in relation to service. Although the objective classification of frailty as risk is important to identify need, assess risk and distribute limited services within the current context of care, frailty has particular implications for older women in relation to service. The use of frailty in research and response may define older women as bodies in decline, depicting them by definition as weak, easily broken or fragile. The combined social values and individual medical criteria clinically embody the woman in receipt of public home care services as frail. That is, the woman is devalued as a sick body; her experiences are shaped around the ideology of need and policy based on medical notions of decline. Within the context of risk, need and protection, frailty places older women in a powerless position in relation to service, ignores older women's strengths, and may stigmatise older women. By excluding the subjective dimensions of older women's lives in health and illness, older women who may normally define themselves in many different ways (e.g., friend, mother, daughter, partner, etc) may be assigned a powerless position based on the combined factors of age and disability. These understandings of frailty raise questions both about the way frailty is used within services as well as the implications of taking or not taking on a frail identity.

VIII. Stories of Resistance

In general, storyline eight exists outside of "what counts as knowledge" within feminism and aging. Although several types of accounts exist outside of the main accounts, I will discuss those that have a relation to the discourses of health[18]. These accounts, told through film, novels and social movements, challenge dominant stories about older women, aging and decline. The stories are examples of rival stories or oppositional discourse (Fraser, 1997b; Lather, 1991), which serve to challenge and/or contest dominant notions (Thomas & Rappaport, 1996). The characters within the resistant accounts are older women and various other characters representing daily discourse about older women. These alternative accounts position that things "could be otherwise" and intend to generate many diverse alternative accounts as opposed to a unified story of resistance. At the same time, resistant stories work within acceptable limits; that is, they reveal tensions between working within and outside the limits of what is deemed acceptable. Resistant stories reveal the tensions between accepting and/or securing dominant accounts, reflect older women's subjective experiences, and expose the contradictions between professional and lay beliefs. Although these accounts exist outside of dominant discourse they are limited and difficult to access. They do however, provide insight into older women's negotiation of this subjective experience.

Working Within and Outside the Limits

Alternative accounts include tensions between stretching the boundaries and delineating acceptable limits according to dominant stories. Key examples of working within these tensions include the films *Sunset Boulevard* (Wilder, 1950) and *Harold & Maude* (Ashby, 1971). On the one hand, *Sunset Boulevard* introduced the older woman into Hollywood and challenged the ascribed asexuality of older women. However, these challenges were on limited terms. Although formerly famous and wealthy, Norma Dezmond is depicted as living through her past, portrayed as mentally ill and mocked for her attraction to the young narrator/actor Joe Gillis. In addition, the character of Norma Desmond parallels the real life situation of the former silent film star Gloria Swanson whose only role available was "a distorted version of herself" (Fischer, 1997, 174). Similar tensions are also present within *Harold & Maude.* This film challenges stereotypical notions and the asexuality of the older woman through her relationship with a man in his early twenties. Yet, Harold is characterised as mentally ill and Maude is kooky and deviant (e.g., theft, police chase, etc). Several voices depict the absurdity of the love affair and marriage between an older woman and a younger man. Her final suicide at the end however, accepted dominant messages of decline through a focus on the escape from the misery of age. Both these films are examples of resistant stories, which work within, yet stretch the boundaries about age and decline.

The two NFB films *In the Company of Strangers* (Scott, 1990) and *When Shirley met Florence* (Bezalel, 1994) are interesting accounts of resistance outside the boundaries. Both films focus on storylines about older women, star older women and are grounded in the reality of diverse older women's experiences. *In the Company of Strangers* (Scott, 1990), is a unique film involving spontaneous actors whose bus breaks

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[18] As such, this excludes important accounts of older women's appearance, sexuality, marriage and motherhood which are characterized by the notions of the old bag, the wicked witch, dependable grandmother and the crazy lady. (Grenier, 1999)

down in a deserted section of the country. In this film, which challenges notions of older women as dependent, older women from diverse backgrounds share their experiences, life stories, private struggles and how each has interpreted their aging. Overall the film demonstrates personal and collective power and is an example of how each woman's knowledge and experience contributes to the collective sense of power and survival. *When Shirley met Florence* (Bezalel, 1994), is a short documentary on two Jewish women in Montreal who have been life long friends. During the film, Shirley and Florence share their life stories and memories. Through their reminiscence, both display strength and knowledge. These film examples which exist outside of mainstream resources and academic resources provide insight into resistant stories.

Resisting Ideas about Age, Disability & Decline

Examples of resisting ideas about age, decline and disability also exist within poems, novels and social movements. Resistant stories are formed in relation to non-compliance, control, the claim to inner youthfulness and discussions of death. Often times, these resistant stories proceeded attention to older women's issues within accepted forms of knowledge. Maya Angelou's (1978) poem *On Aging* is a story of resistance against the notions of pity, frailty, dependence and laziness often associated with age (Angelou, 1978). Specifically, her poem uses the metaphor of the rocking chair, a metaphor also used by older women in this sample, to challenge sympathy and reject decline. She also challenges the age/death connection discussed earlier.

> When you see me sitting quietly,
> Like a sack left on the shelf,
> Don't think I need your chattering.
> I'm listening to myself.
> Hold! Stop! Don't pity me!
> Hold! Stop your sympathy!
> Understanding if you got it,
> Otherwise I'll do without it!
>
> When my bones are stiff and aching
> And my feet won't climb the stair,
> I will only ask one favour:
> Don't bring no rocking chair.

> When you see me walking, stumbling,
> Don't study and get it wrong.
> 'Cause tired don't mean lazy
> And every good-bye ain't gone.
> I'm the same person I was back then,
> A little less hair, a little less chin,
> A lot less lungs and much less wind.
> But ain't I lucky I can still breathe in.
> (Angelou, 1978)

The resistance in Angelou's poem could easily be classified within service as non-compliance. Caro, the main character in *As We Are Now* (Sarton, 1973) also provides examples of active and passive non-compliance associated with medical treatment, professional stories and social expectations (Sarton, 1973). She comments on the pervasive nature of professional power and control: "The only person who can be called "well" in this establishment is he who is totally passive; anyone who resists is mad and dangerous" (Sarton, 1973, p.78). Consider the following account of her anger against the nursing home:

> My anger, because I am old is considered a sign of madness or senility. Is this not cruel? Are we to be deprived even of righteous anger?.....I am kept alive only for one purpose, to end things here while I a still sane enough to do it. But I must, to succeed, be clever appear to be passive and weak. Appear to be tamed, even grateful for small mercies" (p.111)...There is only one fire in me now, a fire of disgust and hatred, and there is plenty of fuel to keep it going until January in this place. (Sarton, 1973, p.124).

Caro's story of resistance is to take active control of her situation by resisting the emphasis on necessary compliance and the repression of anger. Control as a resistant story however, may be expressed in diverse ways, and/or take several forms. On one hand, control may refer to a strong resistance/opposition to decline and death. For example, MacDonald says: "Proving that I am strong, capable, sexual, is a response I give to a negative world a dozen times a day" (MacDonald, 1983). Likewise, Hagar Shipley, the main character in *The Stone Angel* (Laurence, 1988) denies decline, flees from the nursing home and reconciles with her son. On the other hand, control may also be expressed as an acceptance of the changes in body and identification with these changes. Consider the following example, which MacDonald speaks of both an acceptance of change and a positive connection with the body:

> {I like growing old}. I say it to myself with a surprise. I had not thought that it could be like this. There are days of excitement when I feel almost kind of high with the changes taking place in my body, even though I know the inevitable course my body Is taking will lead to debilitation and death. {This is my body doing this thing}. I cannot stop it, I don't even know what it is doing, I wouldn't know how to direct it. My own body is going through a process that only my body knows about. I never grew old before; never died before. I don't really know how it's done. I wouldn't know where to begin, and God knows, I certainly wouldn't know when to begin- for no time would be right. (MacDonald, 1983, p.19)

Within MacDonald's quote is a connection to the body. Many older women, including the earlier mentioned poem by Angelou, speak of their connections to their inner selves. Consider her line: *I'm the same person I was back then, A little less hair, a little less chin.* These sentiments of inner youth expose the contradictions between the outer appearance, or the way others see them, and the way they experience themselves as youthful (Kerner Furman, 1997; Oberg, 1996; Woodward, 1999). Various examples of claiming inner youthfulness exist. These may include such locations as concealing the signs of aging, denying appearance, accepting appearance. In the following examples, Clara denies her external appearance indicating *It isn't me*, Caro refers to her *outward shell* as grotesque and Elspeth questions her change with disbelief. Although these resistant stories take different forms, each is resisting notions of age, decline and disability.

> **Woman at the salon**: When Clara looks at a contemporary photograph, she sees an old lady. "I really do. I see an old lady" I ask her how that feels. "Well you know what I do? I just brush it off. It isn't me. Because the me is inside, here (pointing to her chest). And I am still younger than springtime" (Kerner Furman, 1997, p.106).
> **Caro:** Old age is really a disguise that no one but the old themselves see through. I feel exactly as I always did, young inside as when I was twenty-one, but the outward shell conceals the real me- sometimes even from itself- and betrays the person deep down inside, under wrinkles and liver spots and all the horrors of decay. (Sarton, 1973).
> **Winter Guest:** What do I look like? Is that my face? ……I am the same on the inside as I was at 17 (Rickman & McGarvey, 1997)

In addition to individual stories of resistance, older women's formal or collective resistance exists both within and outside of the traditional formats. Formal collective resistance exists at local, regional, national and international levels. Formal resistance has focused on specific concerns for older persons (e.g., health coverage, mandatory retirement, pension rights, and age discrimination) (Featherstone & Wernick, 1995), social or decision-making organizations/groups (e.g., retirement homes, political parties, social clubs, churches) as well as broader public issues (e.g., war, housing, health care) (Gifford, 1990). The most known collective resistance of older persons is the national Grey Panther Movement founded by Maggie Kuhn. Other popular formal groups include the American Association of Retired Persons, Canadian Association of Retired Persons, and the National Council on Aging. Similar to their position with academe however, older women's issues, voices and experiences seem hidden within larger agendas such as retirement or pensions.

Note however, that older women's collective resistance may look very different from the traditional forms of collective resistance. Older women's resistance may be at the local level, work both within the private and the public, the individual and collective, as well as focus on different issues. In her autobiography of her social activism, Kuhn discusses how she formed the Grey Panthers as a reaction to the failure of social movements to focus on both the individual and the collective (Kuhn et al., 1991). The Older Women's League was founded to address specific older women's issues, and confront policies, which forced older women into poverty (Gifford, 1990). While in Canada there are various groups which address older women's issues such as the Older Women's Network in Toronto and the Raging Grannies in Montreal and Vancouver. In addition to older women's resistance in groups, unintentional communities, which share common interests and experiences, may also serve as a form of resistance. Take for example the way that Kerner Furman (1997) discusses the resistance of older women at Julie's beauty salon:

> There is no self-conscious ideology of liberation operative at Julie's, few pronouncements about the coercive norms of beauty and youth, and certainly no political agenda to take into the streets. Rather, resistance to socio-cultural oppression is embedded in the way that older women treat one another- with respect, affection and attentiveness; in conversations and gestures that affirm and hence make visible older women's pride in

> and attention to their bodies, and that acknowledge the pain, suffering and loss that accompany embodiment; in discussions of their work of caring that is valuable, necessary and demanding. Women in this context affirm their own experiences, experiences that are glossed over as insignificant or excluded from vision in other quarters. So while Julie's does not constitute a politically transforming community, it offers a safe place for 'older women' to be themselves and to be supported in their lived experience, in contradiction to what more commonly happens in the public sphere (Kerner Furman, 1997, p.168).

Resistant stories may also focus on the dominant accounts of death. Similar to other forms of resistance, the location and position of resistance varies on an individual level—some older women accept death while others resist or deny death. In *Antonia's line* (Gorris, 1995)—the story of four generations of women—the main character Antonia accepts and embraces death. The following segment, which both introduces and concludes the film establishes continuity between her life and death, showing that just as Antonia was strong in her life, she is also strong in her death.

> *Even before the sun had risen, Antonia knew her days were numbered. She knew more than that, she knew today would be her last day. Not that she felt unwell, but unlike others, Antonia knew when enough was enough. She would call her loved ones to her bedside, inform them of her immanent death, close her eyes and die* (Gorris, 1995).

Similarly, Caro in *As We Are Now* also resists decline through her conscious control of her life and dying (Sarton, 1973). According to MacDonald (1983), her determination and resistance until the end are demonstrated through her placing her copybook in the frigidaire as a "testament to the politics of her dying" (p. 97). These resistant stories on an individual and collective level provide examples of the ways older women resist notions of age, decline and death. They highlight the various and complex ways that older women may resist the stories that are told on and about them. These resistant storylines show how "things could be otherwise" as well as expose the differences that may exist within common experiences for older women.

Summing up the Stories

The stories told on and about older women provide insight into past responses and establish a context to understand the current response within public services. Stories from the feminist and gerontological fields expose both the problems of invisibility and essentialization that continue with today's approaches; medical stories on and about the body outline how medicine defined and legitimated an area of expertise through older women's bodies; examination of historical transitions of care expose the way care has balanced ideas about social needs, health and the costs of these services, established tensions between dependency and independence, and reflect ongoing ideology related to burden, deservedness and social worth; discourse surrounding older women depicts the connections between the medical and social and the way that expectations are imposed and regulated through identity; new business stories highlight the way that care has shifted away from social notions and dramatically altered the context of service provision; professional accounts describe the ways that these stories are interpreted within practice, including the way that need and professional eligibility, regulate, define and have implications for older women at the margins; the specific story of frailty provides an example of how older women are constructed as bodies at risk, how these accounts create fixed identities based on assessments of the body and exclude older women's subjective, interpretative and lived experiences; while the resistant stories provide alternative accounts that challenge the cumulative stories about aging, disability and decline.

To date, our understanding of frailty and older women's experiences are limited. This is particularly true in the case of diversity, receiving care, and the way older women may experience and/or negotiate imposed identities such as frailty. Researchers in health and medicine are beginning to explore and define the professional concept of frailty (Michel, 2001). However, it has not been explored as a powerful notion that defines and structures experience through eligibility and functional criteria. To date, frailty of older persons has only been examined from a socially constructed position within anthropology (Kaufman, 1994). Although there is growing interest in meaning-making, negotiating health, and reclaiming power over the process of medicalisation, the ways in which older women make meaning of their experiences of frailty in everyday life remain unexamined. Further, critical research in gerontology focused on care-recipients, access to care, and the impacts of care policy have not yet explored the connections between language and experience. Little is known about diverse older women's lived experiences of frailty.

That is, few studies focus on the ways older women interpret and give meaning to frailty in their everyday lives. As such, the stories told on and about older women raise several questions that inform my study:

- What are the social experiences that exist within and/or behind the notion of frailty?
- How does diversity play into identity and the experience of frailty?
- How do older women negotiate and/or resist ideas about the body and through the body?

To address the questions raised by the stories on and about older women, this project aims to explore the micro experiences hidden within the representations of the individual and medical policy and practice concept of frailty. Considering frailty as another imposed identity, this study turns to the everyday stories and experiences of diverse older women. I intend to explore the links, tensions and contradictions between the policy concept of frailty, which is used to define eligibility for public home care service in Quebec, and the private life experiences of twelve diverse older women. As such, this study combines a theoretical approach to language with expectations of diversity, as well as notions of power and change. It also provides a local level gendered analysis of policy. Through in-depth interviews, I aim to discover diverse older women's narratives about their experience, including the various ways in which older women negotiate or engage in body talk, and/or define themselves differently in relation to frailty and the accompanying assumptions of being weak and compliant. These lived experiences may explicate older women's hyper visibility within health discourse, provides a glimpse of the interface between the stories of frailty and potential for resistance and/or negotiation, expose the contradictions of a fixed and imposed identity, and make room for alternative stories more in line with diverse older women's experiences.

<u>*Act III*</u>

Balancing Language, Power, Diversity & Change

This section focuses on the relevance of a perspective based on language, power, diversity and change. It is a fluid, reflexive, and rhetorical account that reveals my starting position, my current theoretical position, and the many questions I have asked myself and others along the way. Relationships and interactions are key. Although I cannot interact with the theorists in real life, I do interact with them through their texts. My account moves between where I was before the interviews and how I adjusted my perspective as a result of the interviews. This account is structured partly according to four key notions, partly in dialogue with key issues or debates, and partly as a dialogue between my beliefs or position as a rhetorical performance, and your reactions as a reader. It is the Act where I raise key theoretical questions, present where I stand at this moment, and use respected authors to legitimate my case. Instead of reviewing numerous theories, this section is framed around pieces relevant to explore older women's micro experiences of frailty. To develop a fluid and reflexive account, I have tried to anticipate the questions that you will ask about my stance. My responses draw on critical theory, cultural studies, feminist theory, literary theory, and a post-modern approach through the writings of various theorists such as Foucault, Fraser, Nicholson, Smith and Bourdieu. Pulling from these various theoretical perspectives, I aim to construct a useful and relevant perspective. I am aware however, that doing so may ignite political sparks as well as expose several untidy contradictions or tensions. My intention in this section therefore, is not to sew the perfect piece, but to sew something that fits—something that is sturdy, tough and practical. Yet, here I do not only intend to show you the final piece, but talk about the way I made it—the process and decisions I made along the way. Extending my metaphor of sewing, I am prepared to show you where the hem is uneven, the stitches slip and where the slightest tension or wear would result in a hole.

To me, theory is not something that exists out there as separate or true, but embodied, emotive—it is full of action, interaction, response—it is lived and relived on a daily basis. Yet, to engage in such a lived version of theory means interacting with others—a task rare to many academics, and even rarer to the doctoral student engaged in solitary writing (otherwise known as me). Throughout my dissertation, I have endlessly struggled with how to convey my convictions, assumptions and beliefs, while at the same time engage in a theory that is accessible and relevant at the local level. I have even re-written this section several times, trying to find a way to present a fluid and active account, trying to figure out where I stand—at least for one moment. There are many issues that I believe in, yet they are shifting, relational and contextual. Locating myself theoretically is an endless process that moves me weekly, daily, hourly, constantly. Just as the telling of older women's stories in various situations and contexts presents pieces of their identities, this section is my imperfect struggle to understand and make meaning of my worlds. Before I outline where I now stand, I have included a piece that I wrote in my comprehensive exam as a starting point. I wrote this piece as an honest attempt to situate myself theoretically:

The Struggle for Relevance: Between Feminism and Critical Theory. In attempting to contextualize my analysis and align it explicitly with a theoretical perspective, I found myself struggling for a name and space in which to situate myself philosophically. What do I call a perspective that works within what Agger (1998) would consider critical social theories (e.g., feminism, critical theory, cultural studies, post-modernism or post-structuralism) within the field of gerontology? For me, this struggle for a name raises critical questions about the social constructions and responses to 'older women', awareness of larger theoretical debates, and resolution of weaknesses of past approaches. This current project is challenged by the need to understand the interplay between language, social response and practice, give voice to older women's experiences, recognise difference, yet counter the tendencies for essentialism and fragmentation in individual difference. This struggle represents the tensions and difficulties in developing a critique relevant to diverse identities and social locations of 'older women'. It is a struggle to present some sort of alternative or discover resistance. At the same time however, I am cautious of falling into the trap of all-encompassing positive reconstruction of age based on health as opposed to illness –replacing one metanarrative with another. Instead, I aim to portray diverse images/constructions that are embedded in, and representative of a variety of older women's everyday lived experience.

This project will also provide both aging and feminism with a new paradigm with which they may question previous and present assumptions, and integrate diverse older women's experiences into emancipatory practice. By doing so, 'older women' may find increased relevance in public portrayals of themselves with which they may more readily identify and societal notions may recognise the differences within older women's accounts. For too many years now, research and theory have perpetuated metanarratives surrounding aging (e.g., decline). It is my intent to infuse these debates with older women's own experience, and with critical theory, to shift these meta-narratives; developing a model of critique which is fluid, borrows from relevant material, and gives opportunity to expand and unhinge notions/conceptions of 'older women' as 'other' and incapable of self-definition. The central point is to identify resistance, not to solidify critical feminist gerontology as a unitary paradigm or competing metanarrative. Although the 'feminist discourse' framework of Fraser (1997), Smith's (1987) 'relations of ruling' and the 'critical gerontology' of Moody (1988) provide useful frameworks for analysis I feared that the label 'feminist discourse' and the position outside of socio-gerontology may result in the exclusion from either feminism or gerontology. For now, this work takes what may be named a 'critical feminist gerontology' informed by principles of discourse analysis, which includes the influences of social construction and deconstruction.

Looking back, I can see how my theoretical perspective has both changed and stayed the same. My emphasis on reflexivity and the focus on language, power, diversity and change remain. Yet, I find this piece idealistic and/or naïve, perhaps necessarily so, as I will discuss later within this section, and reflective of the essentialism it attempted to critique. At the time, I felt that I was required to align myself with one particular theory and defend it despite shortcomings. I felt that I had to choose between theories that were irrelevant at the practical level, commit to a way of seeing things, and live with the ethical implications of my choice. Not being able to do so, I selected from various theories and tried to create a new model of 'critical feminist gerontology' that worked for me. Now, I realise that it was not the theories per say that bothered me, but the limits of a fixed position. I now understand that I may cross the artificial boundaries, draw on theories where relevant and accept that my position can and will shift.

Instead of attempting to create a new essential paradigm, I have chosen to discuss my theoretical position according to the four notions of language, power, diversity and change that have informed my analysis from the beginning. This allows me the space for fluidity that I wouldn't have if I were to discuss the theories in a traditional review sense, while seeming to avoid the pitfalls of generalisations. Theories may include assumptions about practice, inform or guide practice, as well as be informed by practice. In this sense, this approach exists within a complicated diagram where the arrows are going in all directions at one time—it is not possible to say that one is the influence of the other—instead that it is a complicated pattern of influence. In this sense, this account presents the theoretical lens has both informed and grown from older women's accounts. Structured around the four issues of language, power, diversity and change and intersected by key issues and debates, this approach intends to provide a fluid and reflexive account that is useful to explore the narratives of diverse older women in relation to frailty, while at the same time aware of its inherent power and rhetorical function. Note however, that although the divisions between language, power, diversity and change appear separate in this section, they actually influence and are influenced by each other.

Language: Dialogical, Representative and Performative

My theoretical perspective focuses on the meaning of the language used at the local practice level. Until recently, language studies have remained outside of social work and gerontology (Marcoccio, 1995). Past approaches have taken expert classifications for granted, failed to acknowledge the role that language plays in constructing and defining experience, and seldom incorporated a focus on the way language operates within the system. The concept of frailty is but one example. At the same time, fields such as social work and gerontology assumed that the focus on language within literature and linguistics were not relevant for fields of applied practice. The challenges of several client groups including women and seniors however, targeted the power and politics of representation, including the language used to define, classify and claim truth status (MacDonald, 1983; Morganroth Gullette, 1995a). These challenges highlighted the potential relevance of language studies within the more practical social sciences. Focus on language brought an awareness of the meanings of personal and social experiences, contextual differences, the formation of the subject and claims making to the social sciences. Incorporating language in a meaningful sense however, remains a key debate. My challenge within these debates is to develop a flexible focus on language that may be used in relation to applied disciplines such as social work and gerontology.

A focus on language use is key to understand interpretation and representation of practice-based concepts and life experiences. Informed mainly by post structuralism, language may be considered dialogical, representative and performative (Bakhtin, 1978; Eakin, 1999). First, dialogue considers language as communication—the product of interaction between two forces (e.g., texts, persons, etc). It always involves a speaker, a listener/respondent and the relation between the two (Bakhtin, 1978). For example, the older woman and the home care assessment worker engage in a dialogue about needs and available services. Second, language is a social construct or representation that provides access to our worlds, meanings and experiences of social reality (Berger & Luckman, 1967). For example, older women's roles and needs are defined through language. Third, language is performance in the sense that it is intentional, purposeful and useful (Hall, 1998). For example, older women may use certain ways of talking to claim their needs. Together the notions of language as dialogue, representation and performance mean that language is the basis for the individual to understand themselves and their identity (meaning-making) (Goffman, 1959), in relation to social experiences and making needs claims (Fraser, 1997c). Drawing on language-based approaches where appropriate may assist to understand older women's stories in relation to frailty.

A focus on language in relation to diverse older women's experiences may help to understand the way older women are represented in public services as frail. This includes understanding the multiple and competing discourses that exist within this construction, as well as how these powerful discourses shape older women's identities and experiences. Language provides insight into the connections between subjectivity and representation—the way older women use language to make meaning of their lives and stories told about them. As such, language can help to understand how and where the binary of frailty is constructed as well as how and where this binary breaks down. It may expose the gaps between older women's perceptions of themselves as well as reveal how older women talk about themselves and their needs—reflecting on naming as a political process (i.e., naming and being named). In this sense, a focus on language facilitates an understanding of the way older women use language to negotiate or interact with powerful ideology or institutions. Older women interact with these messages through discourse, choose and use language or accounts that represent their identities or selves, make claims, and negotiate their needs.

Despite the contributions that a focus on language could make within social work and gerontology, integration of language studies remains a key debate. Although language fits within the theoretical perspective focused on the combination of power, diversity and change, several debates have surfaced in relation to the use of language in practice. In particular, authors have challenged the focus on the use of language at the local level as a retreat to the particular, a game played by the elite, as well as a process of endless deconstruction. They question whether the focus on language is a shift from real issues and actual experiences of oppression to issues of representation and claims—focusing on talk as opposed to action (Nicholson, 1997). I would argue for an approach however, that considers the local as a site where language use and interaction may provide key clues to understand meaning and experience. In this sense, language is not a mere representation or interpretation but is interactive purposeful and negotiated. Language provides a view of the local, which helps to understand the larger systemic operations. Language may expose power differentials, reflect the way identity claims extend into the social, and create possibility for political claims. The following questions reflect key debates and my thoughts in relation to the relevance of a language-based approach:

- How may an approach focus on local level language in a relevant way without retreating into the particular, endless critique and/or extreme relativism?
- How may an approach understand the local as a site of lived experience and negotiation without creating barriers, and/or further distance between the professional response and the lived experience?

Meaning and Interaction at the Local Level

The first question focuses on the critique of relativism: How may an approach focus on local level language without retreating into the particular, endless critique and/or extreme relativism? My approach suggests that we turn to the local as a site where lived experience and meaning are acted out on a daily basis. Critics may be concerned that the focus on language and the local subject is a retreat to the particular. They may say that my retreat to the local could only result in fragmented morsels of experience and endless deconstruction. Here, their concern is that these fragments may destroy any common ground for social unification or emancipation. They may say that I have become discouraged with the difficulties within practice, have given up hope, and that to protect myself from disappointment or disillusionment, I can only look at manageable pieces of experience. Or, they may simply say that an approach based on language is irrelevant for an applied practice. Although these are issues that must be carefully considered, holding a view of language as dialogue, representation and performance, the local provides a site to witness interaction and meaning. For me, this does not mean that the local is all that is left—but that the local holds day-to-day experiences of the use and implications of language. The local is a site, which holds material key to understanding older women's everyday experiences and negotiations in relation to frailty.

Admittedly the humanist and structural models of language are abstract perspectives, taken from a very different context of textual analysis of literary texts. Yet, a focus on language at the local level does not exclude a systemic analysis. I would not suggest a complete focus on the local, thereby ignoring the systemic. The focus on the local must be placed within a social context. For example, the language of frailty exists within a complicated system of communication between public policy, service administration and lived experience. Within these systems, language use is intentional and purposeful—it is a powerful force used to make and legitimate claims. I would argue that, although the focus on the local challenges traditional knowledge and theories of emancipation, the strength of poststructuralists like Bourdieu and Bahktin are the concerns for the use and implications of language at the local level (Bakhtin, 1978; Bourdieu, 1991). These theorists integrate a focus on the micro experience, meaning, and performance within the larger system that formulate or create the subject. Bahktin considers language as a means for articulating ideology (Bakhtin, 1978). Local stories, which are available through language and discourse, provide key glimpses into the understood meanings and negotiated interactions of the subject. In this sense, focus on the local is not a retreat to the particular, but a focus on the particular to understand the general ways that identities and claims are played out in practice. The local provides keys to understanding issues of subjectivity, truth and representation—the experiences and interactions that produce meaning at the local level. As such, the theories focused on language do not intend to retreat into the particular or the relative, but to provide a glimpse of the local to understand the general. When combined with power and considered as a political process, language is key to understanding the claims made about and by older women in public service.

Language, Power & Politics: A View from the Local Level

The second question focuses on the critique of elitism: How can an approach focus on the local as a site of lived experience and negotiation without creating barriers and/or further distance between the professional response and the lived experience? My approach suggests a turn to the particular to understand the general. Yet, several critics are sceptical of my approach. Even my perspective would hold that only the privileged or elite are permitted to gaze at the local. As such, critics may indicate that the language and process of my approach sustains distance between professional practice or analysis and client experience or action. They may say that my focus on language is a game of the elite meant to segregate, be inaccessible and create barriers to participation. Considering the tendency to view language as a game or play, these critiques are very powerful when viewed from a practical perspective. I would argue however, that the focus on language is a way to understand the powerful games and becomes a strategy to reclaim power and politics at the local level.

Language is an organising principle, which structures, defines, and regulates experience (Smith, 1984). A focus on discourse[19] reveals for example, how particular groups such as older women in need of public service become the object of disciplinary knowledge and are constructed as frail (Foucault, 1994). A focus on language shows how language used by powerful interests (relations of ruling) claims legitimacy and becomes truth (Fraser, 1997c; Lather, 1991). Fraser (1989a), refers to the process of making claims through language as "needs-talk" and the context of validation, interpretation and

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[19] Discourse is a "body of thought and writing that is united by having a common object of study, a common methodology, and/or a set of common terms and ideas" A Foucauldian study of discourse must include: statements about madness; rules of inclusion &

satisfaction as the "politics of needs interpretation". In this sense, language is ideological, and dependent on activities of power and social differentiation (Bourdieu, 1991). For example, the construction of frailty as an example of social differentiation between those in need of public services and those with no need takes on regulatory potential within home care services. An approach based on language therefore does not aim to create further barriers but to expose those that already exist.

The temptation to focus on language as a game is not only a critique, but may also be useful metaphor. Derrida (1978) and Lyotard's (1984) approaches concern themselves with play, action and fun; both have numerous metaphors related to games. Language as a game however, may be useful in relation to applied disciplines if game is interpreted as a purposeful strategy. Take for example the way that literary forms use language to invoke for example reaction, emotion, and identification. In this sense, a genre or form is matched with a purpose. For example, poetry has been associated with an aesthetic function of delight, while novels with a didactic function to teach or inform (Bakhtin, 1978). Language as a strategy may help to understand the way language is used to impose and marginalize. Consider for example, that "every utterance should be thought of as a move in a game" (Lyotard, 1984). Language as a strategy therefore is useful to make claims for the recognition and redistribution of services and may expose the path for a strategy of resistance. A focus on language, when combined with power and systemic understandings therefore is not useful as a game of the elite academic, but a powerful analytic strategy and potential resistance. The focus on language becomes a way of understanding the powerful play that exists within the system, which critiques the distance between professional and lived experience, and which leaves space for the political potential of language.

Just as language provides the means for professional classification, language as purposeful (rhetorical) and powerful may provide an impetus for change. It can be used to understand meaning making and identity formation of the subject as well as to render language use a political act. Borrowing from Fraser's notion of feminist discourse for example, a focus on language can help us understand: how people's social identities are formed over time; how under conditions of inequality, social groups in the sense of

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exclusion; subject (personify the discourse); how it acquires authority or truth status; practices within an institution and discursive collective agents are formed and unformed; how the cultural hegemony of dominant groups are secured and contested, and may shed light on emancipatory social change and political practice (Fraser, 1997b). This process may reveal how older women resist or alter those constructions, and has the capacity to further older women's social transformation (Lather, 1991). As language extends into the social and is involved in making claims about diverse older women, an approach which focuses on language facilitates how language is important for identity, representation, claims making and resistance. Language therefore, connects power and politics at the local level—an approach based on language is not meant to create barriers, but expose, understand and change those that already exist.

Coercive & Relational: Understanding the Complexities of Power

My theoretical perspective focuses on the power reflected in everyday practices. Power creates and sustains oppressions, structural conditions and systemic barriers, yet is also present within local activities and practices of resistance (Foucault, 1980b). Critical theories, which focused on power as structural, ideological and repressive, identified the sources and locations of this power, and organised against oppression. For example, Marxism focused on class oppression, feminism on gender oppression (Smith, 1987) and anti-racist theories on oppression based on visible 'race' status (hooks, 1984; Lorde, 1984). Although critical theories provide strong social critiques of power, they have been criticised, mainly by postmodernism, for their foundationalism (e.g., X as the best method), universality and essentialism (e.g., claims made on behalf of all oppressed women), as well as the portrayal of the subject as a victim (Nicholson, 1997). In general, they have failed to account for the relational power and/or forms of resistance that may exist within and between accounts. Guided by a critique of structural conditions, women's resistance has typically been associated with formal resistance of organizations or advocacy groups (Agger, 1998). Local and personal examples of resistance have been less recognised. Further, critical theories have been exposed as reflections of modern knowledge claims (Nicholson, 1990). As such, the ways of talking about power, developing relevant social critiques and claims-making remain the subject of key debates.

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formation (ruptures, radical breaks) (Foucault, 1980b; Foucault, 1992a, 1992b; Foucault, 1994)

My challenge within these debates is to work from an approach that recognises both the coercive power of structures and systems, as well as the relational power necessary for negotiation.

Various forms of power may exist in relation to public home care services, women and research. Informed by critical theories, including cultural studies and feminism (Bourdieu, 1991; Foucault, 1980b; Fraser, 1989b, 1997b), my focus on power considers the structural forces of power of ideology and institutions (i.e., coercive), the various power formations that exist within and between institutional structures and older women's experiences (i.e., relational), and the power involved in constructing an account (i.e., reflexivity). It focuses on the experiences that exist within and between the way power is constructed, secured and maintained. As such, it moves from an understanding based solely on coercive or structural power to one that includes relational power. It combines an understanding of the way coercive power is located throughout the system with a focus on the local level interpretation, negotiation, and resistance. That is, this approach looks at how power operates within and between the spaces that were previously considered the 'powerful' and the 'powerless'. This approach is useful to understand the way the power of the frail/non-frail binary and defines older women's experience, the voices and experiences, which negotiate or resist these classifications, and reflect on my power as a researcher.

Power as both coercive and relational however, is subject to critique. In one sense, retaining a structural analysis continues to make claims based on identities that have already been rendered problematic (e.g., marginalized women). In another, any claims of negotiation and/or resistance are limited within the current context of globalisation, health and social services. While, a focus on the local level may seem to weaken both the social critique against social barriers and buy into liberal claims of freedom and individual responsibility (Fraser, 1997b). Recognition of power at the local level seems to render the challenge for resistance futile. However, the current context requires new ways of focusing on power and critique (Leonard, 2001). Under these conditions, I would argue for an approach focused on both coercive and relational power. This approach would consider the complexities within power; recognise the existence and implications of structural power, as well as the acts of resistance, which exist within and between. It would retain the strength of a structural critique informed by local understandings as a base for making strategic claims. Making the choice to consider power as coercive and relational however, raises several questions in relation to truths, the subject as victim and claims making. The following questions reflect my thinking and choices surrounding understandings of power.

- How may an approach maintain a structural critique of oppressive power without making truth claims in the name of the oppressed?
- Further, considering current pressures, how does a focus on the local level actually move the subject from victim status to agent? Does a local focus further marginalize persons by accepting limited forms of power?
- How can such an approach based on both the structural and the local make relevant claims?

Retaining the Structural: Understanding Powerful Conditions

A structural critique accompanied by a complex understanding of power operations may address some shortcomings of critical theory. Admittedly, this approach retains the possibility of certain truths and assumptions about the applicability of claims. It recognises power differentials and therefore, that some persons are more marginalized than others (e.g. women in need of public services) (Mann & Kelley, 1997). Here, some theorists would be sceptical of an approach that seems to replicate the universal and modern claims in the name of less powerful groups (Nicholson, 1997). Based on the past power claims of critical theories they may question the ability to move beyond this problem. A typical question may be: How may an approach maintain a structural critique of oppressive power without making truth claims in the name of the oppressed? Although reflexivity is required, retaining a structural approach that recognises complexity may assist to understand how power operates and produces oppressive conditions. I would argue that the powerful claims made for older women require a structural response which questions the taken for granted power. However, instead of viewing power as an 'either/or' situation (e.g., powerful and powerless), a complex approach would consider the potential for power as a 'both/and' situation (e.g., power as relational and contextual) (Foucault, 1980b). It would consider the possibility of multiple forms and operations of power, recognise the structures, which use power to create and maintain oppression or marginalization, the local forms of power, or agency, which may negotiate or resist these conditions, as well as the very power involved in constructing this account.

An analysis relevant to the conditions facing older women in need of public home care services requires both the recognition of certain realities or truths and the realisation of the limits of these truths. Older women who require public health care are faced with a certain reality of illness or declining health and a need for public services. At the same time as older women make claims to have their needs met, health services makes claims to ration services through risk. The actual conditions or real experiences may place older women in a marginal location in relation to health, while restrictions in service may mean that they have restricted access, are excluded or marginalized within services. Although older women's strengths and needs may vary, the conditions of power and inherent power differentials may limit their potential to make claims. Powerful systems may make stronger claims than older women in need. It is for this very reason that an approach to power must retain a focus on structural operations of power as well as certain truths about older women's potential experiences vis-à-vis public services. This approach recognises the complexities of power and truth, and therefore retains truths useful to develop a relevant critique. A focus on the structural conditions and complexity of coercive power may therefore, inform an analysis of older women's experiences in relation to public services. However, although a structural critique may provide a useful analytic tool, it is no longer possible to make overarching truth claims for a marginalized group—they must be combined with the local experiences of resistance and understood as partial, limited and/or strategic.

Local Negotiations as Acts of Resistance

A focus on the local level may assist to understand the power that exists within and between structures. It may address the truth claims, essentialism and victim status within past critical theory approaches. The local may recognise diversity within accounts, the strengths or agency of older women at the margins, alternative forms of power, as well as individual interpretations of experience. As recognised in the previous paragraph, we may no longer make the claims previously made by critical theory in the name of the oppressed. Here, Foucault's notion of relational power and resistance located throughout the system are helpful (Foucault, 1980b). An understanding of power as relational expands the structural understanding of power as imposed to power as circulating and variously located. Relational power may move older women from a victim status to agent status by giving the local a new radical potential. "Where there is power there is resistance" (Foucault, 1980a, 1994, 1995). Resistance in this sense refers to the critical questioning of discursive representations and instructed responses, 'subversion', 'rejection', and 'movement' within and against the powerful (Katz, 1996). Further, notions of relational power expand power to subjects who have potential agency and power in the form of resistance. This understanding shifts the focus from the person at the margins as an oppressed victim to a subject with agency and emancipatory potential. Understandings of relational power looks for resistance believing it is there—it believes that power exists at all level and considers all sites of experience as arenas of struggle.

Here, some theorists would be sceptical of an approach that places such an emphasis on the individual and local differences. They may view this as a retreat to local level and questions about the actual agency or potential power present within a local claim (Leonard, 2001). A typical question may be: Considering current pressures, how does a focus on the local actually move the subject from victim status to agent? Does a local focus further marginalize persons by accepting limited forms of power? Critics may question whether this approach may actually move the subject from victim to agent status or does this local approach merely weaken claims (Butler, 1990; Elliot & Mandell, 1995). Although reflexivity is required, balancing understandings of coercive or structural power with local or relational forms of power may assist to understand the complex experiences and power within and between structures. I would argue that in addition to the structural conditions which marginalize, the situation of older women in need of public service require attention to the way that power is experienced, negotiated and resisted at the local level. These local notions of relational power may expose how power plays out at the local level as well as how agents may engage in acts of resistance. Relational power provides the potential for agency, which could not be addressed within understandings of coercive power. Admittedly, these acts of relational power may be more limited than previous claims within critical theory. Instead of changing an entire system they may negotiate and resist in smaller yet relevant ways. Yet, under the current context and structure, power and resistance look different than previously conceptualised (Leonard, 2001). This approach is an attempt to recognise the various examples of local negotiation and resistance that are present on a daily basis. The local understandings of relational power however, are not enough on their own.

Complex Recognition: A Base for Making Strategic Claims

Critics question how can such an approach based on both the structural and the local make relevant claims? Reflexive and complex power is subject to critique; two of the strongest critiques include the concerns for cultural relativity and the limits of power for persons at the margins. If we can no longer speak for certain groups, there would seem to be no power within our claims. If the approach considered only the structural power, there would be no room for the local acts of resistance. The system would seem too large and pervasive to make change, yet, considering that no narratives have truth status would seem to maintain unequal power relations and oppressions (Leonard, 2001). Further, it is all well and fine to say that relational power gives the persons at the margins a sense of agency and potential. Yet, considering the powerful institutional structures this power is definitely not equal to the power of the institutions.

When understood as a more traditional either/or choice between the structural or the local, the understanding of power as both coercive and relational would seem unrealistic, perhaps impossible. On the contrary however, when power is understood within the both/and context, this complex understanding of power provides the potential for both a reflexive account as well as a base for making what Ristock & Pennell (1996) refer to as 'strategic claims'(Ristock & Penell, 1996). A complex understanding of power exposes the constructed nature of each account and its location within the relations of ruling or systemic power. This understanding provides insight into how power may both exist as truth as well as vary within this truth. As such, a complex understanding of power requires a scepticism and reflexivity toward all truth claims—including our own (Hall, 1998). This means that any account may be questioned for its role in making powerful claims.

On the flipside however, an approach, which combines focus on the coercive (macro) and the relational (local), allows for the necessary recognition as a base to make strategic claims. This means that the various experiences of power may receive recognition and thus form the base for a claim. A complex understanding of power exposes the problematic nature of an either/or choice within the current context. A complex understanding of power is helpful to this account which tries to balance the way that the stories and actors interact to produce a relevant account about older women's experiences. Within this complex understanding of power, the local is all that is left—in the current context is it given a new potential (Davies & Collings, 2001) where it may be the site to understand diverse experiences and form the basis for strategic claims. The recognition of the various forms of power has implications for understanding power, recognising diversity as well as for making claims that will lead into change efforts. Opening our understandings of power to include a both/and perspective which integrates coercive and relational power can assist to understand local level powerful operations as well as how despite coercive power, agents use their strengths to negotiate and/or resist. Together, this approach may expose the power imbalances for what they are and suggest alternatives.

Diversity: Social Location as the Key

My theoretical perspective focuses on the diverse experiences or individual differences that may transcend the common. Common experiences and identities, such as older woman (i.e., 65+), form the base to recognise and respond to target groups and/or service populations. Differences within these categories however, often remain overlooked (Lorde, 1984). Early theories and practices in feminism, gerontology and policy excluded varying identities within and between the recognised categorisations. For example, it was assumed that all older women shared similar experiences despite diversity, which may include ethnicity, 'race'[20], class and sexual orientation. Older

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[20] Race is bracketed as a socially constructed concept. According to Christensen, "race is a European folk concept associated with colonial expansion and oppression in which skin colour and other visible, socially selected, traits are used to arbitrarily classify populations of the world into hierarchical order in terms of human qualities. Ethnic groups are often confused with races, but they actually comprise people who associate with each other to maintain common bonds of language, ancestry or attachment to geographic location (Christensen, 1996), p.141-142

women challenged the exclusion, claims of 'truth' and assumptions of representation[21] espoused within categories of "woman" or "senior" (DeBeauvoir, 1972; Friedan, 1993; Laws, 1995; MacDonald, 1983). Although feminism and gerontology have attempted to respond to these claims, the challenge to include diversity in a meaningful sense continues. Identity politics and claims-making remain the subject of key debates. My challenge within these debates, is to work from an approach that recognises both the common experiences important for making claims, as well as the individual differences which allow for interpretation, meaning making and negotiation.

Diverse[22] social locations may exist within an individual or group identity such as the frail older woman eligible for public service. Informed by a post-modern view of difference, social location focuses on the subject as having multiple possible locations and considers identity performative and negotiated (Fraser, 1997b; Nicholson, 1997). Here, older women are considered to live multiple truths— no one location may be said to represent a woman's experience. Further, they may choose to present themselves differently depending on their experiences or interpretation of the context. For example, an older woman may situate her identity within varying locations, roles or experiences such as "woman", "mother", "professional", etc. Social location may also draw on intersectionality (Crenshaw, Gotanda, Peller, & Thomas, 1995; Harris, 1995) – the interconnections between identities and systems of oppression (hooks, 1988) p. 21. This means that although a woman may be assigned an identity, identities and locations may exist and intersect within fixed categories such as age and gender. A focus on social location provides older women with various identity-based choices. The possibility of multiple and fluid identities gives older women the power to chose if, when, and how they identify. Older women thus have power to negotiate and/or resist certain identities as well as maintain meaningful identities despite decline. In this sense, social location is particularly useful to this account, which challenges the primary classification of older women as frail.

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[21] For a theoretical and historical account related to the issues of representation, consider Riley's exploration "Am I that Name?". (Riley, 1988)

[22] The choice of the word diverse or diversity is intentional. This word reflects that until the person self-identifies it is difficult to impose a label or identity. We may impose an identity based on various characteristics, but that this identity may not have the same meaning for them, or that they would identify differently.

Social location as choice and performance however, is subject to critique. On one hand, social location is inclusive, leaving older women room to make claims and negotiate their lives. Older women may choose an identity that is relevant and meaningful to their lives at a particular point in time within a particular context. On the other hand however, there is a limit to choice and relativity (Butler, 1998). Further, choices may seem to fragment political claims (Hill Collins, 1994). This is especially the case in the current context where identity choices are viewed as a binary either or situation, as well as a hierarchical choice between a greater and lesser choice. Take for example, my choice of gender as a common experience and social location as difference. Some theorists concerned with oppression and emancipation along particular lines (e.g., feminism, anti-racism) may feel that choosing one identity (e.g., retired) may deny structural conditions, weaken the collective gender based claims of feminism or anti-racist claims of anti-racism (Dominelli, 1998; Dua, 1999). However, I would argue for a fluid and flexible approach that would allow for multiple locations and intentional choices dependent on context. Making these choices however, leads to necessary reflexivity and key questions about the foundationalism of particular methods, how to focus on the differences that exist within the commonalties, as well as the intent of diversity. The following questions reflect my thinking and choices in relation to debates surrounding diversity:

- How may an approach focus on gender and social location without falling into a dichotomous choice which positions feminism as the ‘right’ or ‘better’ method and diversity as the secondary piece? And how may an analysis organised primarily by gender as universal, focus on the differences that exist within commonalties?
- Why difference? How may an analysis focus on diverse social locations without falling into an approach that only considers difference for the sake of difference?

Foundations & Strategic Essentialism

The first question focuses on critiques of foundationalism and the response of strategic essentialism: How may an approach focus on gender and social location without falling into a dichotomous choice which positions feminism as the ‘right’ or ‘better’ method and diversity as the secondary piece? And how may an analysis organised primarily by gender as universal, focus on the differences that exist within commonalties? My feminist analysis imposes a gender identity on older women. Here, some theorists may say that I have fallen into a trap of foundationalism, which places feminism as the 'right' or 'better' method, and diversity as the less important value. Although this question has perplexed me for several years, I am cautious to provide a response. On one hand, I wish to forego the debate and the politics that exists within the bitter struggle for the 'right', 'better', or 'true' theory. I do not intend to claim that my way of doing things is the best or the right way. Yet, on the other hand, I fear that by very means of asking and responding to the question, I am trying to persuade you that I have the right answer. Hence, my question seems to fall into the trap of dichotomous thinking and the very foundationalism it is trying to expose and avoid.

My choice of gender and service location as starting points was based on the intent of my study: to explore diverse older women's experiences in relation to the imposed identity of frailty. First, gender is a readily available division, which reflects structural barriers and marginalization within society. Second, characterisations of older men and women in case files seemed to vary—in this sense, gender and service location seemed to provide a useful organisation for the current analysis. A feminist or gender analysis makes a strong claim in relation to the experiences of older women at the margins of health. A study focused on the systemic barriers within service may have chosen race as their starting point. Although a gender analysis makes a strong claim where the majority of care receivers and caregivers are female, it is also a claim that is rooted in and reflective of my power as a researcher. In this sense, I realise that although gender is a useful common location, which often divides experiences, it may not best reflect the older women's self-defined identities or experiences in relation to services. Some older women's experiences may be better reflected by a focus on 'racial' and minority status, for example (Brotman, 1999).

Diverse social locations, may be more reflective of the divisions between experiences. Feminism is no longer able to make the wide sweeping universal claims in the name of women's oppression. My choice of gender and diversity reflects feminism's current struggles to retain a focus on the structural conditions, which oppress and marginalize, make claims that are relevant to common experiences, as well as recognising the diversities and differences, which cut across these similar experiences. Gender analysis alone however, is no longer enough—ignoring the impact and meaning of diverse social locations would continue to exclude older women's complex experiences, which reach beyond gender experiences, such as race and class. Although it seems that gender precedes diversity in my analysis, this is a reflection of the research process as opposed to priorities. My choice of social location was intentional and purposeful, yet I was unable to discern each woman's identity prior to speaking with her. Her choice of identity was revealed only through discussion. In this sense, purposeful affiliation or strategic essentialism (Ristock & Penell, 1996) may provide feminism with tools useful for making claims that recognise differences within and between social locations.

Strategic essentialism—choosing identities in order to make claims—may eliminate the dichotomies that have existed in relation to women's varying locations (Ristock & Penell, 1996). Instead of having to choose between affiliations, older women may unite under a political cause in a strategic or purposeful sense, without having to give up another identity that may be important to them. Strategic essentialism and/or purposeful affiliation thus recognises for example, that a woman may be "older", "black", "queer"[23], "mother" and "daughter". An understanding of the "intersectional differences" (Fraser, 1997b) that exist between locations guides purposeful affiliation and/or strategic essentialism. This understanding may assist a gendered analysis to correct past hierarchical classifications of double and multiple jeopardy, which consider each identity as an added oppression, and mask inter-connections amongst categories (Smith, 1998). Older women may chose and negotiate their identities in relevant and meaningful ways, as well as exert strength and agency as opposed to feeling torn between identities and locations. My choice of gender and social location is a strategic choice or purposeful affiliation relevant to the task of exploring diverse older women's narratives in relation to the imposed identity of frailty. As such, this approach permits a gender analysis that focuses on the differences that transcend commonality as well as leaves room for negotiated experience.

I can hear you asking now: If you are saying that your step into the trap of feminist foundationalism is a strategic choice, but that older women have the option to

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[23] The terms 'black' and 'queer' are used in this sense as specific political choices. Language choice is connected with self identification for political purposes. This choice of identity, articulated through language, demonstrates the power and utility of strategic essentialism

deny structural conditions through self identification, then do the categories such as gender, age, class, race and sexual orientation really matter? If so, what are their purposes? Does your focus on difference really matter if these categories are all socially constructed and negotiated based on personal experience?

Difference with the Intent of Making Relevant Claims

The second set of questions focuses on the intent of diversity: Why difference? How may an analysis focus on diverse social locations without falling into an approach that only considers difference for the sake of difference? Understanding the differences that exist within the common structural oppressions, target populations, or service groups is key to making relevant claims. In the powerful context of health and society, claims-making is both a political and personal process (Ristock & Penell, 1996). Where the common experiences form the basis for larger more general claims, diversity focuses on the personal relevance of claims. At this level, difference is key to subjectivity, multiple truths and representation (Fraser, 1997a). Strategic essentialism or purposeful identification implies that the identity was chosen for political reasons as opposed to personal identification. In this sense, older women may make personal compromises for the sake of their political affiliations—only when diversity within the common is accounted for may older women feel that their needs are being met. Further, common experiences would only be relevant where chosen and meaningful. Neither group nor individual identity would be meaningful if they took the form of fixed identities. The point is that there has to be room to move within categories. Social location moves away from the notion of a fixed identity toward multiple and shifting identities. The intention of incorporating social location therefore intends to make relevant claims, which reflect lived experiences and meaningful identities.

Diversity or difference however, is not always approached in relation to claims making. An extreme post-modern approach would deny all unity and/or representation focusing instead on differences within constructions, stories and words. This position that considers "difference for difference sake" (Lyotard, 1984) is threatening to the collective and/or emancipatory project (Leonard, 2001). A focus on difference for difference sake may be relevant in other fields, however, it has no sense in relation to a practical or applied project. In this analysis, difference is not merely for difference sake but exists within a personal and political context.

An approach that is relevant and useful at a local level requires an approach to diversity that includes both subjective identity and political claims making. Difference is important for recognition of meaningful experiences and integration of political power—it is not for the sake of interest. Difference is important for the experiences of older women, especially when their involvement with greater systems such as policies and services are considered. A focus on difference is a direct challenge to the knowledge claims that have preceded this approach, the claims to truth and representation. It seems that we need something that will allow older women to negotiate their experiences through performative identities, yet that will also allow them to join movements that fight against systemic oppression. Here, the concept of thin and thick needs (Drover & Kerans, 1995) seems to allow older women to negotiate both. A focus on social location provides older women the strength and agency to make claims in meaningful ways. Difference through social location allows useful or necessary choice to be made amongst individual identity and collective strategies. In the context of requesting services, difference is part of the politics of needs interpretations.

However, recognising the common experiences and differences within the politics of need however, is not enough. Recognition of diversity on personal or individual levels may provide space for negotiation or maintenance of a meaningful identity, yet this identity may be disillusioning within a context where it holds no actual power. Recognition of diversity without a stake in power or change seems to reflect a liberal ideology of tokenism of culture and experience. This is where the post-modern focus on difference breaks down. The person is permitted to 'feel' and 'act' differently, but is given no access to rights based on their identity and/or the systemic barriers that may exist in relation to this identity. In this sense, diversity is not enough—it requires a connection with recognition, power and change.

Change: A Necessary Utopia

My theoretical perspective focuses on the emancipatory potential that may exist within local approaches. Drawing on various critical theories, it claims that change is a "necessary utopia" (Leonard, 2001)—that is, change is very important to the situation of older women at the margins of health care. This approach however, extends beyond previous notions of change or alternative understandings to include new notions of change that include difference and strategic essentialism or purposeful affiliation (Ristock & Penell, 1996). A notion of change rooted in both structural and local understandings gives the local a new potential within the current context of care. Older women's marginal location in relation to health and bodies, may therefore, be called into question with the intention of altering current understandings. Critical theories[24] may provide the sense of hope, group unity and emancipation necessary for a change in the structural conditions of oppression. While, the focus on the local incorporates the subject, interpretation, dialogue or communication, self-reflexivity and change. Together, new considerations of change which include both the structural and local experience address past neglect of diversity (Dannefer, 1988), foundationalism, and essentialism within critical theory as well as the problems of fragmented identities, a loss of hope and a weakened potential for change present within post-theories. Integrating change into the current context however, is a challenge. Change remains the topic of debate and faces serious challenges in relation to truth, representation and emancipatory potential. Older women have a precarious position in relation to health and discourse, as such, the theoretical and actual position is uncertain in relation to change. My current struggle within these debates is to reconstruct a relevant and useful analysis that incorporates scepticism toward imposed identities such as frailty and structural conditions of oppression, as well as meaningful change on both a personal and collective level.

Considering the various discourses of power that operate on and about the older woman in relation to health care, change is required. Although this change may have varying possibilities in terms of the way it looks, the process and the outcome, the notion of change is central. Notions of change as a necessary utopia may acknowledge certain truths, which will permit comparisons between situations, raise questions regarding the current language use, power and recognition of difference, as well as create the connections necessary for political change. Here, the local may hold a new radical potential for change—it may provide a base for the previous mentioned temporary,

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[24] Agger has classified several theories as critical theories- here I am referring to them as the emancipatory narratives (Agger, 1998)

strategic affiliation. Here, the notions of language, power and diversity and change. For example, despite diverse social locations, older women may chose to affiliate themselves with an older women's group based on age, gender identity and purpose such as social housing. As such, older women's differences are not excluded or denied, but are less visible at that moment. This example shows how older women may choose a meaningful identity based on the common good without sacrificing their identities. A focus on change therefore, is a helpful way to account for the problems of the past or social critique while at the same time developing something that is relevant for the future. As such, this approach highlights the strengths of making claims for a purpose as well as the emphasis on structural conditions and change. In this sense, Leonard's concept of change as a necessary utopia is particularly useful to this account, which challenges the imposed frail identity and marginal location of older women eligible for public services (Leonard, 2001).

The incentive for change may exist at the personal and political level. This is especially the case for older women, whose activism and resistance may take more local or personal forms. Informed by feminist post-modern approaches, the strengths of scepticism and reflexivity within the post-modern approaches are combined with the structural critique and hope for greater change within the emancipatory narratives. This approach is an example of "useful theory" (Agger, 1998) that despite contradictions, is relevant at the local or ground level. It considers change a necessary utopia that provides the hope, energy and inspiration to work toward change within the system. For older women eligible for public services, change may look different than mass collective protest—it may take the form of daily pieces of resistance. Change for older woman may provide the capacity to challenge imposed identities as well as the conditions that create and sustain larger oppressions. For example, an older woman may choose to resist a frail identity. In this sense, the individual within the current context is given a new radical potential— change and emancipation look very different than previous models.

Change as a necessary utopia however, is subject to critique. On one hand, it is idealistic and allows for the hope that things may be different. Older women may chose their identities and negotiate their health care in a way that is meaningful to them. On the other hand however, within the current system, change seems naive and unrealistic. This is especially the case in the current context where public services are shifting toward managed care and privatisation and less and less toward the social notions of care. Within the current context, theorists are sceptical of such intentions for change and claims of truth, representation and potential. I would argue that it is under these conditions that such a stance is necessary. The choice to claim change as a necessary utopia however, leads to questions about the feasibility for change, recognition of vulnerability and new models of emancipation. The following questions reflect my thinking and choices in relation to change:

- How may an approach focus on change, hope or emancipation at either a theoretical or actual level within the current context? If truths and foundations are questionable than what is left of the collectivism and change?
- How may this approach integrate change without falling into the trap of universalism, which denies differences? How is it possible to focus on both the local and the greater sense of change?

Emancipatory Potential[25]: The Radical New Potential of Local Narratives

The past problems within research and practice as well as the actual situation of older women at the margins highlights how local narratives may provide a radical new view of change. When combined with a critique of language use and power, older women's accounts may highlight the potential for alternative realities, hope and change. Authors however are critical of the attempt to address local differences and emancipatory potential. They may ask: How may this approach integrate change without falling into the trap of universalism, which denies differences? How is it possible to focus on both the local and the greater sense of change? Expanding on the challenges presented within the language, power and diversity section, critical theorists are mainly concerned that the focus on the local differences may exclude any possibility for collective affiliation and therefore change (Nicholson, 1990). Focus on the local is often associated with the loss of the subject and voice, dangers of fragmentation, and therefore the loss of emancipatory potential. The focus on the local has been criticised as a retreat to the local- a loss of

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[25] (i.e., commonalties within the category of 'woman'[25] or 'sisterhood')[25] and inclusion of difference (e.g., ability, age, ethnicity, gender, 'race' and sexual orientation) and fragmentation (i.e., individual difference- lack of collectivity)) (Fraser & Nicholson, 1990; Nicholson, 1997; Weeden, 1987).

nerve in the face of the pervasive forces such as capitalism (Leonard, 2001). The focus on the local has been seen as recognition of defeat—an acceptance of the minimal power available to persons at the margins. These concerns about fragmentation and actual power are very real within the current context. It is in this context however, where resistance seems more important than ever. In the spirit of optimism and looking for something different it would seem that if the local is all that is left—than we should focus on the local. Here, however I would argue that change is not hopeless, but that it requires a new perspective.

Within the current context, the emancipatory project envisioned by critical theories will look very different than previously conceived. Instead of having a fixed position, it may be fluid and shift in the intention of making more relevant claims. Building on the previous notion that social location provides opportunities for making relevant claims, strategic essentialism or purposeful identification also provides possibility for collectivity and change. Combined with holding on to the truths or existence of structural experiences which create and sustain oppression, strategic affiliation provides a purposeful identity intended for change. Identification therefore is a choice and is meaningful to personal and collective goals. The differences of social locations may then be located within material contexts. In this sense, if affiliation is intentional and purposeful there is little room for fragmentation. Leaving space for purposeful affiliation or strategic essentialism, older women may also assert collective identities based on social locations of age, ethnicity, gender, race, socio-economic status and sexual orientation for the purposes of political power. Older women may represent their identities in ways that are relevant on both individual and political levels, challenging systemic barriers and oppressions and participating in a project for change. This would provide a space through which older women's voices for resistance and alternative constructions can be made explicit.

Acknowledging Certain Truths—Recognising Vulnerability & the Promise of Hope

Recognising the new radical potential of the local and making strategic claims however, relies on acknowledging certain truths, recognising our vulnerability and maintaining hope or optimism despite a seemingly gloomy context of marginalization (Leonard, 2001). The current context of increased world domination, globalisation and exploitation compound the concerns of those interested in a project of change. In the face of the seemingly pervasive power, there seems to be no potential for an alternative system to capitalism, and the marginalization produced by this system. The forces of capitalism seem to be stronger than before and the persons at the margins are being pushed farther outside of the limits. In addition to the seemingly gloomy context of the social, the critiques of the universal and powerful claims are relevant—the emancipatory narratives have made essential and universal claims that cannot address the experience of all persons. In this sense, moving toward change requires the recognition of vulnerability—that we do not have the right answers. Yet, within this recognition those concerned with justice must hold on to the idea that there are certain truths that require change or alternatives. For those concerned with an emancipatory project and/or social justice, there must be an analysis of the power differentials that exist between claims as well as the potential for making claims and producing change.

Older women eligible for public services are but one example of those at the margins. Yet at the same time as critics question the relevance of an approach focused on change, others question how claims may be made in the absence of truth. It is here, that this approach recognises truths such as marginalization. Here, many of the same problems in relation to truth claims (i.e., essentialism) and representation (i.e., fragmentation) dominate the arguments (Nicholson, 1990). While the first is pessimistic and fatalist, the second would be unable to make any claims. Yet within the context, there are certain truths. Here again is where I wish to forgo the debates in exchange for a perspective that is relevant for older women's experiences in relation to health care. There are structural barriers and/or oppressions, which require a specific stance. Just as I am aware of the dangers of a solid foundation, I am wary of the anti-foundational beliefs that deny certain realities of oppression and marginalization and the impact that this denial or inaction has on the lives of people at the margins. Post-modern feminists for example, take a stand that some truths are worth maintaining and that some truths are more true than others (Fraser, 1997b). They argue that despite scepticism of truth and representation, the stopping point is gender. Fraser & Nicholson have struggled with this dilemma of combining a sophisticated deconstruction with a mode of theory that would retain social-critical emancipatory force (Fraser & Nicholson, 1990). As older women's experiences are marginalized within the complicated system of claims and truths, this approach requires both the recognition of certain conditions as well as the need for a critical theory that focuses on change.

For this reason, those concerned with change draw a line—the truth they chose to retain is the potential that 'things could be otherwise'. In this sense, it is necessary to hang on to some truths. The current and socio-historic necessities of systemic oppression based on gender require collective or purposeful affiliation. Purposeful affiliation in this sense becomes a political necessity. My attempt here is to try to incorporate the strengths of both approaches to create an account that is relevant for older women's experiences in relation to frailty. This construction is not meant to create an ideal, but a limited approach that is relevant for an applied discipline such as social work. Despite the several debates regarding change and talking about change, it would seem that any approach relevant to social work must include emancipatory potential—the intention is ultimately to create change. However, within current conditions, I recognise that this potential for change may look very different than previous conceptions of change. Emancipation in the current context may look very different from the past vision of a united front. Hanging on to these truths provides hope for change and a vision of a necessary utopia. Change is the necessary utopia, which provides something to hang on to—something to look forward to, something to work on (Leonard, 2001).

Of course, you say...you can hang on to some truths when they suit your purpose or interests...and yes you would be right in saying so. I have questioned this myself. How is my view any different from the modern scientific approach which also claims to have the answers- in a sense I am only competing with them for who has the rights answers- and just as they do, I think that I am right. Who am I to take such a position that I am right- I have the right theories. I can rationalise or support my view saying that it is the older women who have told me so- I have listened to the voices of the older women, which is more than the scientists may say- but they have listened to their logic and their own minds. This difference in starting point is my answer. Where they have started with logic, rationality and objectivity, I have started with a human experience, which attempts *to understand and not have the answers. Combined with my view that change is possible, I can accept that there are many truths (past scientific approaches being included in these truths) and proceed to hang on to truths in the name of making claims and responding to older women's needs.*

Local Relevance

A perspective rooted in the interconnections between language, power, diversity and change may help to understand the gaps between the stories told about older women and the way older women story their own experiences and needs. Just as I have made claims through this dialogical account, focus on policy and service based language of frailty exposes the interactive, purposeful and performative way that older women make claims. This is helpful to understand both claims made about older women's needs as well as older women's claims to have their needs met. Combining this focus with power exposes the complex coercive and relational power that exists within and between the accounts of the larger discourse about needs and older women's stories. It focuses on the power that is located on the body and how the body becomes central to identity and claims (Shilling, 1993). Older women's identities, needs and the claims made about these needs are not fixed. Integrating social location provides the chance to witness how older women's needs may vary according to social location and/or experience. It may also highlight the various perceptions of power within the system and the way that diverse older women use their experiences to negotiate the powerful claims of and through language. Finally, the focus on change retains a capacity or intention for change—that things can be different. Further, this focus on the necessity of change moves this theoretical perspective from an interaction between us, to the actual situation of understanding older women's accounts. That is, it moves this interaction from the abstract theoretical discussion to the ground level of implementation within this dissertation and to in relation to policy and services. A perspective based on language, power, diversity, and change provides an alternative way of understanding and living change through older women's local stories or narratives.

Act IV

Behind the Scenes at Intermission

Understanding Narrative through Older Women's Stories

This section is an intermission—a story to convince you of the merits of a narrative approach and justify the reasons for taking this approach. It takes place behind the scenes, explaining the way the piece was constructed, and the meaning this has for the second part. This is but one story of many that I have to tell, it is only a partial or fragment of the larger dissertation story. It is meant for your eyes only, yet is truly a dialogue between what I share with you, and the way you interpret my story in light of your expertise and experience. It is a story about the way that I began my research journey, this performance and the way I have come to understand the narrative approach through older women's stories. It is a story that moves back and forth between how I understood this approach at the beginning of my journey and the way I now understand it. It moves between my account and the older women's accounts—but they cannot really be separated. It is not chronological, but structured as a lesson. Just as the older women have selected pieces that were appropriate for me to see—I do so for you. Yet don't be mistaken, this story is undeniably an expert account—although pseudo expert—about the methodological path of my research, a way of hearing older women's voices and experiences, and a balance between what is expected and the sensitivity required to conduct research on older women's health issues. It reveals part of my identity as a reflexive researcher, yet, someone who is nonetheless removed. Others would read these words, read my story, and have different interpretations—just as I hope you will. Although this story as it is written on these pages seems fixed, both the stories which led me down this path and this story about the way things were done are fluid, incomplete, and partial just like any—but they have been pieced together for you.

Designing the Set: Narrative as a Method

A narrative approach to older women's experiences of frailty provides a multi-layered account in which the layers are not hierarchical but rather crosscutting and overlapping. This approach is appropriate to understand diverse older women's experiences in four main ways. First, it opens the space or exposes unheard stories or voices of older women at diverse social locations, providing in-depth accounts of experience from older women at the margins. Second, a narrative approach challenges the traditional forms of knowledge such as objectivity, standardisation and truth that exist within research, policy and practice and is therefore, helpful in challenging dominant practices and constructions of older women as bodies at risk. Third, it provides an alternate, reflexive research format, making an attempt to distribute traditional understandings of power. This power includes an alternate to the power that exists between the researcher and the woman interviewee, as well as the space for older women to control, author, interpret and define their stories. The telling or performing of stories is key to older women's self-constructed identities, everyday experiences and meanings. Fourth, a narrative approach may contribute to change and/or alternative understandings. Once heard, these stories may exposes gaps and contradictions between dominant conceptions and older women's experiences thereby re-authoring or re-constructing more relevant stories. For example, older women's varying experiences of frailty may be held up to the predominant individual medical construct of frailty. As such, a narrative approach both recognises and respects the local narrative yet, also has the potential to place the narrative within a structural analysis related to policy and practice. As such a narrative approach makes it possible to look at the ways in which older women negotiate or make-meaning of frailty in their everyday lives consistent with a theoretical approach that focuses on language, power, diversity and change.

When I began my dissertation it was not easy to find key texts written specifically on the narrative approach; this approach seemed less available than the qualitative methodologies of grounded theory, ethnography or phenomenology. It was scattered amongst various studies and published examples (Frank, 1991; Mishler, 1999) and practised differently depending on its roots or tradition (Clandinin & Connelly, 2000; Cortazzi, 1993; Holstein & Gubrium, 1994; Polkinghorne, 1988; Van Manen, 1990). It was as if each example of narrative was a different story, uniquely framed with various structures, plots, turning points and characters. I have drawn on these approaches to create an approach meaningful to older women's local level understandings of frailty. My attempt is not to create a method that be accepted as "The Narrative Method", but to walk you through the choices I have made, the lessons learned about how older women seem to story their accounts. My current understanding however, was formed only in relation to older women's stories. In this sense, it was not an imposed method, but a model that was created through interaction and understanding older women's stories. As you will see, the ways the stories were told became the clues to understanding them. You will see that I use the term's 'narrative', 'stories' or 'accounts' interchangeably to convey a general meaning. What these three terms seem to convey is that each is a way of telling or speaking an experience or understanding of a situation, world or experience. The narrative is an approach that focuses on the self-defined in relation to a situation or experience. Just as the stories told represent fluid accounts of identity, the narrative itself depends or exists amongst social historical context, intention, and readership. To me, narrative is a story that defines both an identity and experience—it is interpretative, relational, grounded and reflexive of experience, and performative in nature. A narrative approach to research is exploratory, meant to discover how the person may situate themselves at a particular point in time, to a particular person or situation (Eakin, 1999). Narrative accounts are meant to produce rich descriptions and provide insight into constructed meanings.

Diverse roots, histories and practices located within varying theoretical perspectives inform narrative research. If one were trying, it would be difficult to draw the disciplinary boundaries and method of practice around a narrative approach. For example, it has roots in anthropology (e.g., lived experience) and literary studies (e.g., the novel), but has also been incorporated into sociology, and specifically the study of illness and/or suffering (Hyden, 1997; Frank, 1995; Charmaz, 1999; Bell, 2000) and social work practice (e.g., narrative practice) (Kohler Reissman, 1993). Narrative is informed by narrative therapy (White & Epston, 1990) as well as humanistic, phenomenological, and biographical methods of research (Moustakas, 1994; Polkinghorne, 1989; Van Manen, 1990). Within narrative, varying theoretical perspectives would position themselves differently. That is, each would consider the purpose or outcome of narrative differently. From a post-modern perspective, narrative may be considered the local narrative (i.e., les petits recits) to exist on its own, or placed in opposition to the big theories of objectivity and rationality (Lyotard, 1984). In critical theory such as feminism, the narrative may represent the unheard voices of the oppressed, which aim to displace the current structure and create change (Lather, 1991). While the post-structuralist influence may take this one step further to say that narratives expose the multiple accounts that exist within one account (i.e., the other sides of the story) or consider narrative as an example of a shifting performance dependent on context (Mishler, 1986). Similar to the performance within literary texts, social interactionists would consider the relational or interactive nature of the stories. Therapeutic accounts such as psychoanalysis would place emphasis on the individual meaning of the story, while therapist working within narrative therapy would emphasise the narrative as an opportunity to re-story the event or account (White & Epston, 1990). The older women's accounts place emphasis on the way that the telling of a story reveals their identity ('who they are'). Rather than police the boundaries of what counts as narrative, I will try to outline how these traditions have informed the way I understand and use narrative in this dissertation. For me, narrative consists of five main pieces of a puzzle that may be rearranged depending on the purpose and context. In general, these pieces include:

I. Narratives are Constructed Accounts which Strive to Make Sense or Meaning
II. Narratives are Unheard Voices or Accounts
III. Narratives are Interactive and Relational Performances
IV. Narratives are Examples of Critical Practice
V. Narratives are Examples of Scepticism and Reflexivity

Narrative as a Constructed Account which Strives to Make Sense or Meaning

Narrative is a constructed account that strives to make meaning or sense of the world and or our positions within it (Polkinghorne, 1988). As such, it is rooted in social construction and has the closest affiliation with an interpretative approach (Denzin, 1994; Denzin & Lincoln, 1994). An interpretative approach studies the processes by which we "make sense of the world" (Bateson, 1972, 1979) and is based on the assumption that we cannot know objective reality. Instead, interpretative social scientists propose that persons know life through lived experience, and the interpretation of meaning (i.e., meaning making) (Goffman, 1961). An interpretative approach listens to the persons who have experienced the event or phenomenon to understand how they interpret the meaning. As such, narrative is intentionally subjective and reflective—meanings may involve personal subjectivity and/or be formed in interaction or negotiation with others (Eakin, 1999). In an interpretative approach, the participants direct content, while the role of the researcher is to listen and allow the voices and experiences of the participants to emerge. From this premise, there can be no one universal reality of experience, but multiple stories constructed according to identity and experience. In this sense, claims of representation through one experience are not possible. All stories are tentatively formed from the personal and interactive interpretation of the one who experiences them—they are constructed by the teller (Eakin, 1999). In this sense, narrative allows older women to construct their identities and make meaning of their experiences in relation to frailty and every day interactions.

Narratives as the Unheard Voices

Narrative focuses on the unheard stories at the local level of experience. In this sense, narrative reveals the subjugated or oppressed voices from or at the margins. Narrative as the unheard voice is informed by critical (Agger, 1998) and/or emancipatory narratives (Leonard, 1997) which focus on change as well as the post-modern influence which focuses on the petits recits of experience as opposed to the large meta-narratives of knowledge and truth. One of the major sources of narrative research is connected with feminist research on oral history or autobiography as well as the post-modern approach focused on diverse local accounts (Gorman, 1993; Kohler Reissman, 1993; Neysmith, 1995; Reinharz, 1992). Although theoretically, the purpose of the stories is different, critical work in these areas provides glimpses of how narratives may inform current understandings of particular locations. Positioned as such, the narratives, stories or accounts provide access to the voices and/or experiences of the suppressed, oppressed or marginalized. Narrative intends to expose voices as both an empowering process for the person speaking, in opposition to the larger or dominant stories, as well as an example of the ways interpretations vary. For me however, narratives as merely unheard voices is not enough when placed in a context where the politically powerful retain their control over what counts as a valid or legitimate voice. This sentiment to balance voices and embodiment is best captured by Frank (1995) who highlights the need for ill people to tell their stories, emphasising not only the voices, but the way these stories are told through the body. In this sense, narratives as the unheard voice must be located within the body and within a change context where the stories are not merely told for story sake but are placed within a context for change. However, narratives as unheard voices represents a starting point to understand the way older women negotiate dominant messages of decline in their everyday lives.

Narratives as Performance

Narratives or stories are purposeful and rhetorical (Hall, 1998) and place an emphasis on readership and interpretation. That is, the narrative is constructed as a means to an end and is directed to a someone; narratives are about the way "identities are defined and expressed through the ways we position ourselves vis-à-vis others along the several dimensions that constitute our networks of relationships" (Mishler, 1999, p.16). As such, narratives have a rhetorical purpose of persuasion and may be considered a performance (Watson, 1999). This component of narrative connects it most closely with literary theory and rhetoric studies and places the focus on the text. Structural elements within the text of the narrative (e.g., actors, plot, etc) may be examined to understand who is being persuaded and of what? Here, the focus is on both the construction of the account as well as how the message is received and the impact that the message has in attaining its purpose. The best example of narratives as performance is Hall (1998) who looks at child welfare to understand the narratives of child welfare as performance. In his account, he considers various examples of constructed narratives including that of the worker, the client and his own narrative. He looks at the available readings (e.g., court documents and case files), including the way that the story advocates and resists. In this sense, narrative seems to reflect roots of structural theory. Yet, it differs somewhat—as it is not only the structure that creates the piece or the story, but the way that meaning is produced and interpreted through this structure. Narratives as performance provide room for older women to define their identities and experiences in a way that is meaningful for them and for others. As such, narrative moves beyond a personal understanding of meaning and identity into a position within a social context. It highlights how stories and interpretations are shifting and differ according to the interaction between the speaker and reader—that is, they may focus on "shifting social identities" (Mishler, 1999, p.16). As such, narratives as performance also reveals the inherent power involved in both the speaking and the reception of a story. It highlights how older women may speak about themselves differently in different contexts. For example, a woman may change the way she presents herself between family, services and research.

Narrative as Critical Practice

Narrative is most commonly known as critical or reflexive practice. As an approach, it emphasises the client's voice and co-construction of the story as opposed to traditional approaches which place the power with the professional therapist. In narrative therapy, which developed as a response to family therapy, the therapist works with the client to identify the problem and create change. The narrative approach of White & Epston (1990) starts with the assumption that knowledge is constructed, defined by cultural practices (e.g., labelling, and classifying), and that these other-imposed life stories do not always represent the person's experience (White & Epston, 1990). In particular, it recognises that people's lives and experiences are often summed up and/or represented in particular ways; often these notions are problem saturated descriptions based on a failure to achieve certain expectations, replicate specifications, or meet certain norms (White & Epston, 1990). Take for example, the professional discourse of frailty, risk and restricted eligibility criteria for services. On the other hand, White & Epston (1990) consider the person an active agent who stories his/her experience, and gives meaning to life and relations. They propose a separation from the problematic or 'objectifying discourses—referred to as the "externalisation" of the problem. This process helps persons identify and separate from subjugating and "objectifying" discourses. This so-called interruption of the dominant reading, creates the potential to identify "unique outcomes" and may lead to a re-authoring of their lives that is more relevant and satisfying (White & Epston, 1990). The narrative approach examines the experiences that fall outside dominant stories, and creates space for alternative stories, which incorporate lived experience. As such, although the context and practice are different, narrative therapy is a model for a co-constructed research approach as well as an opportunity to expose the gaps between the imposed definitions of older women in public services and older women's experiences.

Following this model, narrative research is also a critical reflexive practice. Narrative research stands in opposition to traditional methods, which have silenced the voices of older women and/or disempowered their experiences (Rappaport, 1993). A narrative approach questions the traditional power relations between researcher and researched through a deconstruction of power and focus on in-depth experience. For example, as alluded to in the opening paragraph of this section, this thesis is a carefully constructed account. Yet, it is an example of a narrative or a story that attempts to be reflexive of its rhetorical structure and power. Narrative as a critical and reflexive account provides the means to critique my practice as a researcher involved in the story. As an account it tries to provide an alternative way of conducting research with older women, yet at the same time convince you that the process meets the criteria for the degree. It is also trying to convince you that the account has merit—that it makes original contributions to the field and belongs within the discipline of social work and gerontology. In this however, it is attempting to be read as a sincere and honest account which balances or at lest attempts to balance the voices of older women, with my voice, the voice of policy and the expectations of the academic and scientific community. However, narrative as critical and reflexive practice is relevant to challenge the current power dynamics that exist within current sociogerontological research and practice with older women considered frail.

Narrative as Examples of Reflexivity and Scepticism

At the same time as traditional methodologies are sceptical of narrative, scepticism and reflexivity are built into a narrative approach (Gergen & Gergen, 2000). A narrative approach holds that any approach, such as narrative, which stands in opposition to tradition, power and truth must also reflect on its own relation to these claims. It attempts to step outside for a few moments—not to be objective—but to be sceptical of the messages conveyed. Although varying assumptions, including the critical and reflexivity within narrative convincingly make it an attractive, relevant and useful approach, I am also sceptical of the claims of a narrative approach. Narrative may seem to be more relevant to hearing older women's voices, and confronting the traditional power base of therapist or researcher. While this is a laudable aim for a feminist or post-modern project, it may render a narrative account less valuable in certain arenas dominated by standard and objective research. It allows the powers that be to restrict access—to render the account subjective, particular and invalid. In a traditional sense, the account may be read as naive, insincere, pessimistic, relative or perhaps a retreat to the local. Specifically, scepticism toward narrative therapy has focused on the potential for co-construction, the limits of client empowerment and the context of therapy within private practice.

Using the very structure of narrative itself, combined with its existence as a purposeful and rhetorical account, scepticism may also be expressed in relation to the narrative research project. I have considered whether a narrative method actually achieve its multiple purposes of exposing voices and producing alternative accounts, whether the researcher imposes a starting point through the requirement of interview guides and procedures. I have also considered the limits of research interviews that are structured according to research standards, availability of researcher and client, as well as the purpose of the knowledge and research, which would seem to conflict with a client determined change oriented process. Finally, I have considered the end result as well as the actual potential for change. This scepticism raises many questions in relation to a narrative approach. Yet, in asking these questions I have become more aware of my power relations and the way in which I may negotiate these issues with research participants. Through this scepticism, I have also come to understand narrative as a reflexive method that becomes meaningful through interpretation. Despite the limitations and issues within narrative approach, amongst the available methods, it seems the most appropriate for the purposes. I am not saying that this is the best account, but an account that seems relevant to the collection of older women's stories, reflexive research account and consistent with a theoretical position that focuses on language, power, diversity and change.

The Meanings: Stories that Made it all Make Sense

Diverse Older Women Located within and Outside of Frailty:

In total, I heard the stories of twelve diverse older women located within or outside the frail/non-frail binary. These older women's stories provided insight into varying life experiences, the ways that they perceived, negotiated and resisted frailty, as well as understanding narrative approach. The twelve older women were selected from the population of heterogeneous older women. In general, the category of *older* was defined according to the commonly used age-based criteria of 65 plus. In this sense, the population of diverse older women refers to women who are commonly referred to as *the aged*, *the elderly*, or *senior*. This is not to accept the notion of age-based criteria, services based on eligibility, nor to deny the existence of women below the age of 65 who may self-identify as old, but provides a reference point between generalisations about older women and the twelve older women's experiences. As such, the sample of older women may be contextualised with older women in Montreal who may at sometime require home care services.

As earlier mentioned, the various definitions of frailty make it a difficult term to operationalise[26] for research purposes. Frailty is not an objective experience, such as a hip fracture for example, but an imposed socially constructed individual medical concept. Although there is no one definition clarified within policy and services, the way that the term is used in service best marks the imposition of the frail identity. For this study, older women eligible for public home care services (i.e., service recipients) are classified within the binary as frail, while those outside the binary are classified as non-frail. Locations in relation to services mean that only older women within the public system are considered frail, while older women not considered frail may not need services (i.e., healthy), may not be eligible (e.g., lower level needs or unrecognised needs) or may pay privately for services.

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[26] Here the effort is on determining dominant notions of frailty. The effort to define frailty is to understand the dominant notions and set the boundaries for sampling purposes. This task is particularly difficult, because frailty has not been clearly defined in the policies and services of health and home care, but has been repeatedly used in gerontological service provision. I consider the notion of frailty to be a socially constructed term.

Addressing the concept of frailty within the interview raised particular challenges. Although frailty is a widely recognised policy, research and service concept, my dissertation committee and I were sceptical that older women would discuss their situations in this manner. The concept of frailty however, is inseparable from the more general discourses of health, aging and decline. As such, the interview topic was framed in relation to lived experiences and health—addressing frailty in the title of the research project and in research probes. Older women were asked to define and locate themselves in relation to frailty. For example, a probe related to frailty was phrased in the following way: "Policies and services often use the word frail to describe older women who receive public services—How would you define frailty? Do you identify with this term?" Framed as health and illness, it could be argued that the older women performed or altered their stories to suit a particular agenda. In a sense, I had framed their stories for them and they performed the interview based on the way they interpreted my question. To account for this frame, older women were asked to tell me about themselves. Nonetheless, when older women were asked directly about frailty, older women defined their perceptions of frailty and situated themselves in relation to this term. Interviews were audio-recorded, transcribed at verbatim, and coded by number. Formal documents, including this dissertation as well as publications have replaced identifying information with pseudo names.

In addition to age and position in relation to frailty, this study explored varying sites or social locations where older women negotiate frailty. Contrary to what has been portrayed in the literature, this study begins with the recognition that the population of older women in Montreal is heterogeneous. Hence, the sample was not stratified and does not intend to be representative, but rather is exploratory and reflective of the some varying locations within the Montreal urban population. The purpose of the sample is not to compare varying identities or differences, but to understand the factors and multiple realities that influence meanings and experiences in relation to frailty. As such, eligibility criteria selected for this study included diversity along the lines of ability, age, ethnicity, race, socio-economic status and sexual orientation as well as service location (i.e., frail and non-frail). Further, the sample was limited to Montreal residing (514 region), English speaking older women. The sample however, was ultimately based on access and identifiable informants. The twelve older women interviewed had varying social locations (see descriptions in Chapter One); the small sample size however, meant that there were various locations that were not represented within this sample. For example, my sample did not involve any never-married women, nor did it include older lesbians. Further, my sample is over-represented in relation to visible minority women. This may be a result of the population of visible minority women in the English speaking region of Montreal as well as a sampling strategy where each referral source was asked to refer diverse older women. Seeing that I was referred three visible minority older women, it seems that services associate diversity with visible minority status within services. Prior to interviewing the women, I had expected to see differences between persons within and outside of frailty, differences based on social location as well as negotiation and/or resistance to the dominant notion of frailty.

Cast Call

To include varying situations and experiences within frailty, this study involved various referral sites. Older women were contacted through health professionals and recruitment at community organizations. At health care agencies, informed professionals were asked to mention the study to older women who are eligible for services (i.e., frail). Older women not currently involved with services were located through discussions with local community centres, and the snowball technique. That is, professionals and community workers were asked if they know of older women who may be interested in participating. Decisional capacity was accounted for in both sample selection and the ongoing research process. Recruitment was based on workers perceptions or knowledge of the decisional capacity of potential participants; it is not uncommon for workers to have administered a cognitive evaluation (e.g., mini mental) at service intake. Workers also selected clients whom they knew were healthy enough to participate in an in-depth interview. In this sense, the older women within my study are likely the less frail of those involved with public services.

Six older women involved with public services were selected to reflect the experiences within frailty, while six were selected to reflect the non-frail identity and/or experience. Service providers referred frail older women. To determine this eligibility, a combination of clinician assessment, location in relation to services, and specific guidelines for at-risk clients (i.e., guichet unique checklist) distinguish between the groups. See the appendix for a copy of this instrument. Agency workers were asked for their referrals and brief rationale for their choice. Non-frail older women were referred by community groups and organizations. Two older women in the frail category were excluded from the study. One woman was excluded from the study after an initial interview as a result of her decisional capacity, physical weakness and fatigue. Another woman was excluded after several telephone contacts and cancellations as a result of her health.

Two concerns for recruitment identified in my proposal however, were the inclusion of varying social locations and informed consent. There is often a difficulty in gerontological studies to recruit and include older and ethnic minority women (Brotman, 1999). This did not seem to be problem in my study. If the sample were to be compared with the statistical population of Montreal, my sample was over-represented by visual minority older women. This was likely a result of the recruitment process, which requested diverse older women from various agencies. It is likely that the agencies had many diverse older women on their caseload, yet perceived diversity as visible minority status. Looking back, perhaps I should have selected from one agency or perhaps asked for specific variables. However, I was trying to avoid classifying people's experiences into their minority status and wanted instead to explore self-defined identity. The final sample composition raises questions about the number and type of referral sources, agency perspectives of diversity and how particular groups are included within research studies.

Older women were informed of the study and participated under the conditions of informed consent (i.e., information, comprehension, voluntary participation, and freedom to withdraw without consequences) (Padgett, 1998), and principles outlined by the McGill Research Ethics Board (II) (refer to Appendix for the Ethics request). I reviewed information on the telephone, in person in an information letter describing the study, procedures, and expectations (e.g., length of interviews), which also included my identity as a doctoral candidate at McGill, and contact numbers. Participants were assured that participation was entirely voluntary and that they may withdraw at any time without consequences. Participants were assured that under confidentiality agreements their identities would not be revealed. Pending a clear understanding of the study, participants were asked to sign a consent form. One copy of both the information letter & consent form remained with the participant, and I retained the other under lock and key.

In addition, the sample of older women who may be frail, pose ethical issues of true informed consent, burden, and decisional capacity. Kayser Jones (1994) indicates that for older persons, true informed consent may be jeopardised by coercion of powerful individuals, or human contact as a result of isolation. While the level of risk for this particular study was low (e.g., burden), and no deception was involved (i.e., participants were aware of the purpose and procedures), I have considered and accounted for the unique ethical issues for this population. Considering the potential for coercion within health care (e.g., power differential, and requirement of service), especially for older persons, I stressed that there was no link between participation and services, that participation was entirely voluntary, and that they may refuse to participate or answer questions. That is, participants were informed that their services would not have been affected in any way, nor would they receive services that they would not have otherwise received. To decrease potential burden and/or fatigue, open interviews were conducted in a comfortable setting of the participant's choice and the participants concerns for their health were respected.

Rehearsing for the Performance

The original approach guided by three general questions was modified after the first two interviews to be more open and participant directed. Older women spoke more openly about the issues related to their health when permitted to control their story (i.e., performance). After the modification, older women were asked to *tell me about themselves*, thereby defining their stories and identity. The following section will describe the original methodology, the lessons learned about health-related interviewing and the revision which resulted in more flexible and relevant responses from older women. Participant-directed individual interviews were used to best explore older women's experiences in relation to health and frailty (Kaufman, 1986).

Practice

The study was guided by three main questions. Interviews set out to explore how older women understood frailty, how they made meaning of being frail in their everyday lives, and how they position themselves in light of dominant stories of frailty. Central areas of focus included (1) older women's voices and experiences as central to making meaning of frailty, (2) explicating dominant discourse, and (3) creating alternative stories about frailty. The following three questions guided the study:

How do diverse older women understand and make meaning of being frail?

How do diverse older women negotiate/resist dominant stories of aging, decline, disability and devalue in everyday life?

How do diverse older women re-story the lived experience of frailty?

Individual interviews were generally unstructured yet, included probes at the descriptive and structural level. Descriptive information was intended to gather rich data about older women's experiences, while the structural questions were intended to address the relationship between dominant assumptions and older women's lived experiences. For example, descriptive questions focused on the woman's definition of frailty in relation to her personal experiences, while structural questions would compare responses across older women to understand how older women negotiate these meanings in their everyday lives. However, once I began to interview the older women, I realised that even my unstructured focus was too restrictive. Instead of being asked specific questions about their health and/or frailty, the older women were permitted to direct their stories and accounts. Questions such as how are you, tell me about yourself and what kinds of things do you do during a day were included as probes only where necessary. I adjusted my approach so that it reflected the narratives of the older women as opposed to responses to researcher questions. It was through this more flexible approach that older women were able to address health and frailty in a manner that was more relevant to their experience and gain control over their stories. This section recounts the problems posed by my slippage into a traditional power-based methodology of the researcher as knower, the way

I reviewed and restructured the process, and the movement to a more flexible approach where older women could perform or story their identity and experiences in relation to sensitive issues about health as well as to a young researcher.

Dress Rehearsal: Ironing out the Details

Allowing older women to direct their stories and express their own meanings meant that I had to catch myself, challenge the approach I had taken to the research, and give over some of the power that I was accustomed to as a researcher. Three forces prompted the shift from a more structured focus to a more open-ended storied approach. These forces include hearing the clues, recognising the limitations of other imposed narratives and taking note of the starting point. Part of this lesson came from the older women's discussions of health as a sensitive and private issue. The other part of this lesson came from the performative nature of older women's stories to a young woman. For many of the older women, talking about their health and decline was addressing their greatest fears or most prominent struggle. Health as a private matter was considered the unspeakable and spoken about within limits. Perhaps this reflects the silence that is imposed on older women's discussions of health. It may also represent the difficulties that women have speaking about health as a result of their coping. Consider the following example selected from my first interview in relation to the private nature of health and their greatest fears, which resulted in movement toward a more flexible interview process:

> *You mentioned to me in March that you were, had some involvement with a hospital or health services...Yeah, I was in the hospital, had an operation. Yup. [And how did that].Fine, the doctor was thrilled (Clara, 40-45)*
>
> *In relation to a discussion of 'frailty' ....*
> *[So what happens if you can't do the things, okay?] This is the future, this is the future, I dare not think about it, is a scary thing for me, being so independent, it's a real scary thing, yeah, that's why I try to keep going. It's mind, your mind, you have to be strong in mind in order to continue until you leave this earth. ...... (Clara, 75-81)*

> *In relation to health:*
> *Well, that, I never discuss.[No, eh?].* No, because I don't really, my closest friends are my family, my immediate family [okay] because I never had a lot of friends. There's only certain people, like over at there, -----------------------, there would be only one person really there that I would, we could speak together because I love her very much [okay] and she's the hit of that place, Irene. Did you meet [I have met her], you have met Irene. Elaine, did you meet Elaine [no] over there? Yeah, she's a real sweet person [okay] and we just clicked from the time I saw her, yeah [she's important]. We could speak, we could speak together and I could tell her. [*So it's a really private matter then?] Yeah, it is. Yeah, it's private. (Clara, 86-101)*

These and other related examples within the first two interviews, highlighted how my intent of hearing women's voices or stories did not match their reality. Although women seldom have the chance to speak of their health, my initial way of approaching the subject was invasive. I was speaking with them about their greatest fears, the impact of actual and potential decline, and impending death. The responses given to me were not structured as mere answers—they were told to me as stories. This clue led me to believe that my questions were limited in relation to the great deal of experience that women had to offer. Further, I realised that by asking my questions, I had limited their direction and power in defining their responses in a way that was relevant to them. The narrative therapy model, which insists that other-imposed stories are not always relevant, struck a chord with me. If older women were to be given the space to talk about their health, it would have to be on their own grounds where they felt safe and comfortable to author or perform their stories in a meaningful manner. The less-structured approach is consistent with a critical approach, which works the boundaries of research and practice, provides an embodied account, as opposed to functional assessments, which account only for the body. In addition, this approach emphasises dialogical learning where as a researcher, I could learn from example instead of through a set of instructions. By turning to a storied approach I could recognise women's strengths and perseverance and allow them to tell their lives in a way that is relevant, meaningful and natural.

At this point you may be expressing scepticism about the change in method as well as the ideas about story as performance. I expect that your scepticism is not in relation to whether these changes address women's experiences in a more relevant manner, but whether these changes are acceptable within the limits of academic *research. This methodology stretches what is traditionally understood as research- it also stretches the boundaries of qualitative research within social science and especially health research. Your questions may reflect some of the questions I have asked myself: In whose interest was the shift to a more flexible method? Was moving to a more flexible method a more comfortable way to deal with difficult topics? Will the women address the key areas that I set out to explore? If everything is a performance based on the interpretation of another what can be said for validity? These questions raise important debates within research and are valid concerns. Although I cannot state that I have all the answers- I can provide my rationale and reflections.*

Considering my shift toward a more flexible method, I would ask you to consider that qualitative interviewing is an iterative process in which each interview contributes to new questions, insights, and therefore a re-shaping of questions and process (Riessman, 1993). Changing the interview format to a more flexible, participant-directed, storied approach produced in-depth elaboration on women's experiences and meanings in relation to frailty. In this sense, the qualitative interview may also be considered as a performance. Changing the approach did not mean that women excluded health and fears from their discussions. Instead, I noticed that each woman approached discussions of health, death and fears in unique ways. Instead of being imposed or forced upon the women, women were permitted the space to define their experiences in a meaningful way. Allowing women to author or perform their stories recognised and respected their self definitions (e.g., not frail), allowed for the creation of authentic accounts where women's voices and experiences were recognised as women and not as bodies in decline, recognised the multiplicity, complexity and negotiation within their stories, and made room for alternative stories or accounts. Further, allowing women this control of the stories also provided great insights into the way that women would story their accounts (i.e., narrative approach) and the way the structure and elements of their stories were interconnected with both their identities and the meaning of frailty. Consider the following example of the fear of Alzheimer's that emerged from the storied approach:

> *I don't tell, I don't talk to my husband about it, I don't say, you know, I'm very worried about it, how do you feel about it, if we don't talk about it, and he's the type of person who does not talk about illness, he does, he thinks it'll go under the carpet, he does not complain about anything and he certainly will not talk about Alzheimer's as far as we're concerned, so it's under the carpet, but I do fear it, I do think about it a little [mhm]. (Martha, 345-351)*

Early exchanges also led me to question the issue of trust within our relationship. In most cases, I was an unknown young researcher who had been referred to them by someone they know—I was a stranger. For some, this may have made them more comfortable to share their stories with a stranger. For others however, it may have restricted the way they discussed some of the issues—especially sensitive issues such as frailty and health. My source of reference for the frail women was a social worker or nurse. Therefore, although I was not connected with a service, I was by nature of my referral source somewhat connected with it. I was working from a situation where the women had established a trust relationship with the worker. Although I stressed that my involvement was not in connection to a service, this referral source may have impacted the performance of the women. In the first few interviews I thought that perhaps I was being given acceptable responses. After repeated references such as luck across interviews I began to see some of the common ways that women would discuss frailty and in this case death. Further, in the context where services are restricted there was a possibility that older women should perform in a certain way in order to receive services. This however, did not seem to limit women's stories—as they were not asked to evaluate services, but instead talk about personal meanings.

Another lesson, which encouraged me to change my approach to hearing women's stories, was the performative nature of women's accounts. In both my interviews and continued analysis, I began to realise how my identity as a young woman was connected to the stories chosen for me as well as the way that these stories were told. I began to understand the interview as co-construction and interpretation. Yet, co-construction has its limits and interpretation is interactive and relational. That is, it involved both my interpretation and theirs. In my experience, I would now say that the nature of performance and reception or readership may not be underestimated. Reviewing the transcripts I found several examples of the way that the stories had been constructed not only as reflections of the women's larger identities, but as lessons for me as a young woman—stories which older women would tell me as a young, white, privileged, social work doctoral student. (Despite that many of the visible minority women referred to me as Asian). I was told stories of life and stories for my future. The story is told for the telling, perhaps to give voice to silences, but also with an educational purpose—to inform a young woman about the way things have been, the way things are or they way they will be. Within this performance, women's stories were also located within acceptable behaviours, norms and guidelines as well as dominant discourses about older women and health.

Re-Designing the Set: What is it Trying to Say?

This section outlines the pieces that I would not have heard if I had continued with the more structured framework. Women's stories taught me to listen to the accounts within context. Instead of a linear narrative based on my structure, movement to a more flexible approach meant that narratives started to unfold in their own ways. Similar to Frank's illness narratives, many of the narratives told were circular as opposed to linear—unfolding around events, chronology or as life review. In the following section, I will outline some of the structures or guiding points that helped me to understand the narratives. Borrowed from various authors and disciplines such as literary theory, structuralism and narratology, I have constructed a way of looking at narrative accounts that was meaningful for me as a researcher. These elements are not intended to define the boundaries of a narrative approach, but provide insight into how the telling of a story or performance, gives insight into meaning. Each of these elements were important in understanding key findings concerning women's views of themselves, their identity and the way they negotiated frailty in everyday life. These elements responded to the original research questions in a relevant and meaningful way but also helped to organise the narratives for presentation, moving beyond the individual stories to connections within and amongst the narratives. In order to define the elements I have cited examples from the research, which will be discussed in greater depth at a later point.

Data analysis and interpretation were ongoing processes concurrent to the stage of data collection. My analysis involved reading each narrative to get an overall sense of the woman's story, identity and individual negotiation of frailty. To get a sense of each interview I looked at the structure of each account—making comparisons between interviews. Next, I read between interviews to understand the threads between the interviews. I then highlighted the issues that were similar between the interviews. Finally, organisational strategies including metaphors, theme clustering, and significant statements, assisted to make connections between interviews. The object however, was not to identify an overarching theory, but to demonstrate the ways in which diverse women negotiate or resist the meanings associated with being frail in their everyday lives.

Take your Roles Please: Elements of Narrative

Older women's stories varied according to structure and purpose. Often times however, the structure and/or organisation provided insight into the meaning of the story, their identity, and the way they negotiated frailty in every day life (Clandinin & Connelly, 2000). Older women stories were chronological, event-centred and framed as life review. Many of these stories combined these structures, telling a story for example, that began as chronological but was interrupted by an illness event or experience. Connected with the structure, women's stories would give examples of the acceptance or uncertainty, resistance to dominant messages as well as an overall sense of life review. Several elements within the stories provided structural clues to understand the purpose and meaning of the account. These elements include:

I. Genesis or Starting Point
II. Temporality
III. Space and Context
IV. Voices & Relationships
V. Turning Points or Benchmarks
VI. Silences
VII. Tensions
VIII. Metaphors

Genesis or Starting Point

The starting point of each woman's storied response was key to how the woman sees herself (i.e., who she is) and the unique meanings associated with health and frailty. This starting point may be seen as the structural beginning of the narrative journey

(Frank, 1995). Structural theory would say that this starting point structures the narrative. In a sense, this starting point is the "you are here" on the map. The story then unfolds according to varying actors, plots and sub-plots. Throughout the story, each woman provided check-in points related to the overall structure and connections with her story of personal identity and experience. When starting points are considered as a structural feature of each narrative, they also provide means of understanding content. Women's starting points are key to the intention, organisation, and purpose of the story. Each story is a meaningful account told as a performance. As such, the starting point is a major insight into understanding women's accounts.

Starting points were only possible however, within the more flexible narrative format. Starting the interviews with 'tell me about yourself' some would begin straight away while others would ask 'where should I start'. For those who were not used to such a flexible format, I followed with 'where would you like to start, pick a point'. It is necessary to note however, that this start is in the context of the study of health and frailty. Proceeded by the process of informed consent, the starting point had in a sense been defined for them. However, beginning with an open-ended question that allowed the woman to choose her starting point re-opened the path within the framework of health and frailty. Having storytellers choose their starting point allowed women a sense of agency over the stories they chose to share, authenticity in telling their own stories, and minimised researcher control; women could negotiate and define their identity in relation to me as the listener. Consider some of the following starting points which structured women's narratives:

> *Well, uh, I came to Canada with my parents when I was six months old. And, um, went to school here, you know, difficult times but we were very fortunate, we came to my aunt and uncle's home which we, welcomed us warmly so we had, we started off better than a lot of other immigrants. (Martha, 15-19)*

> *I'm looking for the pictures of my father's restaurant down on St. James Street. Oh I found them, that's what I brought the whole thing out for—that starts the story of my life (Ella, 150-154).*

Temporality or Time Structure

Combined with the starting point, the temporality or time structure of the story provides clues to understand the type of story being told and the inherent meaning or message within each account (Clandinin & Connelly, 2000; Polkinghorne, 1988). Time structures vary and may include such structures as linear accounts, cyclical accounts, and interrupted accounts (Gergen & Gergen, 1984). Defined by the starting point, the temporality within the account has a rhetorical function. That is, stories are organised in a particular fashion to achieve a purpose, make a point or reveal underlying meaning or message. For example a story that starts with birth and is arranged according to a linear lifeline may intend to portray life review. A circular story may reveal a continued struggle throughout life and contain a moral lesson or life strategy. A story interrupted by illness or crisis may structure the account as an illness narrative or a moral lesson. Within each story however, multiple time structures may exist. That is, there may be both an overall structure as well as mini structures within the larger account. These stories within stories as well as the shifting between stories may provide clues to understanding the meanings of accounts. Further, they may depict how meaning changes within and between varying contexts. For example, within a linear account there may be an illness narrative and a life review in relation to this narrative.

> *I thought I would sail in and have this knee replacement and sail out again and, do a bit of physio and everything would be okay, but it didn't work out that way. Um, I caught this bug, and um, I guess I wasn't as strong as I thought I, you know, as I thought I was because it really got me and, um, uh, for two and a half months I was very ill (Dorris, 35-43)*
>
> *You see 4 years ago I had a very bad accident and I really, you know it's affected me I got a metal elbow these fingers are not much good. [Okay.] And, uh, myself I've got backache and knee ache, and this happened four years ago through a fall. Just a fall. (Margaret, 17-20)*

Space and Context

Space and context define the story and influence meaning or interpretation. Here, space refers to boundaries or distances such as settings or locales as well as the way in which this space influences the account. Context considers the story in relation to other parts- it refers to the larger way in which the story is woven or hangs in relation to (coherence) other accounts (e.g., words, sentences, histories, situations, etc). Space and context provide clues to understand the meaning, impact and/or strength within an account (Clandinin & Connelly, 2000; Hinds, Chaves, & Cypes, 1992; Kaufman, 1981). In this way, they are closely connected with notions of performance and readership and/or interpretation. Two of my best examples of the way that space defines meaning involve interview location and the meaning of home. Although the interview location was left flexible and to be determined by each woman, only two participants preferred to be interviewed outside the home—both of their identities were clearly connected with their professional and community roles. The first example provided one clue to understanding the importance of maintaining her professional identity. The second example provides insight into the way that a context takes on meaning in relation to life and health.

> *I have been working here for something like twenty-six years, um, I enjoy it, um, I greatly prefer this setting to belonging to bridge clubs and the heart clubs and things of that sort (laughs)(8-11) ....Uh, well the um, it gives me a chance to peddle what I like to do. I like to deal with problem solving situations, with numbers, a little bit of technology, theatre, and I like it, as I say, when bright young people come in and have to be nice to me. This is a convenient place to come to every day,..............(Elizabeth, 24-28)*

> *My grandmother died she 1920. She died in this room. My mother died in this room. My father was taken away from here to the hospital, where he died. My brother died in that room, so you see it's all tied up. I don't know where I'm going to die. (392-395)...So there's quite a history and that's why I'd like to stay here, you know? (Alice, 402)*

The contexts within the stories gave strong insight into understanding the women's accounts. Contextual understandings were key clues to understanding larger discourses of frailty and the reasons that women chose to negotiate or resist this imposed identity. The strongest examples of context were the way that frailty was storied in relation to the bus as well as the contrast within and outside the home. The connection between frailty and the bus was key to understanding the connections between women's accounts. This context highlighted the issue of transportation and housing that are threaded throughout women's narratives. Paying attention to the contextual nature of frailty highlighted the meanings associated with frailty and how frailty may be experienced differently depending on social location. Consider the following examples about the contextual nature of frailty:

> *Contextual Nature- Inside & Outside: As she sat on her couch I could not see her as frail. She was smiling and gathering photos of her life. Throughout the interview I saw her as strong- an independent woman- her identity an entertainer. After the interview however, she got up to make tea and in the process spilled tea over the cup onto the table and floor. It was then I realised that frailty is contextual. I started to wonder how would I see her differently if I were to follow her on the bus, to the grocery store, etc. I realised that her story about her fall happened on the bus. There are differences between bus and home. I had a better understanding of how she could be seen as frail in public. Home for her was a safe place where she could negotiate. This made me think however, of home as isolation. (Ella- My Notes)*

Voices & Relationships

Women's stories reference interactions with key characters such as other women, doctors, and friends (Clandinin & Connelly, 2000). These actors or characters represent everyday discourses within older women's lives. Hearing how women interpret these interactions provides clues and/or insight into the operating power relations and women's interpretations of these relations. When the voices within each account are considered actors in a performance, the nature of women's negotiation becomes clear. The voices of each character within older women's accounts highlight the multi-layered nature of each account, making the operating forces of everyday life transparent. For example, in many interviews, the voices of doctors, family and the woman herself provided in-depth understanding of the messages that she was receiving and what this meant in a greater sense. Many of the voices present within women's accounts are those of the medical profession and/or their children. In many of these the message was compliance—yet, for some, these voices from outside justified their changes. In the first example below the doctor provided the justification for her change. Maintaining her strong identity was important—the doctor voice however, provided the rationale for her to slow down (Clara). In this case she didn't have to admit that she had chosen to slow down—but that she had to, the doctor forced it on her. In another example, it was the type of relationships that was a key to understanding the way she negotiated age (Martha). She surrounded herself with youth and was not interested in hanging out with older persons. In this case, these relationships were key to understanding her way of coping with aging. The voices within an account therefore are key clues within the analysis of the meaning of each account. Consider how the following voices provide insight into each woman's negotiation of health and frailty:

> *I keep myself busy, do all my own shopping, in the street, in little bits you know. I don't want to carry, the doctor says, don't carry with the hard, heavy things [okay]. And my problem is a problem there, too, they discovered, I don't know what it is, but...I don't carry nothing heavy. (Clara, 201-206)*
>
> *Well, they suggested, practically forbid me not to go down- instilled upon me—not to go down to the basement because it's very dangerous if I fell. Of course I know that, and I don't feel quite, I know I can do it. But I still like to take the chance at this point in time. Maybe I'll get better, maybe I won't. Time will tell. So I can go on the outdoor steps stay out there- that I can do that- they don't say anything about that. (Alice, 90-95)*
>
> *Every hour the bird announces there's another hour. And you know it isn't just. What I like about it the best- it announces to me "another hour has gone by, you better hurry up, look at the time". "oh don't tell me it's ll o'clock, I thought it was only 10 'clock". I t reminds me of the time. I'm so slow to get things done, I can't imagine how long it takes me. (Alice 164-168).*

Turning Points

Turning points or benchmarks within the accounts provide insight into the meaning of an event or situation and an interpretation in light of identity (Mishler, 1999). Examples of turning points include episodes of illness, or significant life events. These turning points within the story are meant to guide the reader—to make connections with significant events that provide insight into meaning. The most common example is of illness as a turning point which resulted in life review and altered the way the woman proceeds through her daily life. Take for example Dorris' narrative where the hospital bug changed her life—this illness marked the beginning of a difficult period, which she is only beginning to come out of. In essence, this turning point has taken over her life as she knew it—the illness narrative dominates her account. Her illness is threaded though her entire account. For many the turning point was a wake up call—a difficult event (e.g., sickness or crisis) that made them re-evaluate their lives. Martha had the episode with cancer, Annie, her daughter's death, Katherine, her divorce. However, turning points may also be significant in relation to larger understandings of social process. Martha provides insight into the significance of her "going grey". Her letting her hair go grey, meaning not dying it, which represented her acceptance that she was an older woman. Here are some examples:

> *'Cause you see, that's how I got on from there on. And from there on, everything went nice for me. And when I finished with the restaurant I started opening canteens, you know, getting them working, you know, opening canteens. Factory canteens I'm talking about. And they, sort of, I (Margaret, 104-107)*

> *Tell you about myself. Uh, in my present life or in my former life? [laughs]. [You get to pick the starting point]. Um, in my former life, I was living under a stone and I was a very shy person, and, uh, I don't know what the dividing line was, but, of course once I found myself on my own I began the change. But really I think one the major turning points in my life was when I joined the peace movement and, uh, just found a whole [pause] new, new direction and, and the most wonderful people I've ever been associated with, and a huge network. So, uh, from that I became pretty much a full-time activist, and, uh, well, occasionally we say 'shit-disturber' (Katherine, 16-25)*

Silences

Silences within accounts provide insight into meaning. In this sense, 'what is not said' becomes a key clue to understanding what is. Silences extend farther than what remains unsaid. They also refer to the choices that women have made in presenting or performing certain accounts. Women ultimately chose accounts that have meaning to their identity and interpretations of experience. They would not tell a meaningless account. Silences however, for the most part involve the interpretation of the researcher—as the connections may not ever be explicitly made. In this sense, they are tentative and must be recognised as interpretations. However, looking at what is not said is often an important clue within the puzzle. The best example of silence within my study comes from Clara who presented herself as a strong coloured woman. This identity organised her narrative and was an essential part of her strength. Although this identity had implications for the way that others perceived her (i.e., non-compliant), it was the way that she was able to negotiate decline. However, this identity became more difficult to maintain as she began to experience decline. Her silence represented her fear of decline and the impact this would have on her identity or perception as a strong coloured woman. Upon attempting to re-interview her, her silence in rejecting the interview in my opinion gave insight into the difficulties that she had in becoming frail. At request to be re-interviewed she said, "I can't see you". Consider the following excerpt that I wrote after contacting Clara. If I were to see her in this condition she would no longer be able to maintain her identity as a strong coloured woman.

> *She finds she is getting bent over...there was a woman who she knew quite well who saw her on the street and noticed her...when she approached, Clara asked this woman how she knew it was her and she said it was because she could recognise her back. Clara said I could notice myself getting bent over, but I didn't know that other people knew" I can't stand up straight anymore. (My Notes, February 7, 2001)*

Tensions

Tensions within the accounts help to understand the meanings and how one identity may fit or function in relation to another (Mishler, 1999). Here, tensions refer to possible strain or conflict, a stretching between two opposites. Tensions within women's accounts highlight the operating discourses and the way that women position themselves in relation. Tensions however are more difficult to locate within the accounts. It is helpful to look at the opposites that women exist within and between. The strongest tensions within these accounts were between decline and strength, resistance or acceptance of the aging process. This does not mean however, that the women would always locate themselves on one side or the other—but rather they worked through these tensions in various aspects of their lives. Tensions within women's accounts highlight the daily struggles of older women in relation to frailty, and the ways that the women try to maintain balance. Here, Clara's struggle between being strong and not strong is the best example of tension within my study. This tension reveals the gap between the way she sees herself and the realities of decline.

> *Yeah, if they're not well, they know they're not well but you got to keep thinking you're strong anyway [okay] yeah. It's like mind over matter [okay]. (Clara, 37-39)*

Metaphors

Metaphors within the story provide access to operating discourse, accepted meanings and women's interpretations (Clandinin & Connelly, 2000). In a literary sense, metaphor is when a name or descriptive term is applied to another object. Within my understanding metaphor is similar to a representation—a re-occurring sign or image that is packed with specific meanings. The strongest example within the women's accounts was the rocking chair. The rocking chair was a strong symbol to understand both everyday discourses of older women as well as their resistance to messages about aging. The rocking chair was mentioned across interviews. Although within some cultures this chair is seen as a sign of strength and community (i.e., Cape Breton or French Speaking Quebec), the rocking chair for the women in my study was discussed as an image of frailty. Rocking chairs were associated with the beginning and end of life—birth and death. Rocking chairs were passive and represented silence and calm. Images associated with death, a passive exit from the world. Clara has a rocking chair, but would only use it as active resistance for a community organisation.

> *Because I've seen people in the past, older people in Nova Scotia, they sit, that'd kill me. Had a rocking chair..and they rock...I said, how can they do that? Seeing that, day in and day out....that chair got them stuck in it [laughs]. I said that's not, I have a rocking chair and never sit in it, wouldja believe it? ... an old rocking chair from Nova Scotia, my mother's [okay], when she passed. It's back there, I don't sit in it. I don't think since that been there I sit in it twice, and I've had it now since she died in '79, would you believe that? I can't stand a rocking chair, I rock when I go to the Rock-a Thon [laughs] when I get in it over there, 'cause I'm doing it for a reason [right, right] that's the only one, oh, I'm so funny, and I don't feel too comfortable in it, believe me, there rocking four hours . (Clara, 316-333). [because you don't see it as active enough, eh?]. No.*

> *You can't stop from having a cold, but you can, you know, you have your headaches and what not and if you keep yourself busy, uh, you're gonna be better [mm], just to go out for a walk [right], you just cannot sit back, you cannot sit on a rocking chair.........(Martha, 217-220)*

In addition to metaphors, women shared mottos and stories about other people that provide insight into the way they live their lives. Carrie's story about a woman who worked with her at the factory shows her respect for hard work and determination. Although there are parallels between this woman's story and hers, Carrie is modest and would never make the explicit connection that, just like this woman, 'she had made it'. Mottos or common expressions also provided insight into the women's identities and way of negotiating life. Many of these mottos or descriptions were used in the first chapter to give you a sense of how the woman views her identity. For example, Carrie's motto: *there is a destiny that makes us brothers none goes his way alone what you say to another comes back to our own (366-368)* shows how she lives her life. Other examples include Katherine's statement that "*this is not a dress rehearsal*" (253) and Alice's "*so that's the way I manage*" (176). Each of these statements gives a great deal of insight into the realities of each woman's life as well as how they negotiate on a day to day basis.

The Final Performance

Before you go back to the main performance, I have several points to clarify. I have walked you through the process of constructing this section, including the design and re-design, practices and rehearsals—the so-called trials and tribulations of research which were necessary to understand both women's stories and a narrative method. In doing so, I have attempted to make the process transparent so that you could see the way that I interpreted the accounts. I have tried to balance the power I had in constructing the account, with a rhetorical critique of my intent to convince you. Within this attempt however, my silence was the fear of being misunderstood and interpreted as invalid or inappropriate within the context of dissertation expectations—pushing the boundaries beyond the acceptable limits. As one last attempt to convince you, I will make explicit the way that the process of constructing this very methodological account relied on the structure of a narrative account as a lesson to produce a meaningful account for you.

I began by giving you a framework or metaphor of intermission where you could understand the behind the scenes process of the account. Doing so imposed a structure on the account that was fairly linear, performative, time-limited, yet open for interpretation. As a shorter and interactive piece mid-performance, I expected that you could reflect on what has come so far and build your interpretation as you go along. Choice, movement or fluidity, experience and interpretation were intentional. I felt that the intermission show gave you a chance to step out of the intensity for a moment and take a behind the scenes look at what was going on. As a description of the process, the temporality was fairly linear however, as it was a description of a process it was intended as an account of the lessons I learned and structured as guidelines for future research. As such, the temporality shifted subtly between this account as a linear lesson and the points in history where I altered my perspective—the so-called turning points in the research process. These turning points including ethics, realising my invasive questions and moving toward a more flexible account were key moments within the process. These were the times where I learned how to trust the process and relinquish my power as a researcher. Yet within my account are the tensions between an acceptable account and a storied account. At many times, I have fallen into a more traditional presentation style using subheadings and explanatory type paragraphs. My tension was to stretch the boundaries without sacrificing my credibility. My account, although somewhat restricted, reflects similar tensions to the women's accounts—how do I position myself in relation to dominant discourse.

Now, we have arrived at the point where I should sum it up—make explicit the meanings of the way I have structured my account as a lesson. If I hadn't listened to the stories within the stories, starting and ending points, voices and actors within the stories, the context within which they were told, the turning points, metaphors and silences, I would have missed the meanings being shared with me through telling. I would not have heard the accounts chosen for me and I would not have been able to share my story as I am doing with you here and now. Instead, it would be a very different account with a different structure and purpose—although, it would still be meant to convince you, just not explicitly so. I would not have learned to recognise the fluidity within and between accounts, the multiple, competing and contradictory elements of each account, the selection of stories, the partiality or fragmentedness of each account, nor the complexity of each story. Sure there are many stories that have not been shared, and yes there are partial, individual, even fragmented accounts—but these stories are real—they are accounts from women who negotiate health and frailty daily. They give us a look into the messages women hear and the way they in turn negotiate on a daily basis. Their stories although individual do not and cannot stand alone. There are connections between them and threads of acceptance, resistance and negotiation. They tell the story of women who have identities that reach well beyond body, health and risk, and of another that is privileged enough for having heard them. Looking back on this story, I am convinced that my original starting point would not have allowed me to hear the sensitive issues women had to tell me about their personal lives, health and selves.

Although my account seems to be a smooth story which in the end has triumphantly convinced you that 'narrative is where it's at', there are differences between what I have chosen to present and the internal struggles I have in relation to this method. Despite my questions, I position it to you as an acceptable approach. I am not saying that narrative as the way I understand it is the way to hear women's stories, but that it is the approach I was most comfortable with- the one that worked for me. In this reflection, I am struck by a student's comment in my class who said "I hear what you say but I don't know if you understood what I meant?" This question continues to impact me as I search to understand women's accounts and provide interpretations of these accounts for you. Although from a theoretical perspective the question would point to the notion of performance and readership as well as the uncertainty within the narrative puzzle, on a more daily basis I hope that I continue to ask in a reflexive manner: Can we really ever know what someone means?

Act V

Storied Responses, Illustrations & Experiences: Challenging the Stories told on and about Older Women

Women's storied responses, illustrations and experiences within and outside the frail/non-frail binary challenge key stories told on and about older women. Specifically, their stories interact with and challenge the medical stories, stories about need, social stories of devalue, management and professional response, as well as the culmination of these discourses within the notion of frailty[27]. Although women's accounts include varying storylines about their lives, experiences, and needs, the common links between stories expose the gaps between dominant discourse, professional notions and women's experiences. This chapter explores these commonalties in order to expose the discrepancies. To do so, it follows some of the distinctions that women seemed to make within their own stories. It separates the way women responded to my questions about frailty, the illustrations women used to define frailty, and the way they story their own lives and experiences in light of and apart from the stories told about them, including frailty. Women's responses and stories were not generic; at times they would reflect dominant stories and constructions, at other times they would reject these constructions. Instead of a fixed individual, medical and professional story of frailty, their illustrations and stories expose how frailty is contextual, relative and temporal, as well as how medical needs are intricately connected with social experiences and social location.

I. Responses to My Inquiry about Frailty: Reflecting & Rejecting Dominant Notions

Women's responses reflected and rejected dominant stories including frailty. Stories from within and outside the frail/non-frail binary expose how women understand the concept of frailty, position themselves both in accordance with and against this discourse, and discuss their needs and experiences accordingly. Their positions were not static; at times, women's understandings reflected dominant notions of being in need, such as being physically fragile and/or weak. At other times, they resisted or rejected

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[27] Frailty is ultimately a discourse about needs. It is difficult to cast distinctions between the concept, the discourse within this concept and the meaning associated with this concept. This section therefore, moves between using the term frailty when referring to the discussion of the term and/or common notion in policy services, and needs and experiences when referring to women's more general discussions. At times, I also refer to the experiences which are commonly associated with frailty to mark the distinction between the way women view frailty and their needs.

dominant stories including frailty, focusing instead on the social or emotional needs that accompany physical decline. Instead of a standard, measurable notion, women's positions seemed to depend on their perceptions in relation to the context and/or their life experiences. Women's accounts seemed to separate the notion of frailty from lived experiences and need, including those associated with frailty. They also made distinctions between the experiences and/or needs, and the meanings associated with these experiences. Women's reactions challenged the common stories and uses of frailty, exposing it as a slippery notion with shifting interpretations and personal meanings.

Dominant Reflections of Frailty

Women's responses to my questions about frailty revealed the complexity within stories about need and the concept of frailty. When asked how they understood frailty, women's responses tended to focus on dependence, physical descriptions, illness and hardship, or difficult times. Women's responses sketch an image similar to the dominant concept of frailty. At times, their responses reflected the needs discourse including dominant notions of dependence. Frailty was discussed as negative terms—frailty was defined as being unable to do things, not being strong, and not being in charge.

> *Yeah, because you're always thinking you're not strong and you're unable to do something ..that's why. So then you put yourself in a very bad situation just thinking all the time inwardly that you can't do anything you're so frail, you know.[So frailty for you is not being strong?](20-26)..Yeah, not being strong for yourself. To support yourself and do things (27-28)....Any person, any age person, elderly person, that is unable to help themselves. And because of frailty, they are frail, they really are, whether you want to try to say you're not frail but you're frail because you can't do the things you would wish to do, you see? (Clara 69-74)*

> *When you are not in charge of you and somebody else makes the decisions I guess I would consider that as being frail. (67-69B)..I don't think it's choice. I mean ultimately it happens. You don't choose to be frail but there's a time when you simply can't manage things. (Elizabeth 91-92B)*

> *Someone who isn't strong, first of all, someone who doesn't have a lot of emotional resources, they um.....they, I think...I think someone who has frailty as someone is needing, who is need. I need of um, to be taken care of....they don't have the resources themselves, they haven't found the resources themselves. I haven't really thought about it. Frailty, I think of someone who is dependent, who is at risk and all...At risk of deteriorating,*

> *they, you know, week by week, becoming more and more isolated.. that doesn't sound very thought out, does it? All that for frailty, but, that's the way I see it (Annie 592-610)*

Within a Western context of residual service provision based on need and/or risk, ideas about dependence are assigned a lower or negative social value. These ideas of dependence within women's accounts reflect the ways that stories are told about their needs. As such, they give insight into the potential meanings women assign to frailty, their experiences and others. Further, their accounts reflect the regulation of bodies—just as the dominant stories tend to regulate women's experiences, their stories include examples of regulating other women. Women's accounts reflect a discourse that discriminates between the eligible and the non-eligible, the deserving or undeserving. For example, Margaret talks about a woman who doesn't need a walker—"*she's not bad enough*" (315).

While women's responses connected their perceptions of frailty with the discourse about need, they also reflected the social stories of devalue based on character and/or physical descriptions. These physical descriptions establish connections with the lack of social value that is assigned to older women. Similar to dominant discourse and literal definitions, women located frailty on the physical body, and referred to woman as breakable or small. These descriptions were based on appearance, strength and health. Frailty often involved the gaze of others—how you are perceived. Reflecting medical definitions, frailty was described as a look, and often involved a loss of weight or pallid complexion. At times, this description or look was combined with the absence of physical strength. In these cases, women would refer to someone who is not steady on their feet, wobbly. In this sense, there seemed to be a connection between size, strength and social power.

> *It makes me think of a very small person...a person who doesn't talk very much, a girl who would sit in the background of a room at a party...Not too talkative. (677-679)...Oh, well I think more of the body, the health. And, uh, I think they've lost like I, I, used to weight 145, 150.. now I weigh 125....As I got older my weight kept going off and I'm a 120, 20, between 120 and 125 now (Ella 683-687)*

> *Frailty is frailty physically, I think frailty is someone whose bones my crack that type of (591-592)……Someone who is slightly bent over and they when they walk, its as though they're not sure their feet are going to find that solid ground there and um, pallid complexion, withdrawn..yes, that's….that's what shows I think of frailty, that I had become dependent that I might become withdrawn so I think that's possibly why I say withdrawn, not wanting to be a bother yet here I am. [hmm] I am not longer able to take care of myself. I'm at mercy of…..*(Annie 624-632)

> *You've got to be small and skinny, and, now if you want to see frail people, you'll see them down there, one little woman she walks on tippy toes like this, and she looks as though you could blow her. But she is frail….well there's a woman there, a big tall woman, and do you know how many pounds she weighed? Eighty-six pounds. Eighty-six pounds. She's nothing but skin and bones….I felt like saying, "You look awful," that's what I felt like telling her...She's so poor. (664-684)...Usually, they're a little bit uncertain on their feet, too, a lot of them, you know they kind of tippy toe, you know, they can't, I think, they, that, I think it's nerves too, like a lot of it is nerves, with them you know. But they are very thin, and they don't eat very well. They usually don't eat very well. (Margaret 727-731)*

Reflecting the medical and service stories, women's responses commented on frailty as illness, sickness or death. Women's responses include physical descriptions of the sick person, reference to worn out bodies, as well as common reference to weight and/or eating. Yet, their responses also resisted dominant notions through connections with the emotional experiences associated with the physical experiences of sickness or physical decline, as well as the connections between frailty and death. In this sense, the descriptions challenged accepted individual medical notions of frailty and need. Frailty as illness overlaps with responses based on physical or character descriptions, yet also places frailty within the context of medical and professional services.

> *I don't, I think frail, frail, uh, comes in term of anybody. If you are, ill, you're frail. In my, what I, my interpretation is... If, if you can't walk on your own, you're frail, if you can't eat by yourself, you're frail, that to me is frail. I, I don't think it's anything to do with age, I would say that most of frail people are older people, your body is worn out. You're frail. My mother died, she was 101, she was frail when she died. She was small, I'm short too but I'm chubby and when you're thin and, and you can't move, you can't do things, you're frail. That to me is, is being frail. (121-129)...If you're young and sick you're going, you're frail. But, it, it mostly with the seniors. You would, you would, you would, um, turn the,*

> *you'd go into a senior home, you will see 90% of them are frail.* (Martha 133-136)

> *I had a hard time getting across to them, because I would cry but I would cry because I was weak whenever they were here I would start to cry and it seemed to me that some new ailment or some new ache or ...It's uh, if you have never been that ill before, and you feel, especially when I dropped so much weight you know, that I'd look in the mirror and my face was hanging down and my, I seemed to be hollow here and, and uh, you, you look frail, I used to look in the mirror and say, my gosh, you are so old and you are so frail [laughs] and my friends used to say that, oh you look so frail. (Dorris 931-950)*

> *Well, I guess, um, if you have a stroke..a lot of our friends are having strokes..Some of them, ah, have cancer, and, ah, after the cancer treatment, although they're well, ah, they're not as active...Even in our age group, a lot have passed away with, ah, heart problems or arthritis, cancer. I guess, ah, heart and cancer - oh and a couple have passed with Parkinson's disease...I think it's the same in every, ah, nationality...You have to be ambulant to enjoy life. Once you're not ambulant and you have a walker to walk, then you really feel, like, old. (Kumiko 454-468)*

Moving beyond frailty however, women defined frailty as weaknesses, difficult times or struggles. These responses ranged from the things that the woman did not do, to illness experiences, to loss. Maizie connected frailty with not having your needs met, and therefore, becoming worse than you would have been if someone could have helped you out. Her description highlights how resources and access play an important role in frailty. These responses which connect frailty with the social and the emotional completely challenged the common notions of frailty, which locate women's frailty on their bodies.

> *Well, you just look as if, you look weak and you look tired and that's exactly the way you feel, you, I couldn't, you know, I couldn't make my own bed um, I'd just, I used to stand and try to do the dishes but it was always * dishes, there were just a few dishes done and um, I didn't cook very much because I didn't want to.... (Dorris 952-958)*

> *Well, I would imagine someone probably that didn't get around too quickly or too easily, would be some, they may need some assistance or, I my frailty are things I failed to do... or be doing. [Like?] Oh, like exercise, like making the decision to get this move done.. uh, getting rid of a thousand pounds of excess paper in this house {laughter}...Those things, sort of, sit on my conscience, but, uh, that fact that I'm ignoring them to... If it works for you the denial is...(Katherine 509-519)*

> *Well, I think a lot of the frailty part too really comes in because of how the government got into this position too, you know. [Okay] You know.[Tell me more about that.] What I mean? What you would have got before or where you would have gone, there's nowhere there that you can go there anymore, for health services. And you may be expecting and looking forward to get...get some help from the CLSC. And, it's not there, you know. They told us how much they were going to be able to do, whatever, at least the government tells us about doing whatever. They agreed. It's not there. I mean that can affect people badly and it, it will make who wasn't even frail, frail. You know, that is a very, very big part of the factor because, if you can't get out to do certain things that you were hoping to help to get these things done..because of whatever financial positions, or whatever. It's not there. It's not there. (Maizie, 72-86)*

Reflections of the dominant stories told on and about older women were also reflected in worker referrals. Worker definitions corresponded with the policy language about eligibility criteria of risk, impairment and mobility. In general, individual worker definitions were framed in relation to physical risk, emotional coping, or risk related to cognitive impairment. Specifically, worker classifications focused on size, physical weakness, stability and emotional awareness. It was common for the worker to refer to the woman as having several impairments or losses, as well as mobility difficulties (e.g., 'getting around'). The 6 frail women were referred for the following reasons. Ella was very thin, had several falls and was over 90; Clara has had moments of frailty including a fall on the bus and is not able to do things as before. However, she was still described as a very sturdy woman. Dorris was very ill and had a very difficult time adjusting—she was referred as psychologically frail; Carrie is a frail woman who does not get out much, she is beginning to experience some cognitive impairment; Alice is a spirited woman whose physical health issues prohibit her from participating in services. She was a caregiver for 13 years and had a long and difficult recovery from hip replacement surgery; Margaret had a major fall a few years back and has had major difficulties recovering. In this sense, workers notions reflected dominant eligibility criteria and character descriptions, many of which were related to physical injuries as a result of falls. The description of women and connection with injuries seems to reflect the current policy of ambulatory care, where eligibility is linked to post-hospitalisation. Further, although many of these women were considered frail, their involvement with services was limited—they were only involved at the moment of their crisis. Despite various needs, they were only eligible at the time of their crisis. To understand the connection between labelling and eligibility it would be interesting to explore how workers use their language to negotiate assessment, eligibility and service allocation.

Frail Resistance & Rejection

Although I didn't expect that women would use this concept in relation to their experience, I was shocked by their responses. Women casually rejected frailty. At first, I had expected stronger reactions—the women seemed to matter of fact reject this notion in relation to themselves. It began to look like no one was frail, and that the stories about them didn't seem to affect them. Maybe it didn't matter—maybe frailty was not such a big deal? Perhaps I had selected an irrelevant topic. I had a group who seemed very far from being considered frail and another who brushed it off. Yet, it was within the contrast between the two groups, and the commonalties between responses that I began to understand their responses and storied experiences. Women's responses displayed a naturalness that I would have taken for granted without the contrast between the two groups. The responses of the eight women showed me how negotiation of this identity is a common activity. The natural response, which could be referred to as a prepared defense, suggested that frailty was a concept that they frequently negotiated. It was as if they were subject to this name-calling, labelling or dominant messages on a regular basis and had developed a common response of "no I'm not and I'll tell you why" or perhaps a more polite, compliant version—"well, not really".

For the most part, women's responses actively challenged the dominant stories told on and about older women. Women did not self identify as frail—instead, they automatically denied or rejected the concept. Only one of the women (Dorris) used frailty to discuss her illness experience. The other eleven women discussed frailty only when asked specifically. However, five women (not Carrie) in the frail category and two women in the non-frail category who had had previous illness experiences (e.g., hip-replacement surgery and cancer) positioned themselves against this discourse using a statement such as *That wouldn't be me!* (Ella). Women resisted and/or differentiated themselves from this concept and associated experiences.

Consider the following examples:

> *My mother died, she was 101, she was frail when she died. She was small, I'm short too, but I'm chubby and when you're thin and, you can't move, you can't do things, you're frail (Martha, 126-129).*
>
> *I'm not frail, I'm too big to be frail. I will never look frail, because I'm too big (Margaret 662).*
>
> *I don't consider myself, I don't want to consider myself frail (Clara 16-17).*
>
> *I don't think of myself as frail. I think of myself as being, I suppose handicapped to an extent...(Elizabeth 51-53B).*

It seemed that the rejection of frailty was connected to the experience of physical decline or having an illness experience. The woman who did not automatically reject this notion (Carrie) had no previous illness experiences—she was referred in relation to suspected cognitive impairment. The seven women who rejected the term in relation to themselves, explained their understandings, and often told a story of someone who was frail. One woman said "*it's not something you say about yourself—it's something others say about you*" (Margaret, 708), while another said '*it's a way of talking*' (Elizabeth 241b). Here, women's responses reflect the power of the stories told on and about their bodies and the connection between frailty, being pathetic and being pitied.

> *They don't tell you that they are frail, you, you, they don't tell they're frail. You notice that they're frail....somebody else says, "Oh, she's a frail little thing," they'll say. You know, I've seen it written down, I've seen it in books....I'm sorry for all them, because they, they are so frail. You see. This, it's a description, actually, of a person. It's a description of a, oh, she's a very robust person, or a very fat person, she's very frail. Yeah. ....I can point out to you, all the frail people when you see them. (Margaret 704-727)*

Women's resistance or rejection of the stories told about them highlight the potential meaning that frailty may have in relation to older women's lives, and the delicate ways women make meaning for themselves, and negotiate other people's perceptions. Women's responses highlight how frailty seemed to be about the way you are perceived or talked about by others. Women rejections of the term in relation to themselves challenged the appropriateness and potential relevance of the term, as well as rejected the inherent power involved in being perceived according to their bodies or physical status. Women's responses, particularly those that rejected frailty, taught me how their daily reality is replete with negotiating dominant questions and messages about their bodies, age and abilities. During the interviews, I was both the voice of dominant discourse attempting to classify and judge them, and a young woman whose body distanced her from understanding. Those who had no previous health problems had nothing to fear—they could not possibly be classified as frail, others seemed less certain about how I would classify them, and seemed to position themselves accordingly. Here, women's choices in relation to this concept are delicate. It seems that any woman who has the slightest potential for being labelled frail (i.e., has or has had health or illness experiences) must either differentiate themselves from this concept, or accept the dominant meanings assigned to her body. The contrast between the seven women who rejected frailty in relation to their experience and the five women who simply avoided using the term, shows how the potential meaning of the concept seems to vary depending on past experience and/or current situation. By performing their daily acts of negotiation and/or resistance within the interview, women's responses challenge the powerful concept and stories that have the potential to change the way others perceive them, and subsequently the way they feel about themselves. Women's accounts however did not always reflect or reject the stories told about them. At times, times, their stories completely blurred any distinction between the frail/non-frail binary.

II. Marking Distinctions & Blurring the Frail/Non-Frail Boundary

The blurred boundaries between frail and non-frail women's responses, stories and experiences challenge the binaries within the stories told on and about older women. Admittedly, real differences seemed to exist between the stories and experiences of the 'frail' and 'non-frail' women within my sample. That is, the characteristics of women's stories within and outside this frail/non-frail binary differed. For example, "frail" women's stories tended to focus on health and adaptation, while "non-frail" women's stories tended to focus on their life experiences. The differences between accounts initially led me to believe that there is a real distinction that exists between the stories and experiences of the women located at each extreme. Frailty seemed to be marked by the presence of physical health problems. In this case, health may be considered the main characteristic, which divides the stories. However, age also seemed to play a part in these distinctions. As previously mentioned, women within and outside represent two distinct locations on the hypothetical health continuum of diverse older women. In general, the women in my frail sample had health issues and generally were older. In this sense, perhaps there is a connection between age and physical decline.

The distinction between the two groups however, does not necessarily mean that there is a reality of being 'frail' or 'non-frail', rather it reflects the social construction of two groups based on medical criteria of physical decline and reflects how the stories about them are defined and organised. This was particularly evident in the three cases, which transgressed the boundaries of this social construction. Carrie, considered frail as a result of cognitive impairment had no accounts of illness or injury, while Martha and Elizabeth, who were not considered frail, had stories related to illness and surgery. Cases which transgressed these boundaries highlighted how group distinctions were more a function of a professional classification than a reflection of a real experience of frailty. Women's stories show how this binary has particular health characteristics that may aid classification, yet how this construction is more about regulating the demands for public services. Cases which transgressed the boundaries show how frailty is a story about classifying, assigning and regulating public services.

In addition to the presence of health issues, income and/or resources also seemed to both mark the distinction and/or blur the boundaries between the frail and the non-frail. That is, the women in the public system had less access to income or resources. Elizabeth's case provides a good example of how income blurs the boundary of the binary construction. Although she had a health issue, her access to resources and/or income meant that she could make adaptations without falling under the public service classification of frail. In this sense, it seems that resources may make a difference in the way a health issue is experienced. While both health and income are a privilege, the presence of one or the other within women's lives seems to impact on both temporary and/or permanent experiences in relation to health. Sufficient income seemed to permit women to make choices that women with less income would not. It is also possible that women who have had sufficient income throughout their lives have less general health problems. As such, it is difficult to know whether it was resources that impact the experience of a health issue such as hip replacement or vice versa. Further, this income discrepancy may also be reflective of the way services are implemented to prioritise those with the greatest risk. In this system, a person with no available resources (i.e., monetary or kind-family) would likely be classified as having a higher priority for service. Yet at the same time, it highlights how the social construction of frailty may only exist within the current system where services are restricted according to need. Exposing how income and/or resources transgressed the binary exemplified how resources provide women with choices that may enable them to meet their needs in more acceptable and/or meaningful ways.

During data collection I had questioned my methodology, wondering if I should have focused on only the stories of frail women so that I could better understand their situations. At this time, it seemed that non-frail women had no health problems and had nothing to say about frailty. Yet, as originally planned their different social locations assist to understand the concept of frailty in relation to everyday life. The space that exists between these two socially constructed groups however, is revealing. These extreme locations and the transgressions which blurred the boundaries were key to understanding the constructedness of the binary and the contradictions that exist between policy understandings, stories told on and about older women and women's experiences.

In addition to distinguishing and blurring the frail/non-frail binary, women's stories differentiated between experiences commonly associated with physical frailty (e.g., mobility, falls, etc.) and the idea of 'being' frail. This differentiation seemed to distinguish between real experiences such as illness and/or disability (whether accepted or not) and the experiences and/or meanings that women associate with these experiences. Women's stories moved beyond the distinct event such as illness, disability or crisis and the particular meanings and/or implications that this event may have on a woman's life. In a standard sense, women experienced certain events that are commonly associated with frailty, yet they would not necessarily describe themselves as frail. The potential meanings associated with 'being frail' seemed to depend on past and present experiences. Distinctions between the physical concept of frailty and being frail are distinguished less by the official classification of frail or non-frail and more by the meanings that women assign to their experience of illness and/or physical disability.

Women's stories highlighted how the idea of 'being frail' was not necessarily related to a health issue, but an experience which brought a recognition of potential vulnerability and/or mortality. For some, being frail was related to crisis while for others, it was related to the meaning of physical vulnerability. For example, Annie talks about her daughter's death as a tragedy where she struggled emotionally, while Dorris used frailty to describe her identity during her illness experience. Both stories highlight the reality of vulnerability and despair and the way that these types of experiences impact on both their life at the time and way that they live their life from that point on. This understanding seems to be represented by a sentiment of being at wits' end. The idea of frail seems to imply a forced acceptance of vulnerability and a precarious sentiment of uncertainty.

Here, it would seem that those who have experienced it best understand the meanings and implications of being ill or experiencing physical decline. As someone who has a serious illness experience, I understand how illness brings a certain level of uncertainty and may alter life accordingly. Until now however, I did not connect my experience with the distinctions that women seemed to make between the event and the meaning of the event. I had not made the connections between uncertainty and/or precarious existence and frailty. It is as these ideas of 'being frail' represents a slippery slope from which people do not know if they can hold their ground. However, frailty can only be reviewed from a position of privilege—that is, from a position of having experienced and moved beyond, as opposed to being located within. It would seem that those who have not moved beyond frailty would be unable to discuss their experience. This leads me to question: If I had not experienced illness could I have come to understand these women's lessons? Overall, the distinctions between the events commonly associated with frailty and the potential meanings in relation to women's experiences expose the differences between individual medical notions and women's experiences of vulnerability, uncertainty and/or the recognition of mortality. Women's responses challenged common understandings making clear distinctions between the event and the meaning of the event, thereby blurring the boundaries of the distinction of frailty.

III. Illustrations about Frailty: Understanding Frailty as Contextual, Temporal & Relative

While women's responses focused on physical descriptions and the rejection of the concept frailty in relation to their own experiences, their stories about themselves and others reveal how frailty and the experiences commonly associated with frailty are contextual, temporal and relational as opposed to fixed and measurable. Women's examples exposed the underlying connections between frailty, fear, loss and death, as well as how these meanings influence their interpretations. The storied approach to understanding women's illustrations and experiences uncovered three main themes about frailty: as related to particular contexts such as the home and the bus, as temporary struggles or hardships, as well as relative to situations of illness and death. When used in relation to themselves, frailty was often a situational or incidental manner—a past event. "My Frailties" was a term used to characterise the struggles and the way women manage. In relation to others, frailty was commonly illustrated through reference to specific situations of illness and death of their mothers or family members that the woman had cared for. The stories of "Rocking Chairs" and "Mom" most poignantly expose women's interpretations of frailty as connected with notions of passivity, decline and death. Women's complex interpretations of frailty as contextual, temporary and relative seem to clash with individual medical notions and the use of frailty within policy and services. Considering the hardship, permanent loss, immanent decline and/or notions of death that women associate with frailty, it also not surprising that they do not identify with this term. This is especially the case for women with precarious health status.

Frailty as Contextual: At Home & On the Bus

Frailty & the Home

Interviews in women's homes revealed how women may experience the realities of physical decline within their homes. At home, women may see that they are unable to do things as before—they may experience limitations and/or make modifications to facilitate their lives. In several interviews, I noticed how the home reflected the extent of the woman's physical needs or disability. While non-frail women had no adaptation equipment, the homes of women in my frail sample had been modified in several ways.

Some of these modifications were actual physical modifications (e.g., bath benches, etc) while others were modifications in living style (e.g., accessible every day items were kept on the counters). Most notable was the bathroom. Particular women's homes (Alice, Clara) revealed the challenges associated with particular health or social contexts. In addition, to the context where women may experience decline, they may also experience isolation. Take for example, a woman whose physical limitations prohibit her from going outside alone. Although her home has personal meaning, it is also the site of isolation in relation to her health.

Frailty within the home however is also various and shifting—the home can also be the site of security. At the same time as the home may be the location where women experience their limitations, it may also be a safe environment where women may feel more secure in relation to their activities of daily living—they may feel that they can better negotiate a familiar environment. Here, they may modify their living arrangements so that they feel less frail. In this sense, experiences of frailty may shift to a location outside of the home. Home, is therefore a context where frailty may be both understood and/or experienced. The connections between the experiences of frailty and the home are particularly visible within the contrast between the homes of women with and without disabilities. The following example shows how my perception of one woman would have been very different within and outside of the home. This example best illustrates the contextual nature of frailty.

I was sitting having tea after an interview when I became aware of the way I was witnessing frailty from the "inside out". By meeting women in their homes, I was entering their most comfortable environment. I was aware of this from an ethical point of view- but I had not considered the impact that this view of frailty would have on the way I perceived the woman, and interpreted their stories- until that day. I remember sitting and talking with Ella in her living room. I remember feeling a slight angst that this was a woman, who had been referred to me as frail, yet had such a rich history and life experience. Admittedly, she had lived a privileged life- and I could not see her as frail. She was old but she did not meet my vision of frailty- she was content and smiling, sharing her photos and experiences. There was however, a sense of loneliness that I felt guilty about- here I was one of the only persons she would speak with in her week. Amidst *all these sentiments of respect, admiration, angst and guilt, there was one moment however, where I realised the contextual nature of frailty.*

She made a tea for me and proceeded to pour into the teacup. The stream of tea however, jutted over the cup and onto the table un-noticed for a second. Yet, as she noticed and I offered denied assistance, I realised how the very comfort zone of her home had altered my perception. My ideas about Ella would have been very different should I have met her for the first time in a setting uncomfortable or foreign to her- what if I would have met her on the bus? I then felt that perhaps this label of frail was valid in some contexts- perhaps it could serve some use in protecting her from harm or risk. Yet, judging from my reaction to this term, as well as the women's discussion I see her as non-frail- but rather frailty as contextual. To write this, I am thinking back to the interview and connecting my observations. I remember how I was on edge while her cat proceeded to walk in-between the fragile ornaments placed on the shelves just behind her- any misplacement of a paw would have sent the porcelain crashing down onto her. But I can only make this connection now- her frailty was, as the cat that walked on the ornaments- it depended where she placed her foot. Just as the many times I'm sure the cat weaves daringly among and between the porcelain, Ella's steps may be risky on the outside and safe on the inside- her frailty would depend on where she placed her next step. This experience or awareness led me to flip or play with the perception of what is presented to me- it expanded my view- and taught me that I was in fact seeing things from the inside out.

The context of home in this case may be both a site to understand women's needs, as well as a location of the professional gaze or judgement. Home therefore is a location of power in relation to frailty. That is, the worker may judge a woman for her physical limitations. However, the power available in relation to home may also be used to permit women access to services. The question is whether the woman's experiences are framed as limitations which make her frail or needs that require assistance. This would seem to depend on the perspective of the worker and the context of service provision. Current assessment models and policies (i.e., Virage Ambulatoire) however, have moved away from this type of assessment focusing more on medically-based needs. In the current context, one could argue that even home assessments are rarely conducted—emphasis has shifted further into the medical post-operative cases. If a home assessment is conducted it tends to focus on the physical needs and overlook the connections between the physical, the social and the emotional. Women's connections between frailty and the context of home question the current notion of frailty as well as the delivery of services. Women's illustrations which revealed the role of home challenged the location as well as the way stories are told about them.

Frailty & the Bus

The bus was both a site or location of frailty and a catalyst of discussion in relation to women's needs. Frail and non-frail women's illustrations exposed how the bus raised particular issues such as safety and questioned the changes in women's abilities and independence. Women's illustrations of the frail person were often located on the bus. For example, women spoke of people who had a difficult time getting onto the bus:

> *I just saw a frail man the other day, he was on the bus [okay] and, uh, he was an elderly man, he used a cane of course, and was so hard for him to come up, get up the steps to get into the bus and he sat down so, just so difficult for him, then when he had to get off, it was a big procedure for him, it was a big job, he, uh, the bus driver was very patient, very nice, he waited until he got off, somebody was waiting to get in and they were very patient, but, like, when he sat down at first he says, omigod thank god I'm sitting, you know, that's frail. When you can't do for yourself-- that's being frail. (Martha 140-149)*

In addition, some of the women with disabilities or physical health discussed how they themselves do not feel safe on the bus—for these women this fear was connected to past experiences of falling. These illustrations highlight both the potential and actual difficulties that women face in relation to getting around (i.e., transportation). Experiences of frailty on the bus are likely to be the case in an urban sample where the bus is an important mode of transportation.

> *Yeah, I fell down, I fell down, about, the first time I don't know where I fell the first time, when I hurt my ankle and then was just getting better and I went on the bus coming home to grocery store, I had bags on each, so the bus gave a big jerk and three or four of us fell down on the, on the bus. (Ella 362-366)*

> *I'm frightened on the bus, dear...You see, when you get on the bus, you just put your money in, or you put your ticket in, and that's alright, but*

> *then he starts the bus. And then you... unless you've got something to hang you're really wavering. And one sharp movement can throw you right down. (Margaret, 597-602)*

The illustrations of the women who had particular health issues showed how women's needs tended to depend on both their abilities and the context. Women's experiences in relation to the bus or other methods of transportation would depend on their physical limitations and/or unique situations. Women's needs would also differ depending on their social location and/or choices in relation to transportation. For example, a woman who drives would not have the same experience as a woman who relied on public transportation. The bus may therefore be considered a real location of frailty as well as a representation of the issues surrounding transportation. The bus may be a representation or an illustration to highlight how women may be perceived by both themselves and others. Similar to the home, someone like me may see that the woman is no longer able to take the bus.

Illustrations or representations of the bus also revealed the sense of loss and/or emotional adjustment that accompanies a decline in physical mobility. The bus also exposed the hidden meanings that women associate with frailty and/or decline. Within their examples, women spoke of their fears about their health as well as the emotional adjustments, which accompany these changes. For women with physical limitation, the bus is also a daily reminder of the way their bodies have changed. These feelings expose the precarious nature of women's situations and highlight both how a context is capable of changing their experience. For those who were accustomed to taking the bus their fears or lack of safety in relation to the bus became a reminder or reality of their decline, as well as an example of the way they negotiate their health and decline in everyday life.

Some of the meaning within the concept of frailty in relation to the context of transportation is captured in the statement used by two women "*I don't run for buses any more*" (Clara, Martha). This statement captures a change in situation as well as implies meaning within the change. This statement implies that she is no longer able to continue with the way she previously did things—it implies that at one time she did run for buses, yet running is now a past activity. This contrast not only applies a change in physical ability, but a change in realisation and gives a clear example of the way this woman negotiates her health in everyday life. The contrast between a previous lifestyle and activity and a current change in way of doing things highlights the emotional coping that is interconnected with physical decline. However, this statement could be interpreted as a limitation, yet it could also represent a conscious choice. Later in her story, Martha discusses her 'slowing down' as a conscious choice where she accepts her age. This illustration therefore highlights the potential meanings such as decline that women may associate with an event, as well as the way that women may make meaning of their experiences through life lessons.

Some women spoke about the changes they had experienced in relation to getting around. Women who drive or who had previously driven or whose husbands drove spoke about making the transition from driver to rider as well as the challenges of access. Driving and available means of transportation were also connected with issues of physical decline and/or disability. One woman discussed how losing her license affected her level of independence (Ella). She speaks of the difficult transition she encountered when she moved from being a volunteer driver to being the person who needs the ride. For her, losing her license led to her social isolation. She discusses how as a volunteer driver she was always busy- she would also go to visit her relatives just outside of the city. Now, she often stays at home and her family does not often visit. Another woman spoke of how her and her husband's choice to give up their car places some limits on their activities (Martha). While another focuses on how she is still able to drive, but finds that parking and access have become issues (Elizabeth). Together, women's illustrations highlight how frailty may be located and experienced in relation to particular contexts such as the home and/or the bus. It highlights the variations in need, the way that women may make meaning of particular contexts such as the home and/or the bus as the perceptions of others.

'My Frailties' Temporal References

Women's stories also highlighted the way the concept of frailty was understood in relation to time. Connected with the distinction between frailty and 'being frail', frailty seemed to have two temporal references—it was either a temporary and past event and/or an uncertain future. Past stories discussed a difficult situation, or an illness experience which either result in an improvement in health situation or death of the frail person. This temporal context was most visible in the distinction between the illustrations of frail and non-frail women. Non-frail women made a distinction between the concept of frailty and the frailties of life. Women would say "my frailties" are about the difficulties or things I didn't do (Katherine). Non-frail women with no experiences of health problems would provide stories, which related to their frailties in life. Not having experiences where they would be considered physically frail (e.g., mobility, and weakness), they used frailty in a temporary sense related to struggles or difficulties. The frailties of life were not connected to age, instead, they were connected with difficult periods of their lives or things that they failed to do. In addition, these stories reflected the social, relational and interactive nature of frailty. That is, women did not experience frailty as an individual event, but in interdependence to another person or event. The temporary experiences of frailty could not be controlled. They were generally described as unexpected situations that challenged, depressed, or resulted in sadness. In the interviews, women's frailties of life included the death of their children (2), death of their spouse (1), divorce (1). Through interdependence they moved however, beyond the frailty experiences. Only in looking back could women describe their experiences with frailty.

Frailty was also discussed in relation to illness cancer (1), operations (2), and sickness (1). Here, the temporal references were also temporary and/or uncertain. Some women discussed their frail experience as a past event, which was no longer, a concern to them. Others discussed their illness or disability as uncertain. Those who discussed episodes of temporary illness or frailties (non-frail women), discussed the event as a turning point or life lesson. While women with illness experiences talked about how they made adjustments and changes to their everyday lives. *You live for day by day* (Alice, 964). At the same time as these temporary stories highlight the temporary nature of frailty, they also highlight the uncertainty related to frailty. It is within this uncertainty that women negotiate their health.

Those with current experiences were uncertain if their frailty issues would go away or whether they would have them for the rest of their lives (Dorris, Alice). Women who were still located within the illness experience would discuss how they would negotiate what seemed to be permanent issues related to their health. Although all women's stories were located within the temporary or uncertain, the difference is that one looks back at the illness or frail experience, while the other remains within it. These differences highlight the potential importance of the term frailty- frailty does somehow reflect a difference in situation or need. It also highlights the potential uncertainty of illness and/or disability—many of the women with current illness experiences are not sure that these will go away. It is not surprising in this sense, that some women framed their narrative as life lessons while others focused on the negotiations and/or adaptations. The differences between the two temporal references and the way women storied their accounts highlight the different meanings that may exist in relation to older women and frailty, as well as how these understandings seem to clash with policy notions.

The contrast between frail and non-frail accounts exposes the slippery slope that exists between frailty as a temporary condition, being frail and the uncertainty of moving between these states. These types of stories expose the potential uncertainty within the term frailty. Non-frail women's stories highlight how they have not experienced first hand the physical issues that would result in a frail classification. Their stories therefore reflect a very different understanding than the understandings of women at particular social locations who have not had an illness experience as well as a way of connecting with the stories of frailty. This notion of illustrations of the past highlights both the uncertainty for those who are currently experiencing illness as well as the emotional adaptation required to deal with physical decline. In both cases however, perceptions of frailty highlight the emotional nature (i.e., acceptance or coping) which may assist a woman to move beyond the temporary condition of frailty or accept the emotional adaptation, which accompanies the physical changes. My interpretation is reflected in Elizabeth's words "*Perhaps I should not use this term anymore, it is hitting too close to the bone*"(239B). Temporary identification with the concept of frailty is only for those persons who are not currently experiencing health related issues. Yet, the physical conditions which would be classified as frail bring uncertainty—women are not sure whether these issues are temporary or permanent. Women's resistance was related to the frail identity and meaning of the concept as opposed to the everyday physical issues associated with frailty. In this sense, frailty is not only temporal, but is also relative to women's perceptions of decline and death.

Frailty as a Relative Concept: Rocking Chairs & Mom

Frail and non-frail women's illustrations and examples of "rocking chairs" and "mom" challenge frailty as an individual medical notion. Women's illustrations about the relativity of frailty and death reached beyond the current status of physical decline into the realm of impending death. Women's illustrations extended beyond standard physical descriptions to the associations and underlying meanings which they associate with frailty. For women, frailty was understood as a concept which implied relativity to death. Death was both implicit and explicit within women's discussions of their lives and situations. Frailty therefore, is connected with uncertainty, loss and forced adjustment to the reality of impending death. Identification with frailty in relation to health, therefore seems to imply movement on the continuum toward death.

The metaphor of the rocking chair makes the clearest connection between frailty and death. Repeatedly, women would discuss the role of the rocking chair. According to one woman, there are only two times when you use a rocking chair: the first, is to pacify a child, the second is to soothe yourself. (Martha). The older woman, commonly associated with the rocking chair, is either a grandmother or an old lady who is expected to rock herself gently to sleep. As such, frailty is the passive older woman who falls asleep in the rocking chair. Yet, this metaphor seems to stretch beyond sleep—there seemed to be an implicit message of laziness, decline and passivity that may only be followed by death.

> *I used a rocking chair when I had a baby. But I wouldn't want a rocking chair now...Well, because rocking chairs are associated with old people, or young mothers who are nursing, or, or, feeding their child, because the motion is going to make the mother happy, the child is soothed. Once you're out of that stage of feeding the baby, then old, then the rocking chair is for people to fall asleep, to rock yourself asleep, does it serve a purpose...Because years ago, you always saw picture of an elderly person sitting in a rocking chair [okay, okay]....If you go to a nursing home you'll see rocking chairs, you see. When you're not well and you can't do anything, well, that's, that's what happens [mm]... (Martha 225-236)*

In many of the interviews it seemed that the older women I interviewed did accept some sort of reality of frailty, yet not as a description of their experience or self. Discussing frailty, many (Clara, Elizabeth, Kumiko, Katherine, Ella, Martha) would raise stories or examples of their parents, usually their mothers (or persons they provided care for), at the end of their lives. In this sense, the women connected the larger concept of frailty with the end of life. *My mother died, she was 101, she was frail when she died.* (Martha 126-127) and *I think of my parents at the end of life-it's a scary thing- I dare not think about it* (Clara 76-77).

> *As of now I guess I wouldn't think of myself as frail because I am still in charge of me, but there'll be a time when I won't be, and I saw this in my aunt and my parents. (Elizabeth 65-67B)....Well, as I say my parents and my aunt, they're the ones that I, in recent memory saw, uh, when they were dying and this period of sickness before they died. You know they all ended up in the hospital and were essentially at the end, helpless. But there was a period before being absolutely helpless when they still, they were perfectly conscious and reasonable and could talk but didn't really want to do anything [okay]. I mean, they, somebody else would make the decisions. (Elizabeth 73-79B)*
>
> *..My mother-in-law was ninety-four...And she was active, she went to the Centre and, ah - she was a senior...at ninety-four. She was a senior. [Okay]. But she had, ah, breast cancer when she was, ah, I would say about fifty-five...So, after that, she didn't work, and, ah, maybe after the operation, she felt that she was a senior, couldn't do anything...she was always catching a bad cold...She couldn't get rid of it. But she lived to ninety-four, so I don't think that's so bad...(Kumiko, 470-489)*

Here older women's discussions of their mothers reflect the eminent death and uncertainty they have in relation to this death. Discussions of the death of their mother is the mirror which they currently look into- they realise that they are also aging and are faced with the realities of mortality. This is particularly the case for the older women in my study. Perhaps their discussions of their mother's experiences were ways of negotiating, more so for those experiencing issues of illness or decline, that this may soon be their reality. Perhaps, it was their performance to a younger woman who could not possibly understand. For the most part however, older women did not locate frailty within the individual- if they did it was only just prior to death. When discussed explicitly, frailty was described as the loss of control and eminent death (e.g., *You get frail and then you die*- Elizabeth). Many times, this frailty was connected with the loss of decisional capacity and independence at the end of life.

> *There's a kind of transitional area when you have a choice, uh, so that uh, the end, at the end of life everybody's frail. So I suppose it enables you to*

> *be functionally self-determining a bit longer if you have more resources but um, so it may push back the definition of frailty a little if you have more control over your life [okay], but uh, as I say, we all get there in the end [okay]. (Elizabeth 41-46B)*

> *Oh, no, I think I would, I suppose depends on what goes first, but I would envisage it more as not being in charge of myself [yeah]. I mean there's going to be a time when I can't handle my bank account and, um, uh, you know, this sort of arrangement [okay], which all these things that I do and have been doing for years but there's gonna be a time I can't. As I say, I mentioned that I took this over from my parents and for my aunt, I don't know quite, I seem to be the designated person in charge of people's affairs [laughs]. And, um, I, uh, so I, I am very conscious of this. (Elizabeth 115-122B)*

Older women's implicit connections provided shards of meaning into the way these women negotiate the meaning of death in their lives. Women discussed the challenges of planning future events: *You can't because you don't know* (Alice, 967), living experiences as the last: *I will go- this will be the last time I go home* (Carrie 53), satisfaction and readiness for death, as well as the uncertainties of their lives. The older women's stories simultaneously reveal the tensions between struggle, resistance, life review and acceptance. One woman talked about her acceptance using a strategy of life review and the metaphor of luck. In her account she talks about how she is "*lucky*" to be living. Remembering that the older women I interviewed did not identify as frail, considering the relativity of death and frailty, many women conceptualised death as the impending event- the '*not just yet*'. Making meaning of frailty means dealing with death. When connections between frailty and death are understood, women's illustrations show the contradictions between dominant notions and women's experiences. Although the relativity of frailty and death is not assumed in service, women's stories provide insight into the connections between the two. The relativity between frailty and death therefore, challenges the notions of frailty as an individual medical notion of decline.

IV. Older Women's Stories: Exposing the Social Location of Need

The stories of older women within and outside the binary challenge the stories told about older women and their needs. Although the older women's accounts were diverse, the commonalties between the women's stories I interviewed were surprising. All of the older women's stories include reference to four central issues of issues of housing, transportation, coping and talking about death. These issues clearly transcend the frail/non-frail binary, expose both the commonalties between experiences, as well as question the medical and professional stories told about older women's needs. Although these issues cut across all of the older women's stories, the experiences and choices were very different between older women who had current illness or disabilities and those without current health issues. This is not to say that the experiences are static or that generalisations can be made which gloss over the diversity between accounts, but that there are both commonalties amongst older women's experiences as well as variations in the way that older women experience their needs according to social locations.

The stories of older women with illness and/or physical decline provide specific challenges to the individual, medical notions of frailty. These stories extend beyond dominant stories where need is perceived as individual, physical and medical. They reflected real physical experiences of illness or disability, made connections between the physical, emotional and social experiences, as well as exposed the type and extent of older women's unmet social needs. The connections between the physical experiences and social needs challenge the individual medical notions and highlight the differences that exist between policy concepts and older women's experiences. As such, these stories of need reveal the contradiction between a policy that shifts more and more toward the medical and excludes and/or overlooks the relevant social needs that accompany physical experiences.

Housing & Transportation

Older women's storied experiences revealed the role that the home plays in defining and meeting older women's needs, the varying types of needs in relation to health and housing, how the home was a location to view the extent of need, as well as how particular social locations changed the nature and experience of their needs (e.g., home ownership vs. rental status). Older women with illness or disabilities tended to have particular types of needs in relation to housing. These needs included having safe and affordable housing, being able to get around and take care of their activities of daily living within their homes (i.e., access and modification issues), and having someone to take care of the home maintenance. The nature of these needs however, depended on social location. For example, home ownership marked clear divisions between the nature of older women's needs. Renters tended to focus on rental increases (Martha), safety and suitability/access (Margaret & Clara), while home owners focused on home maintenance, finding suitable tenants, and adapting their living conditions. (Ella, Elizabeth, Alice, Carrie). Many of the woman who owned their own duplexes decided to rent to their families either out of frustration with poor tenants or being closer to their families—these choices however, tended to depend on older women's income. Women who rented apartments spoke about not being able to purchase a home, as well as the implications of rent increases and safety. One woman highlighted how she would have liked to have a home but had never had the means to purchase one (Clara). As a result she lived in housing conditions where the landlord did not keep up with the maintenance and garbage piled up in the basement.

Three older women spoke about their housing needs in distinct ways. Elizabeth talked about her choice to purchase an apartment that was single level, wheelchair accessible and had a parking garage. This choice was part of her overall planning for her changes. Her example highlights the available income to make suitable changes as well as her previous involvement with her parents which informed her about possible needs and available services. Alice discussed how she made the choice to adapt her family home despite how this required her to move all materials and storage to one level and be restricted from all but one level of the home. Further, her need for income forced her to have tenants that she felt at times jeopardised her safety. Her social location of limited income and the personal meaning attached to her family home did not give her the same choices as Elizabeth.

> *You know, I would say it could be more than that. Because, I would say that that makes people frail too. [Okay] You know? I mean, this money situation you have it, you had it, you don't have anymore...I mean, you're not going to have it ...now you're not going to have anymore you're not going to have. The living conditions, and if it's not the living conditions, it's the rent. [Yeah] And now what they're doing, you know, they're not even making many apartments, they're making condos.* (Maizie, 116-124)

Older women's storied experiences also highlighted the types of needs that older women have in relation to health and transportation, how the bus was a location to view the extent of need, as well as how particular social locations changed the nature and experience of these needs (e.g., woman who takes the bus vs. woman who drives). Similar to housing, all women I interviewed discussed transportation stories—as a concept, frailty was commonly connected with stories about the bus. Transportation stories tended to involve an incident, the way current systems of transportation did not meet older women's needs (Ella) access issues (Margaret & Clara), as well as the process of losing one's licenses (voluntary or non) (Ella, Martha). The bus was often commonly discussed as a potential peril or a symbol to slow down, while, not having appropriate services and not being able to drive oneself raised issues of independence and isolation. Two older women shared their experiences of falling on the bus and the way in which this shaped their current experiences. Often times the bus was sighted as a location of older women's fear of falling (Margaret & Ella). At other times, the women in my sample discussed exposed how the bus did not meet their needs: *I take a bus at the corner..I go to the grocery store, and then I sit out on the bench and wait for it 'cause it's twenty-five minutes between* (Ella, 544-545). Although many of these older women would prefer a taxi, they cannot afford a taxi.

Similar to housing, older women's needs varied according to their social location. There was a clear distinction between those who relied on public transport and those who drove their own cars. The largest distinction however, seemed to be the examples of difficulties during periods of illness or disabilities (Dorris, Ella, Margaret). In these circumstances, the connections between transportation and health seemed to take on particular implications. Non-frail older women's discussions rarely included mention of the bus (except Martha)—getting around was not yet an issue of concern. Women who continued to drive talked about accessibility as an issue related to home care: *But um, it's not uh, not the driving that counts, as I say, it's the parking somewhere* (Elizabeth 779-780) as well as the transition from being a driver to a rider or someone who takes the bus. Two women talked about the meaning of giving up a license (Martha/Ella). For example, they talked about the clear difference between giving up the license as opposed to having it taken away.

In addition to the way transportation is experienced differently according to social location, older women's stories highlight the contextual nature of these findings based on an urban sample—the issue of transportation is likely to be located and experienced quite differently in rural populations. Although there are some understandings that people who ride the bus are students, the poor and the elderly as well as the environmentally conscious (less so in large cities where these divisions are less fixed), hearing older women's varying social locations in relation to transportation alone challenges the idea of an accessible public transportation system. Perhaps it is taken-for-granted that when older people do not drive any longer they may ride the bus, however, the bus is not a choice for some persons, nor is it accessible for others. However, for many, the socio-economic position associated with riding the bus may not be understated. True, Montreal is a large Canadian city and it is easier to ride the bus, yet those with extra cash would rather have a car and/or be able to pay for a taxi. This raises questions about access and the implications of health status.

The stories of the women I interviewed exposed the social connections between their specific issues related to health and social issues, showing how housing issues and issues of transportation were experienced differently depending on social location. The connection between physical issues, housing and transportation raises questions about the current definition of frailty, which is both medical and located within the individual. The overlap and contrast between older women's storied experiences call for recognition of social issues as well as a flexible understanding of the differences between older women's situations. Discussions of housing and transportation issues expose common social needs as well as how these experiences vary based on the woman's social location. Although housing and transportation are not currently included in home care, it would seem that older women would benefit from an integrated system where both are seen as integral. Housing and transportation issues raise questions about accessibility, resources and the emotional/social adaptations that accompany a loss in functioning.

Coping with Decline & Talking about Death

Older women's storied experiences, especially those located at the frail binary, revealed the unseen element of emotional adjustment. That is, they highlight the unrecognised need for older women to adjust or cope with decline and challenge the invisible stories about older women. If frailty is considered as Margaret put it, "*something people say about you*" (708) then older women's illustrations must be seen within the lens of being perceived and negotiating the perceptions of others. Women tended to discuss illness or disability as an emotional process: *It's tough.. I just can't do it today* (Alice, 506-508). The connections that the women in my sample make between the physical and the social highlight forced coping or adjustment that accompanies illness, disability or the frailties of life. Their stories show how typical health-related issues commonly located on the body are intricately connected with emotional loss. Their stories highlight how particular contexts take on meaning, as well as how their understandings are relative. Understanding frailty requires a focus on both the physical changes and the meanings assigned these changes or experiences—it is not merely the experiences or the power that exposes the potential meanings of frailty for older women, but the meanings that are associated with these experiences. The need to adjust or cope related to decline challenges the individual medical construction of frailty. It exposes the way that emotional or social needs have been overshadowed by a focus on the declining body and highlights the human feelings and emotions that exist within the body surface. Older women's stories raise a challenge to recognise and reincorporate the social and emotional experiences that are connected with and experienced through the body, as well as focus on the meanings of these experiences.

> *The feeling of frailty is, was so foreign to me that um, that I think that's, that's what depressed me too. And then, at one point, the GP, thought maybe it would be a good idea if I would take an antidepressant, I took it for three days and [unintelligible] and I had a terrible time. I just wanted to crawl up these walls and I wanted to go out and I can remember one night about eight o'clock getting my jacket on, 'cause I couldn't, I couldn't stay here, I had to get out, you know, it was the medication making me do that. And I, you know, I stopped at the door and I thought I can't go it's too cold, and besides I can't walk outside, oh. So I said I'm not taking this antidepressant, it's not for me. So I stopped taking it and uh, that was a pretty bad two week, too, now that was really frailty when all I wanted to do was get out of the house and I didn't have the energy to go out and I knew I shouldn't have gone out and I, I don't think I would have got back in if I'd gone out. Now if I'd got down the front steps I don't think I would've got back in. [sigh] anyway, uh... (Dorris 968-991)*

Older women's illustrations in relation to frailty and home show how older women may struggle with the loss associated with their inability to perform activities of daily living, as well as the uncertainty of the way in which they may be perceived by others. Social contexts and locations become the locations where older women experience, perceive and are perceived. It is in the complexity between the experience and the perception of others that the social contexts become key sites to understand and making meaning of the concept of frailty. Older women's stories also highlighted the way the context of home may structure women's experiences and needs.

Older women's storied experiences also revealed the silence surrounding death. Parts of their stories focused on the relativity of frailty and death, expose both how they interpret frailty in relation to death. Their stories about themselves and others (i.e., mothers in particular) exposed how frailty was connected to death as a personal, emotional and social process. They also exposed the lack of space that older women have to talk about death. The connections older women made between the physical, social and emotional reflect the gap that exists within current services and highlight again how the emotional aspect is just as important as the physical changes themselves. Older women within my sample highlighted how they are not able to change their physical conditions, but they are able to change their perceptions. In this sense, recognising emotional needs recognised older women's strengths and strategies of dealing with decline. Older women's storied experiences about death challenge current approaches, which focus only on the body and exclude the interconnected emotional issues. Some older women may specifically frame their discussions as spiritual needs. Older women's stories challenge current individual medical approaches of distance, standardisation and neutrality. Older women's stories raise the challenge to create space for discussions about death and mortality.

This silence was not only a silence imposed on the woman, but also on myself as a researcher. Throughout older women's discussions of frailty and death, I began to experience the imposed silence of talking about death. As many qualitative researchers, conducting these interviews with older women made me stop and re-evaluate my life. Speaking with these women thrust me into a state of question. It was as if layers of stories, both mine and theirs, have been added to my previous conceptions. I began to *take a more tentative and uncertain stance in relation to life and death, and relinquish both control and certainty. Women wanted to teach me their lessons, but perhaps in taking in their lessons I am living through others experiences which are premature to my years. I do not experience the same events: I am not experiencing the many loses that the older women I speak with are. For example, my friends are not dying. I am not even sure how I feel about saying that this experience is premature to my years. I feel very lucky to see what others do not, to learn from the wisdom of years, yet in this understanding there is loneliness for what other older women feel in their daily lives. Yet, it is quite noticeable that my comfort level is not reflected by those around me- it is actually silenced. In comments and discussions, I was constantly asked if I had experienced death of someone close to me- it was as if my comfort with death reflected a naive ignorance or lack of emotional closeness. Or, that my experience would change as I get older. I would not deny that perceptions and experiences are fluid- at this point I would anticipate feeling loss and sadness for a life lived. Overall however, I began to feel that despite my comfort of death as inevitable- there is no room for death in any of life's discussions. Perhaps death has become too much of a reality- perhaps an obsession. Nonetheless, the silence that I experienced about talking about death was reflective of the silence that is imposed on women's everyday lives.*

Older women's responses, illustrations and stories about their experience challenge the dominant stories told about them and their experiences. Specifically, their stories reveal how they have integrated discourse about their needs, how they reject the notion of frailty as commonly understood as well as how their actual experiences challenge the medical and professional stories told about them. In particular, their accounts challenge the dominant construction of frailty as an individual medical concept. They highlight that although this construction may be relevant and useful to classify and organise experience, that it does not necessarily reflect older women's experiences and/or identities. In fact, older women's accounts highlight the gap which exists between the dominant understanding and use of frailty within services and the older women's understandings. The differences between older women's understandings and policy concepts expose how at many times, professionals and older women are talking about two different things. Each may use the language, yet the meanings for service providers and older women are different. The imposed label for older women may therefore mean that their involvement with services means defeat, a lack of potential and weakness. Recognition and decline may be forced upon older women, and/or they may be too weak to engage in the required emotional coping. Yet, social based services are available only at the expense of the woman. These contradictions between policy and older women's understandings expose the inconsistencies between policy intentions of meeting older women's needs.

Older women's accounts and experiences break down the frail/non-frail binary within services. Their understandings challenge the inherent power within the medical and professional construct. They challenge the static concept, exposing instead as complex, situational, temporary and relative. If frailty is considered contextual and/or conditional this raises questions about social location, identity and the role of interpretation. Older women's responses, illustrations and stories highlight the claims being made by frailty as well as their role to negotiate these claims. They expose how when considered, as needs talk, the current concept overlooks the connections between their physical experiences, the forced emotional coping and the social locations of their needs. In this sense, it shows how frailty is a slippery concept with varying interpretations. As such, their accounts highlight the way older women may negotiate this discourse on a daily basis. Frailty is not a concept that older women use to define themselves or their experiences, but rather one that calls into question their identities and personal meanings. Older women's experiences, needs and ways of negotiation seem to depend on the way they view themselves, the meanings they make of these changes, and the strategies they adapt to integrate change in a meaningful way.

Act VI

Resistance, Acceptance & Change: Narratives Negotiating Frailty

The women's stories about themselves expose how their self-perceptions and identity are fluid, shifting throughout time. On one hand, the small stories/recits de vie told by the older women in my sample are examples of the way they construct their subjectivity, or make-meaning of their lives in relation to the past, present and future. Their stories are examples of the way they negotiate with themselves and others to have meaningful experiences. Polkinghorne (1988) would refer to the selection and presentation of details to "create a self-narrative that is coherent and satisfying and will serve as justification for one's present condition and situation" as "narrative enrichment". Their stories exist within a context of culturally produced discourse, some of which are problem-saturated descriptions imposed on the body. Older women's stories reveal how these messages are filtered and experienced through language, their bodies and abilities. In this sense, older women's self perceptions, identities and stories are key to the way they negotiate common messages and live their everyday lives—the way their experiences have meaning (Kleinman, 1988) (Frank, 1995) and the way they enrich their lives through the meanings they create for themselves (Eakin, 1999; Polkinghorne, 1988).

This chapter explores the ways that older women construct their identities and events, and use combinations of resistance, acceptance and change to negotiate health and/or decline. Older women's stories and experiences show the variations that exist within the frail/non-frail binary and the implications of using frailty as a standard fixed concept. This section discusses how the differences within older women's experiences and self-perceived identity may assist the older women to meaningfully negotiate or resist dominant constructions of age, disability and/or decline. To expose how these individual differences within the common experiences are meaningful to identity and negotiation, this section will discuss my interpretations of older women's stories (i.e., 'aboutness') as well as the lessons of each account. It will present examples from each woman's story that highlight the intention of the story, as well as examples of how they negotiate. In addition, it will draw on some of the tensions that exist between accounts, highlighting how policy and service solutions must focus on both the commonalties within and between older women's stories as well as the different experiences that exist within each.

Clara's Story: From Mind Over Matter to Slowing Down on My Own Terms— A Tense Struggle between Acceptance & Resistance

Clara's way of negotiating her health is best characterised by her statement ***"it's mind over matter"*** and the way she uses this strategy to slow down on her own terms. This strategy has allowed her to both develop a meaningful identity and negotiate the perceptions of others. The intersections of age, race, and class are clear within her story. Clara has always considered herself a strong coloured woman—an identity used to negotiate the daily negative messages about race, poverty and laziness.

> *And, uh, I said I'm gonna go in the army, mom, I'm going in the army, I guess it made her feel bad but I was determined to go. I tell you, I'm brave, I'm not afraid of nothing, up 'til this day, nobody bother none of my children, nobody touch me...'cause you got a crazy woman on your hands [laughter]. Even now, I do my best. Anyways, I was real disappointed, they wrote back, they didn't even write back, they put on the paper like this, "No negroes—negroes not wanted in the army". Right on the big headline like that, negroes not wanted, now wouldn't that turn you off? (884-895)*

Her experiences of racism show how her strength was necessary to combat racism for her family, herself and her children. Her story recounts the many struggles and successes throughout her life that have led her to where she is today. She frames her account as a life review, showing me how she has made sense of it all. Similar to the way she has negotiated throughout her life, Clara uses her identity as a strong woman to negotiate her current health issues (i.e., breathing, heart, back).

Although Clara has always used her strong coloured woman identity to negotiate the perceptions of others, her strong identity is becoming difficult to maintain. As such, her account moves between how she used strength in the past and how she adapts this in light of her current physical limitations. At the moment, her narrative is replete with tensions between maintaining her strong identity and therefore, resisting dominant ideas about age and decline, and accepting her limitations. Her account reveals many tensions between being strong but not strong, and frail but not frail. Despite the importance of the strong identity to negotiate racism and messages about age and decline, Clara is struggling with the realities of decline and the meanings this decline has in relation to her life. She has had past illness experiences, yet she prefers not to talk about them—they are in the past. Yet, her narrative includes slippage within the identity of strength that reveals how she is not able to do the things that she used to do—her body has placed limitations on her. Yet, it is not her limitations that are the main focus, but the way that Clara interprets and negotiates these limitations. She is very careful. Clara talks about the difficulty that she has in making these transitions—she describes decline as her greatest fear but understands that this is her reality. Similar to the way that she has done so throughout her life, Clara uses her strong identity to negotiate frailty:

> *No, I try not to remember me as being, even though I have a heart problem [okay] I do what I want to do, all my own work and everything so I don't consider myself, I don't want to consider myself frail. (14-17)...You gotta be strong even if you know that you're not that strong, but you have to act strong anyway and I think it works very well for everyone that is not well. (32-35).*

For Clara, there are serious implications of a frail identity. Frailty is contrary to the self-definition that she has used to fight racism throughout her life. Maintaining the identity of a strong coloured woman is necessary for Clara—an imposed identity of frail would take away her life identity and mean that she has failed. Despite limitations, she tries to use her identity to resist frailty. To do so, she uses a strategy of 'mind over matter': *Yeah, if they're not well, they know they're not well but you got to keep thinking you're strong anyway yeah. It's like mind over matter.* (37-39). It is not that Clara is denying the changes, but that she does not want to lose hold of her meaningful identity. Clara negotiates the messages of others through control and choice. That is, she tries to control her life and experiences despite decline—she tries to do things just as she always has. Take her example about using a cart to do her groceries:

> *Oh, I've got a cart, I've got a cart there, but I can't get used to the cart, [you can't get used to the cart], I don't know why I'm so used to going on my own, I can't get used to these things, it's hard to get used to something that you're not dragging along, I've always carried my parcels, all my life, even when the children were young, you'd see me with two big bags, yup.(216-223)*

In this sense, her strategy is one of protection. She does not wish to see herself as frail, nor does she wish to be perceived as frail. She tries to continue as always—to fight and/or resist frailty in a way that is meaningful to her. It is 'mind over matter' and Clara is going to do the things she is able to. Not being able to do things is one of Clara's fears:

> *[So what happens if you can't do the things...?] This is the future, this is the future, I dare not think about it, is a scary thing for me, being so independent, it's a real scary thing, yeah, that's why I try to keep going. It's mind, your mind, you have to be strong in mind in order to continue until you leave this earth. Yeah, that's the answer, that's my answer, I don't know about anybody else. (75-82)*

She never says I can't or I am unable. Instead, she presents her limitations through the voices of doctors and friends (e.g., 'my doctor says'). In this way she can maintain her identity and makes choices about what she does and does not want to do. *I keep myself busy, do all my own shopping, in the street, in little bits you know. I don't want to carry, the doctor says, don't carry with the hard, heavy things [okay] (201-204).* Using the voice of the doctor seems to be a strategy of legitimacy and distance. Yet, as her account unfolds, her strategy of 'mind over matter' becomes threaded with another strategy of taking things at her own pace. Within these accounts we see both the way that the realities of decline force some type of adjustment, and the way that she accepts some of her limits on her own terms. Clara is still active but can't do the things she used to. Her body has placed limitations on what she can do—it tells her to slow down. Although her body imposes limits, and the doctor legitimates her 'slowing down', Clara's way of negotiating is to chose—instead of saying that she may not be able, she re-frames this as not wanting to do something. In this sense, she does not have to admit to a defeat of the strong coloured woman that she has always been. She talks about her adaptations as a choice. She takes her time, stays as active as possible and insists on her strength. In our interview she has decided to share her lessons with me. She shares with me how 'she knows what to do' and that she has learned not to rush—slow down, don't try to do everything.

> *Going, walking, the doctor ways walk, it's the best exercise..But I can't walk fast, like I used to, that's better, when you walk brisk, but I got to kinda drag myself along when I'm walking....I can't rush myself, 'cause I get angina when I rush, can't rush, can't even run for a bus...[So what does that mean then?] ...You would have a heart attack if you ran, overdid it [okay], oh yeah, for sure. But I know what to do, I know what to do...And I'm surviving...[What do you do?] ..Take my time. I don't rush for nothing. If I get ready to go out, I really don't rush, I can't rush, you know, I gotta be very careful. (230-249)*

> *Yes, I'd go catch the bus but I can't run now. I know that, I see it, it's there right at the stop, I could make it in the days past but now it's there, I'm not running, I get a hurt in here [chest] so, so I have something to tell me to stop. Because it hurts here [okay]. That's the thing, otherwise I would get a heart attack 'cause this thing hurts [okay], you see, so I have to slow. Let it go, there's another one coming [laughs], this is the way, it's the way to live, girl. (265-274)*

Such a story seems helpful to the maintenance of her identity. But what is also evident is the meaning and/or emotional issues that accompany these physical and/or medical changes. At times she admits how difficult these changes are for her.

> *It kills me [okay]. The things that I can't go like I used, you know, and I know I can't, that's another thing I got to get, [taps on head] knock, knock in my head [laughter], so hard, that's a hard thing to do, girl. 'Cause I'm still active like a worm ... (252-277) ...how am I gonna come down, how am I gonna come down off it? [laughter]Yeah, you just can't, you can't, deal with it, it's hard to deal with it. ...It's hard, but you have to live with it, make up your mind, that's the way it is. (284-285)*

Clara's resistance of 'mind over matter' accompanied by her choice to slow down, therefore, becomes both her strategy to negotiate dominant messages, the realities of decline and make her experiences fit with the way she sees herself as a strong woman. As such, her strategies may be seen within the tensions between acceptance and decline. Throughout her narrative it seems that she is coming to accept the changes, yet only on her own terms. As such, Clara may keep her strong identity, yet also adapt new strategies of life. In the end, Clara sums it all up that she is satisfied with her life. She says:

> *Yeah, yeah, it brings you to this point. [yeah] And it's a good place, I'm in a good place now, ready to go up, to the good Lord, ready to go up, oh yeah, for sure, I'm ready to go up. I know I'm sure of that. (1391-1394)*

Clara's strategies of using control ("mind over matter") as resistance and accepting her limits on her own raise questions in relation to services. Resistance as strength and choice however, have implications for Clara within the public system. Her insistence on her strong identity is easily interpreted as managing—her level of risk would be considered a lower priority than someone who admits they need services. Clara's insistence on her strength may therefore, exclude her from services and further, her insistence on her choice and doing things on her own terms may be classified as non-compliance. Considering her strategies of negotiation within Clara's life and in relation to her experiences with racism however, show how they are important pieces of her identity. Asking Clara to relinquish these parts of her identity is really asking her to leave all her strengths at the door in order to receive public services.

Elizabeth's Story: I'll Adapt, Modify and Negotiate- No Sense Getting All Emotional

Elizabeth's story is about making the necessary changes in attitude and living conditions. It is a story about how she defines her needs, how she uses her professional identity and knowledge of the system to negotiate changes in physical mobility, and maintains her independence. Her story is about being in charge and having the resources to do so. Elizabeth takes a very rational approach to meeting her needs—her past experiences of caring for her parents made her aware of the needs associated with physical decline. She understands what resources are available, what changes may be required, and will act or talk in certain ways to meet her needs. Her story focuses on the strategies she uses to adapt to physical changes and how she negotiates both her perceptions of herself and the perceptions of others. In addition to adapting, modifying and negotiating, at times her story slips into smaller stories about the meanings of both the strategies and the changes. She discusses how she had to adjust and/or make changes in her life, and therefore, does not see the point of getting emotional. She is however, bothered by the perception that she is mentally incapable. Elizabeth draws a clear distinction between physical and mental capacities and the importance that decision making ability has at this point in her life.

Her story reveals several examples of the way her knowledge of the system has helped her to successfully negotiate her physical needs. At the same time as her examples highlight her knowledge of the system, they also highlight her willingness to act in particular ways to have her needs met, and the emphasis placed on co-operation and/or compliance. She talks about her strategy with health professionals:

> *Oh, well, you find out who to call and call them and if it doesn't then you try to be as nice to them as possible and don't hope that they will give you an appointment or give you whatever it is you need and, um, uh, my strategy is to try and get doctors well ahead of time so I'm on their list and get doctors that are younger than I am so they'll last me out (308-313a)...My strategy is to find out the first name of the secretary at the*

> *earliest possible moment and try and make myself remembered. (326-328a)*

And with the larger community after her hip replacement surgery:

> *You have to think about getting around in a different way when you're in this situation and every, everything is a project...voting....I called up the political party of my choice and they got me a volunteer driver, I could drive very quickly perfectly well, it was parking that's the problem...so a nice gentleman came, here was I, came right away you know, helped me up the stairs and, uh, so it, it makes a difference (737-750a)*

Her knowledge of the system and professional identity have taught her the importance of the way older women talk about their needs—the way she uses language to make claims and seek access to service. Being on the inside, she knows how to use the labels of service to gain access to service. She uses the concept of the frail old lady card as a way of talking and making claims. For Elizabeth, this way of talking is both a strategy to have her needs met, as well as a humorous way to adjust to and/or accept some of her limitations.

> *Yes, it uh, yes, it's a way in a sense of, uh, well I wouldn't say exactly a way of getting help. It's a way of talking about getting help. I mean I think I get the help anyway, I don't, I don't say I am a frail old lady carry my computer. [laughing] But I, if somebody's offering to carry my computer I might refer to this as playing the frail old lady card. (234-238b)...Well some of this is just getting, you talk about ideas, it makes the ideas more acceptable. I mean, um, it, it's sort of reverse denial, you kind of talk yourself into situations. (244-246b)...Whatever denial is – this is the opposite of it, it's kind of, uh, anticipatory acceptance of a change in one's living conditions. (248-250b)*

Elizabeth's financial resources mean that she is in a privileged position—she is able to make choices in relation to her health services, negotiate physical decline and therefore, adapt to her limitations. She talks about how her financial resources allowed her to explore the options of either modifying her home or relocating, seek private rehabilitation services and be released from the hospital sooner than other people.

> *[Could you have stayed and modified the other home?] I tried to but I couldn't...No I, I actually got the original architect in and asked him what I could do, I mean, any chance of putting in an elevator or anything of that sort and he basically said no (161-165b)... So it just, it just didn't work...So I, but that was the first thing I thought of, I didn't want to move (171-174b)*

> *I think I probably could have got someone from the CLSC to come, well I could have stayed in the Catherine Booth for longer, the normal range of staying in the Catherine Booth after hip replacement is from two to six weeks..I got out in two. But I had to absolutely swear that I would have a physiotherapist, privately, and that there was someone at home to look after me otherwise they would have kept me there longer. (876-883a) Well, the wealth one just makes a difference because, I could go home more quickly from the, um, rehab centre [okay] 'cause I would, could get care at home [okay], whereas other people had to stay longer [okay]. (21-23b)*

In addition to using her resources to adapt to her limitations, she also uses a strategy of control. She admits that she has no control over the physical changes themselves, therefore her strategy is also one of using her attitude to adapt, modify and negotiate. Her illustrations and strategies highlight the forced adjustment that accompanies physical limitations and/or decline *Yes I had to. I mean I am, you know, I can tell that I have to do what I have to do.* (191-192b), as well as the limitations of this approach (i.e., it doesn't always work out that way). Elizabeth does not believe that all changes may be controlled, but that it is important to take control of your attitude and emotions. Consider her discussion about having a positive attitude:

> *Well it sounds pretty Pollyanaish but I suppose to some extent it's a positive outlook [okay]. I've always liked the concept of locus of control, do you regard yourself as being swept along like a leaf on the current of life or do you regard yourself as being somewhat in charge? I've always liked to regard myself as someone in charge. But I suppose, um, you know, it's life, too, I mean your genes and a certain amount of physical health, not that I'm any terribly rugged type but [in relation to health you mean or?], yeah...Uh, well I like to think of myself as someone who's in control. Doesn't always work out that way but I mean, I think it's more an attitude, you sort of start by thinking you can control the problem then discover you can't but at least you tend to start by thinking you can. (113-129a)*

Her readiness to be helped and acceptance of decline however, was not automatic. The following examples highlight the difficulty she has had in making this adjustment, as well as the distinction that she has made between requiring physical assistance and the perception that she may not be mentally competent. Her stories highlight the struggle between controlling her attitude and perception of herself, and the way that she is perceived by others.

> *But when, when this first started to happen, I was a little bit insulted because I didn't really think I was quite ready to be helped. You know, somebody held my elbow, but now I feel I'm ready, physically ready to be helped. I'm not sure I'm mentally ready to be helped. (261-265b)*

> *Yesterday I had a guy, uh, serviceman in working on my newly installed quite fancy video, the new one. And, um, I had carefully explained what I thought was wrong with it and the guy came when I was at a meeting... Apparently he couldn't find anything wrong and he more or less told * that perhaps I didn't really understand...I was proper pissed off by that. It was he who didn't understand...the implication that I am not able to understand is insulting, whereas the implication that I'm not able to carry my computer I can perfectly accept the outcome of that. (260-275b)*

Within the forced realities that accompany physical decline and the implications of being incompetent however, are the tensions between control and adaptation. Although she uses her strategy of control to adjust or adapt, she admits that this is a starting point. Her story includes slippage between the rational acceptance of these changes and the contextual and relative nature of accepting these changes. Her illustration of the rehabilitation equipment contains a hierarchy that draws a distinction between the temporary and permanent, and reveals the meaning associated with long-term decline. Consider her discussion in relation to recovery from hip replacement surgery.

> *You start with, you start with a wheelchair, then a walker, then the crutches, then the cane. The wheelchair was quite fun, I enjoyed the wheelchair. (710-713a)..But the wheelchair is fine because obviously you can't stay in a wheelchair long...then you get to a walker, a walker, of course, they had very nice walkers there with wheels and sort of, things like skies under the front so you can push them...But, uh, all these things are, you know, they're fine when you're in a rehab place but in real life they're not. (721-727a)*

This distinction highlights the tension between the realities of physical changes and the meaning or forced emotional adjustment and perceptions that accompany decline. Although she is aware that she must be prepared to make the necessary adjustments, her story seems to reveal that the permanent adjustments are both necessary and real. She realizes that using equipment such as a cane is a necessary modification—it is an adjustment that will allow her to maintain her independence. It is an aid that will allow her to continue to 'get around' and therefore maintain her professional identity. As such, she uses her strategy of rational control to accept this change. It is clear however, that she would prefer to use the minimal assistance possible in her everyday life. A wheelchair however, would be a difficult adjustment. The same sorts of tensions were evident within her discussion of her move—it was a necessary change.

> *I wouldn't mind going through the rest of my life with a cane, I mean, I'd prefer not to but, um, it, uh, it isn't a big deal ... [it's] a matter of attitude, but is also a matter of how you feel when you do without the cane. (664-666a). Well, I mean, I, I, I, it, it isn't a big bother, using [a] cane is not a major problem. I would prefer not to have to use it but it's a small price to pay for getting around. (672-673a)*
>
> *It's still a home, it's still a home. Well, it wasn't for me. I mean, I, I hated to move house, to leave the house, I liked it but no point getting emotional over that kind of thing. [No?] Lots of things to get emotional over...[But that's not one of them?] No, well I mean you do the best you can to make a comfortable life for yourself. [Okay] Selfish, self-interested process. (209-220a)*

Being informed, knowing how to talk about one's needs, and controlling her attitude however, does not guarantee that her needs will be met in a meaningful manner. Negotiating for her needs means making necessary emotional adjustments. It is not enough to know that the service is available—she must be willing to think differently about her situation. This requires a readiness to be helped. Her narrative however, reveals the tension between being aware that the readiness to be helped will make things easier, and the emotional implications of accepting such help. There are times where she is more ready to be helped than others. Her readiness seems to depend on both the context, the way she is perceived by others as well as the meaning she assigns to the experience. She says *I'm perfectly prepared to ask for rides [okay]. I've gone through most of my life offering rides, I've been a ride provider rather than a ride taker [okay] but I've now switched to being a ride taker (770-773a).* She also talks about how the handicap parking sticker made it easier for her to walk from her car to the office. Although she would prefer to do things on her own, her physical changes have forced her to make necessary adjustments. Her strategy is to take control of her attitude and make the necessary changes for as long as possible.

> *Well, as I said, I think everybody is dependent, it's just that when you get older you become a little more dependent in a slightly different way*

> *[right]. But no, it doesn't bother me [doesn't bother you]. I mean, I would like to be able to do things without depending on other people but if I'm in a situation where I can't, I'm happy to have other people to depend on [mhm], life is sort of fun, in a way. (940-945a)*

> *Yeah, yeah, well I mean we all, everybody's gonna get old, everybody's gonna get unhealthy, it's just a case of when, you know, how long you can keep going before you sort of fall off the edge of a cliff...And, um, the, uh, I, when I was working after the war in the CIL nylon plant, we, uh, uh, we had tests as to when the arm would break. I was in a lab and we were quality control sort of thing...And, um, we would plot, or the machine would plot the tension, you know, the thing would stretch, it had a tension and stretch. And you get to a point and suddenly it would sort of bend over and break...they just count the point at which it broke. But I'm, but every, every piece of nylon thread that you gave the test to, always in the end did bend and break [okay]. And I think this is what life is like. You, you're, we're all of us kind of going off a little bit quite slowly and then ultimately you do, you know, the end comes. But the interesting thing is how long it can keep going before this bad bit at the end happens. (483-513b)*

Despite her acceptance, modifications and negotiations, her stories show how her strategies of being informed and being ready to accept help can only go so far—there are times where other people's perceptions about age and abilities interfere. Despite her knowledge of the system and professional position, there is a tendency for others to perceive older people as mentally incompetent. Her example of the hospital shows how she was not taken seriously and was unable to convince professionals. It exposes the imposed lack of credibility assigned to older women and the potential emotional implications. While discussing how she uses the frail old lady card to negotiate she says that she may have to give this term up as it is 'hitting too close to the bone'. In addition, this example highlights the vulnerability experienced within the hospital, the importance of cognitive abilities, and someone to negotiate on your behalf. Overall, these illustrations reveal the potential connections that are made between having experiences related to physical decline and being perceived as incompetent. Older women therefore, must not only adapt to physical changes, but make meaning in relation to both their identities and self-perceptions as well as the way they are perceived by others.

> *I kept saying ..this wasn't right and my son was there and he wanted me, wanted somebody to phone the doctor at home and get the instructions but I was too chicken for that, and anyway I didn't know the optional number, and the nurses, this is I think part of the business about they don't pay*

> *much attention to the elderly patients, they weren't listening to me. And at seven o'clock, I had a miserable night, seven o'clock in the morning the doctor came in and said of course, that's wrong, she was very cross, she said they just hadn't read her instructions...the nurses there were, say, they just wouldn't believe me when I said I was sure, well I was pretty sure I was supposed to have my knee bent [right]. So that in a way that may be a reflection of the slight tendency not to take an elderly patient seriously. (561-579a)*

Elizabeth is not seeking public services; therefore, the frail identity is not as easily imposed upon her. In this sense, it does not seem to have the same implications for her—her resources allow her to make the necessary modifications and purchase the services required. Elizabeth has a privileged position in relation to resources and information—they permit her to exist outside of public services. As such, her strategies of adapting, modifying and negotiating are more available to older women with resources and/or knowledge of the system. This highlights the potential implications for older women with less available resources and options. At the same time however, her story highlights how despite resources and options, the experiences of physical decline that are commonly associated with frailty are coupled with social meanings and perceptions. In this sense, her resources do not protect her from the forced emotional coping, or the tendency for people to associate physical decline with mental incompetence. Although her strategy of attitude and taking charge means that she is able to maintain her independent identity and use her identity to negotiate for her needs, and her resources give her more choices, she must also negotiate dominant perceptions on a daily basis.

Alice's Story: So that's the Way that I Manage

Alice's story is about the way she adapts and negotiates her health and health services on a daily basis. Alice has several physical health issues (e.g., osteoarthritis, incontinence, fibromyalgia), which impact on the way she lives her life. Her realities of health combined with her limited resources and the state of the public system reveal a difficult situation where most of her time is spent looking after her daily care needs. Alice adapts to these changes by accepting her limitations and trying to keep up with her daily activities. This strategy is best captured by the phrase 'so that's the way I manage' used several times throughout the interview. Managing for Alice, means that she is doing the necessary activities required to take care of her health—she complies with services standards. Although she has a supportive community network, she can not always rely on friends and neighbours—she has lowered her standards to a level of 'getting by'. Alice's narrative incorporates several examples of the social and emotional implications of physical decline.

Alice's story highlights the connections between identity, changes in physical health and the forced emotional adjustment. Her lengthy hospitalisation marked a major turning point in relation to her health—it forced her to adapt to physical changes and made her question her identity. For Alice however, these changes do not only occur on the surface of the body, but are always intricately connected with her emotions. She talks about how her bodies changes mean that she is no longer able to do the things that she could before, and how this means that she lives her life in uncertainty.

> *...I came home the end of January, and ah, it was hard to come home. I said to the nurse, she was a very good nurse, there, just about every night. "I don't know who I am anymore, I'm one person here this is where I live now, for so many months in this ward, people coming and going and I stayed on. I don't know who I am here, but I don't know who I am, I don't know what I can do, or will be able to do... (634-640)*

Prior to hospitalisation, Alice was a caregiver, yet she rarely speaks of the before—she speaks of her bodily changes, limitations and the way that she takes care of herself. Her storyline talks about the way that health has taken over her life and the way that she is forced to adapt. *Oh, it takes over your whole life. It's really weird (895).* It is not only her body that imposes limits however, services also direct her response. Her story however, reveals the tension between the service message of forced adaptation and her reality of not being the same. Alice has been told that it is just a matter of adapting:

> *When the nurse told me, she said it's a question of adapting, but you'll, you'll get used to it, you know. Yeah, that's it, I kept thinking in my mind, I hope one day, I have to adapt, I have to adapt, so if I didn't, if I wasn't comfortable with it, while you see adapt, you know. I have to talk to myself, (846-850)*

It reveals how services focus on the physical adaptations and exclude the emotional process which accompanies these changes. Although Alice tries to adapt, she is critical of the messages. Her discussion of her realities exposes how dealing with these changes means a lot more than simply physically adapting. She talks about the tension between trying to adapt and not being able to do things as before. She says that yes she is adapting, but her body is not the same—she can't do things the way that she used to. Her discussion about adapting highlights how adapting as a physical concept may be unrealistic considering her limitations and the emotional adjustments that accompany these changes.

> *I never can adapt, entirely. Because my body isn't the same. I didn't used to do this. At one time, I could do things, I could go out in the garden, sure I went out with a cane, but I could go out...But ah, now I think twice whether I go or not. You know, I just can't, I just, I go up and down the steps alone but I have to hang on down there, I just can't, I just can't do it the way I used to...It is, well, like I say it's been a peripherous year, but I've learned a lot too, you know. I've had to learn, a lot. (854-866)*
>
> *So, this what I mean, adapting. So you see, you're never quite adapted because I'm not the same as I was before.(895-897)...It is weird, you know... "Have I adapted?" What would the question, adapting all the time and I'm not the same as I was before, so I can't adapt to a full- 100% but I'm evolving, adapting, every, everyday I have to do it this way or that. (992-932)*

Instead of using the word adapting, Alice's strategy is to manage. 'Managing' however, seems to have at least a double sense. In one sense, it refers to the activities that she conducts on a daily basis. It talks about the way she organises her care, schedules her appointments and engages in her everyday routine. These examples contain reflections on the way she must cope with not being able to do things like before (i.e., the difficulties of slowing down). Her story is filled with the things that she does during a day. She discusses how she is slower at doing things than she used to be, and how this means she is not able to do as much in a day. Alice's story highlights the amount of time that she spends trying to be clean and take care of herself. An illustration within her story provides a metaphor for the hard work that Alice does everyday. In her account she moves directly from discussing her busy day to what I have called the hardworking ant metaphor. It seems that Alice could easily be compared to the ant.

> *Well, even I swept the floors, there's a lot of crumbs and things like that. That and then the laundry, you know. And I even saw an ant carrying a crumb across the floor the other day. "You Poor thing, I haven't got the heart to stamp on you. You're working so hard, you know." The bathroom you know, the diapers, and I take out the garbage. It's amazing, and I get the Gazette everyday, but so help me, I don't get a chance to read it half of*

> *the time. I got up early this morning, about six o'clock, I woke up and I might as well get up. If you go back to sleep, you'll over sleep, you know. (566-574)*

Her discussion also highlights the way that responsibilities for care are offloaded onto the client. Many times, her word choice and way of talking is reflective of a stressed worker overwhelmed with responsibilities. Like the case manager, she spends her day organising her appointments and co-ordinating her care. She feels pressured to organise and take care of her needs. Her narrative not only highlights the responsibilities that have been pushed onto the client, but question how a sick or ill client is expected to manage, and at what cost?

> *So, like this morning- all the contacts I had to make and all the things I had to do. It's unbelievable. So, you know. There's garbage, get the garbage. We've got it all organised, so that I don't have to take it out. In a pinch I do go outside. By and large. [So you organise everything?]. Yes, I get co-operation from my neighbours next door. To a certain extent, but you see, they got their own problems, their own health problems. I can't lean on them too much. So anybody that comes, I get, if I can, I get them to do a little. Get them to move something for me or. (75-83)*
>
> *Sometimes the adapted taxi want to come so early before nine o'clock in the morning. And I found that too early to get ready with all the things I have to do. I'm so slow in the morning with my arthritis...And old age, I forget to throw that in as a part of the process. Anyway, even if I get up early, it means I take so much longer to do everything and get organised, I have to be organised, I have to be organised but the body doesn't always want to do what my mind tells it. Right? (16-24)*
>
> *There' s always something coming up. I couldn't do it yesterday, well you know, things like that I can't, I can't do it just any day. So, um, you think you have 5 or 10 minutes, you can do it, but it changes your whole mind, you've got to focus on what you going to do. Priorities, I call it, you know....I forgot what priorities sometimes, well this is important I'll do what I should do. But the other's more important....(554-560)*

In a second sense, her strategy of managing seems to imply that she is doing ok—she is not doing great, but she is getting by. Her strategy of managing seems to have an underlying message of loss and/or perhaps compromise. She realises that she is unable to do things like before—she has accepted this reality, but she admits they have an emotional impact and an impact on the way she lives her daily life. There are tensions however between the way Alice manages and the times when she is not able to manage. At times, the realities of her health and situation seem to get to her. She has many limitations and has difficult adjustments to make. Her strategies help her to get by day by day—she does what she is able to do and takes one day at a time. She uses her strategies to maintain what is important and maintain as much as possible, but her standards are lower than before.

> *I only discovered that a couple of years ago. So I was very heart broken that I couldn't get out in the garden anymore, because you see how nice it looks out that window? [Oh Yah]. And the tree blowing in the breeze. And you see over the other side there's flowers. All spring long. ..but in the spring the daffodils come in, the lilacs, the lilies of the valley, ah, there's one thing after another. You know. They keep coming. And it's very, very nice for me and I hate to give it all up. So they come up every year on their own. But they still need attention. And at the back the rhubarb comes and other things there- herbs and things that I can use. You know. Raspberries all nice raspberries too. So that makes it very interesting for me...anybody that comes, I try to get them to do a little. ...somehow or other we manage to get things looking okay. (207-222)*

She has had to give up many things that were important to her. To get by Alice relies on the kindness of friends, community members and strangers. She is a kind woman who is well liked in her community. Although she has several persons who 'keep an eye on her' and drop-in, there are limits to what she can ask them to do. She often talks about how these people have problems too.

> *So uh, that's the way that I manage and then my neighbour next door, she does shopping for me at the corner. Like once a week. Before she could go to more places, but she has her own health problems with arthritis and walking. And uh, she's the baby around here, she's the youngest one. But you know, even the babies get older soon. The pre-baby boomer you know, she's in her sixties now. And uh, some people are still very active but she's had her health problems. So, that's the way I manage and then somebody else comes in and they're going somewhere else, I ask if they could get some shopping on church avenue. (176-185)*

Her physical limitations and managing her care, mean that Alice is rarely able to get outside. She does not say that she is isolated, but does discuss how she doesn't get the exercise that she needs. She talks about the way she gets grouchy sometimes.

> *I haven't been out of the house, oh it was about once in the past month when I wasn't well...So I was getting a bit cranky, but I could tell that little things were bothering me. I had a lot other irritations in my life too, things and people, you know. A lot of irritations. (69-75)*
>
> *So this keeps me aware to do these things, because the cares of the day take over and you neglect your physiotherapy. I have quite a lot of activity, just walking around, and doing my self-care here in the house, which helps but it's not the specific exercise that I need for certain parts of my body (40-44).*

Her situation means that she lives with a great deal of uncertainty in relation to her health. She lives with the uncertainty of each new condition—she is unsure whether these issues will go away or whether she will have them for the rest of her life. Her strategy of managing therefore, gives her a way to negotiate with herself and others. She does not have to fully accept the changes, but deal with them as they come along, day by day. Despite the difficulties of coping and many uncertainties she maintains her humour and appreciation for the small pleasures in life to get her through.

> *I don't know what will happen again, another time. You never know. Things change so fast sometimes you know, you think you're going to do the same thing all the time and then all of a sudden, bingo, the circumstances change, eh (346-349)*
>
> *So this is it, you just can't make your long-term plans, you know. You live for day by day. And you have to make a certain, you make goals. You don't have any plans. So, you see what I mean when you ask about adapting. You adapt everyday to your circumstances. You can't, because you don't know. [right]. And you're involved with other people all the time... (963-968)*

The frail identity therefore has particular implications for Alice. Her strategy of managing does not actively resist this label of frailty. On the contrary, her strategy of managing seems to accept the way services have pushed the responsibilities onto the client, and accept a lower standard of living. Although the frail identity does not seem to clash with Alice's identity of herself, Alice's compliance and assuming responsibilities consumes her life. She is unable to do things as before and is relatively isolated within her home. It would seem that her health continues to deteriorate as she is not always able to keep up with all of the required activities of self-care as well as co-ordinate her health services. Even the respite that is available for her requires too much of her energy—she is seldom able to participate. Alice talks about herself as at times exhausted, overwhelmed or burnt-out. This language seems similar to the professional language of burnout. As such, Alice's story and the way she negotiates provide an example of the conditions of the services for older persons labelled frail and raises questions about whether the persons these services are targeted for are actually able to negotiate the service conditions. Her story highlights how severe needs must be to get access to care, and even with the access to care, the clients are required to take on much of the responsibility and look after themselves. This highlights the importance of having family members. What is interesting here, however, is that Alice was a caregiver for 13 years before her husband's placement and is now left to care for herself. On another level, her story exposes how the current system fails to acknowledge the emotional needs and adjustments as well as overlooks her various social needs for exercise, socialisation and housing. Although sceptical of the demands placed on her, Alice is generally a compliant client who is trying to adjust. Although she manages and despite all maintains a cheerful disposition, her story raises the question about priorities and the cost of taking care of oneself.

Maizie's Story: Negotiating Perceptions through Community

Maizie's negotiations are a combination of personal and political strategies. Her personal strategy combines motivation, prayer and perseverance, and doing things for others. Her narrative is about doing and helping—her account is filled with her professional and community activities. It is separated by the turning point of her retirement, and moves between her personal experiences and her professional knowledge of making rights-based claims. At times, it is unclear whether she is speaking from her own personal experience or her professional and community experiences with older women. This strategy seems an intentional way of providing lessons, negotiating common perceptions, and maintaining community connections. For example, she doesn't exclude herself from having health issues to minimise the divisions between seniors and/or resist the common perceptions that seniors have health issues.

> *I think we all have health issues....I don't think there's one of us out there without. There's some that may be a little bit more severe than others, and there's some .. it all depends on ...you your self, what you want to do, how you feel. And, um, where you want your retirement to go. Because, I look*

> *at this—I mean, there are other age groups that have these problems too, but you mostly seem to want to associate them with your retired group. (12-19)*

In addition to providing a sense of community, she also seems to be saying it is not the health issue that is the focus, but the way that you deal with it—her strategy is based on motivation. Motivation and attitude are strategies that she both lives by and suggests to others. Maizie was active before and after her retirement. She credits her busy lifestyle as the reason she is still here. She is now retired, but stays active in the community. Here, she starts by talking about herself, she says "I may not feel like getting up". Her narrative then moves this into the way attitude and motivation play a large part in health for others at all stages of life. She combines this motivation with faith and prayer. She emphasises the importance of keeping moving and thanking God. Negotiating common perceptions, she makes clear distinctions that these strategies are not only for seniors, but for people at all ages:

> *So you have to put this business of, now I retire, I can, put this business, now I retire, I've got a lot of things to do that I couldn't do before, and I'm gonna jump into them. Every morning and I don't feel like getting up, I'm gonna pray and I'm gonna start to move and I, I know that lots of people are on medication, some can afford it, some can't, but if you find that you can get along without your medication, than do so. And if you find you have to take whatever, you have to do what you have to do [Right.] But the bottom line is, prayer, faith and perseverance. Because if you don't want to, figure that this is the day that God has given me and I'm gonna use it to the best of my ability to what he'll allow me to do, well then, you're not gonna go anywhere. (24-34)*
>
> *So, that's in a nutshell, I don't think you need anything more, that is basically what I think we have to get up and do whether we are seniors or not, because anytime that you decide, oh no, why me, why me, you're being selfish. Just look at the broad, the broad thing. We're all different. And God made us all for a reason. So don't say, "oh Mrs. So and so, she's older than I am and I don't hear her complain." Forget that. We're not kicking ourselves. Do what you can do, and say, "thank you God." And help who you can help and say "thank you God", and just keep moving. (34-40)*

Motivation and activity is connected with her strategy to do as many things as possible for other people—to create helpful communities. She tries to help people out as much as possible and would encourage others to do the same. Her account is filled with metaphors of action and doing. Being active may mean being involved in organizations, or simply making a phone call to Mrs. so and so down the road. She has had this strategy all of her life and admits that sometimes it takes more motivation than others. Within this strategy she also tries to take some time for herself. She believes that it is also important to do things for yourself—although she is not sure that she is very good at it.

> *So you gotta get up, you gotta put that there, and then you're gonna have to figure, am I being selfish, am I only for myself, no, I'm just somebody ...you know, Mrs. So and so down the road. I think she's a little bit under the weather today, I'll go see her, I'll go see if I can make her a cup of tea. I can go and see if I can keep her company. I'll phone her, I'll phone somebody else, you know. (32-36)*
>
> *Who me? Oh, of course, I always need a break, but I don't know when I can get a break. I've actually needed a break for a long time [but you don't take one] Oh yeah, I do get away...No, no, I do get away. I think that um, even in spite of what I've said, whatever people they do for you or can do for you, you also have to want and do for yourself [yeah]. So therefore, oh yeah, I try to take care of myself. I may not do a good job [yeah]. But...but you can show the initiative and show that you really want to sometimes we get more from people out there....but they see you are trying, well you know she always trying, so I mean, I think we should help her, why don't we just do that, but you know, if you're just sort of...You have to get out of that attitude. (340-355)*

Again, seemingly creating a community helpful to negotiate and resist dominant messages, she places herself in the position of seniors. Although she does not currently have health issues, she uses the category of senior to stake a political claim—to make demands for her rights, needs and services. Her use of the term senior has less to do with commonly accepted notions such as age, health, decline, and more to do with right-based claims. She talks about the way that she and other seniors should be treated with dignity and respect, specifically, the contributions to this country and how she expects that she and other seniors should get what they put in. She highlights how seniors shouldn't have to make compromises or sacrifice their needs.

> *We're not asking for much, just want a little bit of dignity, and that's all. [yeah] You know, we want to be able to have a nice decent meal, want to be able to go out sometimes. You know, socialise, help each other where ever we can, we're not asking alot, we're not asking for much. We want to live decent, in good conditions, you know, not having this run down place and figuring it's the only place we can live. (315-320)*

This is not the only time she talks about making claims. Her career as a nurse provided her with an in-depth understanding of the health care system. She talks about the importance of talking about your needs in a certain way as well as the emphasis that is placed on compliance. Making claims in the health services means that you must make your demands known, always be strong and never be alone—she asserts that being strong and making demands is the only way that your voice will be heard. Not being strong or being ill places you in a bad position in relation to the system.

> *The thing is there's a tight view, um, you don't need services anyway if you don't push the issue, and make sure that they understand that you're entitled to the services. And then, from there, then they want to tell you they can only give you an hour, well then you've got to show them really, what your needs are. And impress on them that these are your needs, and you, you need to have them met, if you are to live with dignity....my main point to them, is that, I need this service, why I need it why I pay into the government, how I want my life to be like, and um, that's it. (165-177)...But you have to insist on telling them you are entitled to that [Yeah]. Because they, that anything they do for you, are what they can better their programs and their agenda, is good for you, but no, you have to tell them. You have to explain to them. (211-214)*
>
> *Well, um, like I said, you have to have faith, and you have to pray, you have to be strong. And then in that case, everything is offered to you, you don't just say "yes, yes, yes" You want the answers. And, if you have never been on welfare or any of these other kinds of plans, and you've always worked, that's where it's difficult, you know. You want what you are entitled to. So you have to be strong. (154-159)*
>
> *...you have to be able to stand up for yourself, or have a relative that'll stand up for you. Because in a lot of these cases, either never be alone, when you are with these people, as to whatever your needs are, or whatever you're trying to find out, because, I'm not saying that people tell lies, but some of them are on the line. You always get something in there that you did not say it. But it you have somebody who is there with you, at least, right, things come back again, so, "oh no, I was there, she didn't say that, or that was not whatever". You know, and they're going to always say "oh you can still do this, you can still do that"' you have to tell them, "I know what I can do, I'll tell you what I can do". And, you know what I need to have. (182-192)*

Talking about your needs in a certain way only goes so far—her years of professional experience have given her an understanding of the system. She highlights several of the gaps in services. She makes connections between health, housing, socialisation and transportation. She highlights how current services do not always meet the needs of the person and exposes how there are gaps in everyday needs (e.g., eyeglasses). Within these services she also highlights and resists the expected compliance with service, the financial costs of these services and the implications for the persons needing care. These realities make it more necessary for seniors to resist and negotiate for their needs.

> *You, you didn't have to, you didn't have to decide if you were on the priority list for care. You know, you work there and everybody gets care, it's like you have a bath today, so everybody has a bath...You don't need one, you know. And I mean, that's okay for people who have grown up and have been deprived of water, or whatever else facilities that would cause you not to have a bath. But when you come from an island, that the ocean and everything is there and you can run in it anytime of the day...To look at me and tell me you had a bath this week so now you get one next week. (91-100)*

> *if you have someone you have to help take care of at the house, the house is not only yours, it has to be tuned to suit what they figure it should be, like now, even if you didn't really need it, there are some gonna say, well this is what is what, and you don't do it, well then you're not going to get any services. And then if you do it, and then you still didn't get to use it up, for whatever reason, it's still theirs—into the plan, or whatever. You've wasted all your money, and that's it. (139-146).*

Maizie is a woman who is respected in her community. Her health status, role in the community and personality position her far outside of the concept of frailty. Her personal strategy combining motivation, prayer and doing things for others are not only a personal way to live her life, but the way that she teaches by example. At the same time, her strategy of mixing personal experiences and political claims creates a sense of community and seems to protect seniors that may not be as active and healthy from negative perceptions. It is as if through her strategy of community that she is able to help seniors out in another way. Her strategic claims of both rights and her way of talking about her own and others needs seem to off-set some of the blame that is commonly associated with older persons. Her emphasis on assisting others to negotiate, and the personal satisfaction that she get from others is best reflected in the following quote. :

> *I mean sometimes you're like on roller-skates, but, when you know what you have done and why you have done it and how many people you've made happy and you've opened somebody else's ideas to the fact that they don't have to always buckle on to somebody else's, you know, and you know, well, disrespect, or whatever you want to call it. And you go home feeling good about it – as though you've tried (368-373)*

Margaret' Story: Since Then I've Been Able to Fight for Everything

Margaret's story is a story of resistance and/or fighting. She is a strong woman who has fought for everything throughout her life. Her narrative is presented as a life review involving the lessons she has learned in the past, and the way she continues to resist in the present. Her strategy began when she was sent off at 14 to be a skivvy, and has continued throughout her life.

> *I had my own clothes, but she wanted me to make me look a little bit grown up, you know...And a hat. I said "I'm not wearing that damn thing." (151-155)...my mother had a, they put a label I could wear on me, that was terrible you know, you come to think of it. They don't do it to me now, I'd poke them right in the eye. (142-144)*
>
> *And they said, "Are you Margaret?" I said yes. And I hated it there. I hated them, I hated it. Oh, I hated it so much. Huh! I'll never forget that. So ever since then I've been able to fight for everything. You know what I mean? Lots of things in my life that I've had to fight for. And I think that's it my darling, that's me. (190-194).*

Her strategy of fighting and running however, was challenged a few years ago by a major accident. Just after the accident, Margaret continued to use her strategy of resistance.

> *You see even after my accident, I could, I got, I persevered and persevered and persevered and I could walk a bit. And all of a sudden, all of a sudden, you know, all of a sudden. It may be the age you see. It may be the age that's taking away the strength you know. I don't know. (339-343)*

She realizes now, that it is difficult for her to continue this strategy. Her story reveals the tensions between resisting and accepting decline on her own terms. Her current stories are framed around the things she is no longer able to do, and the emotional impact that this has on her life. Where, in the past she was always strong and confident, these changes mean that now she is commonly afraid for her safety. In addition to her fear for safety, these changes have also placed constraints on her social life.

Consider the following:

> *Stairs, I, I, can't stand, I can't climb the stairs. No. I used to go around the, on the Metro, with my friends. But really and truly, I find the stairs very difficult to go down, you know. And frightening since the fall, that's the trouble, yeah. Frightening since the fall. It's not easy, dear. Why the hell don't they put elevators on there (377-381).*
>
> *I'm nervous. I'm nervous, going out and I was watching, if there's a man behind me or anything like that, because now I'm helpless, you see. Before I'd bash him, I'd do something. You know, before I had the strength and being a big woman I could really use my foot or something with him you know, but you can't when you're, and they seem to be... (394-399)*

Day by day, Margaret is realising that these disabilities are not going away. Her narrative includes her realities of pain, the forced adjustment and sense of loss that accompany physical changes. *Right, like this is it, it doesn't go away, this is the way things are now, and I have to deal with it* (958-959). For Margaret, these changes challenge both her identity as a strong resistant woman, and the way that she has lived her life. The changes mean that she is no longer able to exercise or socialise like before—she must adjust. She talks about how now she is not even able to do the modified exercises. For Margaret, these changes bring a profound sense of loss. She tries to persevere and/or struggle each day. She hopes that these problems will go away, but is starting to realise that they won't. She wishes that she could just go back to before the accident.

> *But all this has happened since in the four years, so I've had a lot on my mind in four years. And I'm always in pain, always in pain, you see, in my back and my knees, and this elbow gives me a lot of pain too. (208-211)... Well, it's changed badly, because you know, I've, I have not felt healthy since. You know, I haven't felt, I used to, let me tell you, I used to walk three and four miles, a day after my retirement. And I did that every morning after I retired. Every morning. I exercised, I did aerobics up at the uh, 50+ up here. And uh, they were quite quick ones too, they were good ones. (215-223)*
>
> *[talking about modified exercises] But, I used to go to that! Now I can't even go to that. That's too much for me you see. I can't get on the floor because I can't get up. You know. The only way I get on the floor, is I often try to do the exercises by getting sliding down off my bed, not sliding down, but grabbing the bed and getting down on my knees and then I gradually sort of move my bottom and do a few exercises like that. And*

> *then, so what the exercises we get, and now only just movements really. But they do something for you, you know. [Right.] They do something for you. And uh, that's it. I'm so glad I can even do what I'm doing now. But uh, I wish to god, if I could only walk, you know. I can't walk, what I do is I get a lift there. (241-253)*

In this sense, her story is a story of the harsh realities of decline and the way that she is forced to deal with them. Margaret therefore, is currently in a stage of trying to re-negotiate her sense of identity and integrate these changes into her life in a meaningful way. Her struggles seem particularly difficult, as she has insisted on being strong and independent all of her life. Her strategy is to resist this loss in all aspects of her life. She is not ready to give up and emphasises trying everything possible. Seeking alternative therapy has costs that she is willing and able to take on for the moment however, she admits she can only do so for a short period of time.

> *Acupuncture-- And she, uh, she massages you though, from the top of your head down, and while these needles are in you, she, she massages you. And it feels so wonderful, and you think, "Oh, thank God, I might be able to walk when I get, you know, the next day." Of course the next day I was in so much pain, but it was easier the day after, so I don't know if it's going to do something. I'm going to give it a try anyhow. I'll try, you have to try everything, yeah. I've tried everything that I can (266-273)*

The reality of her physical decline and age is compounded by the messages of others. In this sense, Margaret is not only struggling to re-negotiate her own identity and perceptions of self, but is also faced with the perceptions of others. These messages seem to force her to confront reality. Her response however, seems to be disappointment as opposed to her common resistance. It seems that the perceptions of others get to her. For example, despite need, doctors indicate that Margaret is too old to receive a knee replacement.

> *I also ...need...two new knee caps, but they, won't even entertain doing them for me because I'm too old...he said, "You'll be 92," ... in any case, you've got to wait first to get it done. You might have to wait, ah, a year, you know before they'll do it for you, when your date is called. Then he said, "You can't really wait nearly wait two years for one knee, and then what about the other one?" Well, I said, "I'll be 96, so what?"*

> *[Laughing] So, it's a thing they won't do, not any of them, I suppose. It's a shame, but there you are. (757-768). I suppose it would be a different thing... if there was somebody to look after me and you know, there was plenty of money ...these are things you have to put up with. You know, nothing can be done about it. It's uh, thing that happens. (770-774)*

She tries to keep as active as possible, but recognises that she has limits. Margaret is slowly coming to a personal level of acceptance. Yet this acceptance is only under her own conditions. Within her narrative she gives the example of resisting a walker. She begins with a rejection of the walker, but by the end of her story she has accepted the walker on her own terms. The way that the perceptions of others play a role in her negotiation of identity and meaning is clear in the way she talks about the woman in this illustration. Margaret perceptions and/or regulation of the other woman's needs highlight her awareness of the way she will be perceived by others. This means that Isis has to come to an acceptance that she is able to accept and defend. She frames the walker as a device to help her exercise as opposed to equipment because she is unable to walk. This acceptance means that she may maintain her life closest to the way she has always done. Margaret's resistance is key to maintaining the way she sees herself as well as negotiating the messages of others.

> *She said that she thinks that I will have to have a, ah, a walker, eventually have a walker. But I'm not going to have a walker unless I have to have it. [Why is that?] A walker is a walker, you know. [So you don't...]. I use a walking stick. [Okay]. Yeah. I use a walking stick. [You prefer that?] Well, I wouldn't like to go down and use a walker, yes, I'm not that bad, you know what I mean? I, I don't, I walk very quick when I walk. This is funny. I, uh, I can't stand the business of, I just saw a woman today, I even told her, "What the hell have you got that thing for? Look it's not even tall enough for you." She was hunched over it like that, it wasn't, high enough for her to walk properly, you know. And yet, I know she's been to therapy, and I know, she just loves to use the walker, she loves to use it...I don't understand the woman at all. Because according to what they said she wasn't that bad at all, you know, but she, she pretended she was, I suppose. I don't know. [So getting a walker, means that it's too far, it's too bad, you're going to fight the walker?] I'm going to fight the walker until I have to have one. But when I do get one, in fact I might get one, just to have it in case, because when the nice weather comes, if I can walk and sit, I can walker further. Do you understand what I mean? [Oh, I see what you mean.] I can walk, sit, and walk again and sit. That way I can do a little bit more exercise you see. Strengthen my legs as much as I can. But, uh, a proper one with a seat, you know. [Right]. Yeah, you can*

> *get, and they're only about eleven pounds, I think, in uh, in weight, you know. Yeah, so I'll have to get a walker.* (296-331)

The frail identity has major implications in relation to her past and current identity. Being labelled frail is contrary to the way she has lived her life and the way she currently sees herself. Similar to Clara, asking Margaret to be frail is asking her to give up the strengths that have allowed her to negotiate a very hard life. Margaret highlights the connections between physical changes and loss, as well as the implications this has for the way she sees herself and lives her life. Recognising the importance of her strong identity and resistance is key to her meaningful existence. Margaret would likely be classified as non-compliant. Yet, within the context of her life and the way that she uses her resistant identity to negotiate, Margaret resistance is meaningful to her. When given the space to maintain her strong and resistant identity, Margaret comes to her own acceptance—an acceptance that coincides with her past, present and future expectations. To maintain her meaningful identity Margaret will continue to fight—she is not prepared for decline and is not prepared for death.

Martha's Story: The Choices I've Made—I Haven't Made any Sacrifices

Martha's account reviews her major turning points and life lessons. Her story is about the choices she has made to negotiate and adapt to aging. Her personal strategy is about the tension between staying active and slowing down—making the choice to do things differently. It is about accepting her age and adapting her life in a meaningful way. This means that she has not made compromises in the way she sees herself or lives her life. The meaning of her strategy to slow down is best characterised by the statement 'it's a choice—I haven't made any sacrifices'. This strategy is meaningful for her, but also allows her to negotiate the perceptions of others. Her account involves the tension between accepting and resisting age as well as negotiating notions of burden and the realities of decline. She talks about recognising personal limitations, slowing down and the importance of being prepared to ask for help when needed.

Martha's story makes reference to the realities of aging and not feeling as well as before. Her metaphor is that life is like a car—at some point it breaks down. Her strategy is to resist these feeling by motivating herself to stay active. Motivation however, doesn't always come easy. She uses her personal strategy of motivation and activity to resist the realities of aging and passivity or laziness associated with being older.

> *I've lived eighty years, something has to give. Our car broke down, ah, so the body certainly works, and then, but if I know I'm going there, if I'm going to do some work, force myself out of bed and I keep going, then, then everything, your body eases up and you know you have a goal, you've got something to do...So it is the mind and the mind tells you you've gotta get up and you've gotta do and you've gotta go, you do it. And mind is very, very important. Yeah, that is the difference between being well and not being well. You can't stop from having a cold, but you can, you know, you have your headaches and what not and if you keep yourself busy, uh, you're gonna be better, just to go out for a walk, you just cannot sit back, you cannot sit on a rocking chair. (205-220)*

Activity however, has its limits—there are real situations that she has to adapt to. Although she tries to stay as active as possible she listens to her body and has made the choice to slow down. Her choices help her adapt to the realities of aging and changes in a meaningful way. Her narrative highlights the emotional adjustment that accompanies the physical changes, as well as the importance of thinking differently about your situation. Martha discusses the choices that she has made—the way she continues on a "*smaller, slower scale*". Her strategy of choice is also connected however, with taking time to enjoy her life—she realizes the limits of her life "*I know I haven't got that many years ahead of me*" (778-779).

> *You can't imagine it, well, I couldn't imagine it either, couldn't imagine when I was fifty, I couldn't imagine when I was sixty, I felt this would go on forever. I thought I'll work forever [laughs], run for the buses in the winter forever [laughs], I didn't think that there'd come a time when I won't be running for the buses. And our thinking has changed, like, when I was younger I wouldn't take a taxi because, why would I spend that money [right], we need it, today I think differently. Today I think differently, in the winter when I have to do to the doctor, I take a taxi, don't have a car [okay], .. I learned that, listen, I'm not going to hurt myself more, it's cold [mm], so I will do without something. When I was younger I didn't always do without the extra blouse or going out for dinner. Now, it's my comfort so I'll take a taxi and we won't go out for dinner. Because if you can't make a lavish meal, you still won't starve, there's always something to eat, like a sandwich, so this is where self-preservation now comes in. (585-602)*

> *I don't wanna make big dinners anymore, but I am eighty. Okay, so a lot of things is not because I was ill or I am ill, it's just time to slow down. But there's still so many things to enjoy, so, uh, and we have to take advantage 'cause the years go very quickly, go very, very quickly at this stage in life, so, uh, we have to take it in. (422-428)*

Her strategy of adapting is based on her own terms and the way she makes meaning of the event. Although this strategy works for her, she doesn't claim that it will work for everyone. She gives an example about their car being in need of major repairs and her husband's license was in need of renewal. Her husband renewed his licenses and instead of repairing the car they decided that they no longer needed a car. This example highlights the meaning of particular changes such as not driving and how the strategy of choice is an important tool to negotiate the everyday experiences associated with health. She highlights that different people may adjust to illness and decline in different ways—they may make different choices. In Martha's opinion, what is good for one person is not good for another.

> *I just spoke to a friend of mine tonight, and, uh, we were talking about being ill and I said, well the only thing is I'm tired, but I give in, so I lie down in the afternoon [mhm] and, uh, I lie down after dinner if I'm tired so that I can do other things after. But, uh, I don't force myself anymore to do anything, that's, that's a privilege now, that's the bonus of not having to do things, I can do it when I want, if I want [mhm], but I don't allow myself to, to, to be too complacent [mhm, what did she have to say about that]. Well, we're, we're in the same position, no, because ... she's a cancer survivor and, um, so she said well the only thing she sees with me is that I'm, uh, I'm tired [mm]. I say it's true. She, on the other hand, is a runner, she will not give in. She could be tired but she will run and, and she survived her cancer just out of sheer, in Jewish we say chutzpah, okay, it just, she's gonna fight it, and nobody's gonna put her down [mhm], you know, she would take, a, a, she would have her, uh, her radiation and go away on a trip right after that, nothing was gonna stop her. So, that's where the mind comes in..what's good for you, and that's when I made up my mind that I'm not gonna worry what you're gonna tell me, I'm gonna do what I think is good for me. (247-267)*

Accepting and adapting to changes is a conscious strategy that works well for Martha. She makes a clear distinction between choice and sacrifice—she has not made any sacrifices. For her, these choices are part of her strategy to think differently about herself and her situation. This is not a new strategy but one that she has used throughout her life. She talks about the way her priorities have changed.

> *Well, I don't feel it's a sacrifice. I don't feel that anything I do is a sacrifice, 'cause it's not that important, so if you don't go out every week, you go out twice a month, it's not, I'm not sacrificing anything, so, uh, I'm not, it never felt my life in any way was sacrificing. We gave our children an, they have an excellent education, but I don't feel I sacrificed. I worked harder, my husband worked harder, but it wasn't a sacrifice because they didn't ask to come into this world, we brought them in this world, you've gotta do the best you can, and they in turn are doing for their children. But, it's never been a sacrifice. 'Cause I, you choose to do things, when I lived in the attic, and was so miserable, I didn't sacrifice, I could have come home to my parents' home and be very comfortable, but I chose to be there, so that's not sacrifice. So that's why I'm not sacrificing (607-620).*

Where possible, Martha uses her choices to carefully negotiate her perceptions and the perceptions of others. Each example shows a tension between the realities that she is willing to accept (e.g. grey hair) and the realities that she struggles with (e.g., friend with Alzheimer's). Her examples show how she negotiates these realities as well as the accompanying social messages of being older (e.g., burden and/or stigma). She talks about the way that she did not want to tell her family that she was ill for fear of being a burden:

> *[When you were saying you accepted help and you felt weak, how did you, like I look at you today and I wouldn't see that at all]. Well, you wouldn't have seen it when I was sick, you wouldn't have seen it either, the only thing that I did wear, I had to wear a wig for a little while, uh, but, um, I had to accept it first of all, I didn't want to talk about it for awhile, because I didn't want people to feel sorry for me. And then when I finally did tell the family, I had wonderful support and I didn't allow myself to be sorry for myself, I just knew I had to fight it, I had to do just what I was told to do and I did...And, uh, and I think that had a lot to do with me getting better, and now I'm just being monitored. (160-173)*

Her association with youth allows her to feel youthful and avoid decline. One of Martha's strategies to stay active is to associate herself with the energy of youth. Martha keeps active in the community and does not often associate with ill or sick persons. She talks about how difficult it is to deal with mental decline and the reality of Alzheimer's that she sees some of her friends going through. Young people give her the incentive to keep busy. Although she could be with people her own age, she purposely chooses to be involved with youth. Doing so, she does not have to face the emotional issues of older persons who have Alzheimer's and/or severe illness.

> *Well, I'm not, I, I, I'm not involved with these people, I'm not, there are people who are volunteering their, uh, they're there to help you, uh, you know with your problems, with what not, their advisers, I am behind the scenes, I, I can hear what's going on , but I'm not involved and, um, but I see how the people who are on the, in the social action and most of them are older, we're beginning to get young people but most of them are older and they're, they're going they, they want to do, they want to stay alert and, uh, unfortunately for some people, uh, they've got this Alzheimer business and no matter how bright you are or whatever, it hits you, it hits you, so, if you're fortunate and you've escaped that well, then you, by working with younger people it sort of keeps, gives you an incentive to do things. (190-202)*
>
> *...It's hard for an older person to look after another person, [that's more emotionally or...], it's emotional and physical too, physical, too. But most of it is emotional I think... but I cannot, uh, uh, and I haven't got the guts like to go and help somebody, like feeding somebody, uh, friend of ours. My husband cannot go there at all, he goes maybe once a month, he just can't see it, there's another reason, because you put yourself in that, it could be me. And you don't wanna face that [mhm], it could be me....So you don't know what you have facing you [yeah] and you don't wanna face that 'cause that could be your, your future [mm]. So, uh...(566-582).*

Within her strategy to keep active at a slower pace, she talks about the real emotional issues that accompany getting older. She talks about the transition she made toward getting older. Her example about the bus shows the meaning that events may have as well as the relativity of the way she perceives herself and is perceived by others (my mother was an old lady). Although she admits that she was disappointed about getting older, there is also a freedom. Her example of "going grey" highlights the changes of showing her age, the way she accepts these changes and associates them with freedom. It also shows how she uses her choices to negotiate the perceptions of herself and others.

> *We have to protect ourselves from many, many things and, uh, at one time I felt funny when somebody would give me a seat on the bus [okay], if a youngster does it, I don't mind, but when, let's say, somebody your age or even older is worse...Except, now I don't mind, but I say, my God, am I showing that I'm, that I'm elderly? I never wanted to look at it that way, never wanted to look at, hey, somebody should give me a seat [okay] but, uh, at the end of the day I look it...so, uh, um, I have to, I have to accept it,*

> *that's it, and I'm glad to get off my feet [yeah] and, uh, and that's, that's what's happening. So you get this, this disappointment that look, I know my age but people are recognising it now, so I feel a little, I'm not embarrassed, and I'll tell you my age anytime of day, but to be recognised as such, hey, my mother was an old lady but I'm not an old lady [mm], but it's not true. I am an old lady [huh], and, uh, and that's it. (802-816)... Well, it's a disappointment, at first, hey, do I look that old that they have to give me, very polite, it's very polite but it's happening to me, so you're disappointed for a minute and that's it. (823-825)*
>
> *It was a nuisance, it was a nuisance and I was in Florida..and I needed a colour and I hated when it would show and I didn't have a colour with me, and, I said gee, I should, should see what I look like with, she said, perfect time, you're away from home and you wear a hat in the sun, so I did it then, and, uh, I liked it, only one granddaughter didn't like the idea I was gray, but I like it that I'm not beholden to anything, like I don't have to worry in two weeks I've got to go get colour, or three weeks colour, I'm free...See one thing less to be, um, uh, what's that word that I wanna use, uh, regimented. 'Cause it's a, you're regimented ...Oh, yeah, yeah, but, uh, you're regimented [that's it].. I couldn't do it myself, wasn't capable, and if I was sick, I had a cold or what not, I didn't go, then I felt terrible that I was showing ...So this way I just, it's natural ...And, uh, I'm old enough to be gray...I don't know, it's just very, very easy...[laughs] (887-905)*

Combined with making choices is the mental or emotional preparation of asking for help and being ready to accept help. Although she doesn't often share her advice—this is a strategy that she feels has worked well in her personal life.

> *Yeah, yeah. And you must never be afraid of asking for help [yeah]. I'm trying to tell, say, I say I don't like free advice but I give it. [laughs] But I was telling a friend of mine who's very, very independent, but after I went through my session, I said to her, you must, that she will not ask anybody for a lift, they don't have a car and her husband cannot drive anymore, and she will not ask anybody for a lift. I said, how does anybody, how's anybody supposed to know that you need a lift that you do not have a car [yeah], and then you think ill of them, they're not offering, they don't know, they just remember the years that you did drive. They don't go around asking, do you still drive? [right] You've got to ask, you've got to ask for help [mm] And I learned to do that [mhm]. ...But I do accept I do accept it graciously [mhm, mhm], because it gives pleasure to the one who does it, and that's what I learned [right]. Don't be so independent, you have to be independent, a person has to be independent, but, if, if you need help, you ask for it, because it does give pleasure to others to help, know they've done something, so don't hesitate, that's the only free advice that I give. (649-669)*

Martha's strategies of choice and associating with youth keep her outside the concept of frailty. Although she has had an illness experience, she seldom speaks of this. Instead, she speaks of the activities she is involved in and the way that she lives her life. The imposed concept of frailty however, would have major implications for Martha. This imposed concept would mean that Martha is no longer able to make choices in relation to the way she sees herself and negotiates the messages of others. Her story highlights the way that events and experiences take on particular meanings (license, seat on bus, grey hair), the differences in the way people chose to adapt to these changes, the meanings that are associated with them and the importance of choice. Martha's story seems to question both the common perceptions about older people and the strategies of adapting to people's needs that tend to be based on common types of services, as opposed to the individual meanings and choices that they may make in relation to these changes.

Ella's Story:
I've Been Lucky—A Story of Privilege, Acceptance & Life Review

Ella uses her past memories and a strategy of life review to negotiate her current physical decline and loneliness. Her story balances the present with the past—often through a metaphor of luck. She contrasts her lucky times with the unlucky. At the moment, she describes herself as lucky because she has lived so long. Yet at the same time she is unlucky to be the last living member of her friends and family. She tries to do the same things as before, keep busy and tries not to complain, but she has experienced many losses and is often lonely. Her account highlights the shifting nature of identity and experiences, and how these experiences impact on the way she sees herself and lives her everyday life. Her story reviews her past accomplishments, the meaning these have for her and the way that her privileged life experiences allow her to accept her current decline, loss and loneliness. Looking back on her life becomes her strategy for coping with the everyday losses and preparing for death.

Ella has lived a good life—she has had various opportunities and privileges throughout her life. She is grateful for her experiences as an entertainer and teacher. She travelled around the world, has met many interesting people and has learned a lot. Her narrative highlights the key points in her life—she has lived a full life and has had several opportunities that she would not have "missed for the world".

Threading her narrative with the metaphor of being lucky and unlucky, Ella seems to tell a story of balance. Her metaphor of luck reveals the tensions between her past and present life. In her past, she did not experience problems associated with poverty, racial discrimination or poor health. She had a privileged life full of opportunity. This does not mean however, that she was protected from loss. Her metaphor of luck makes a subtle distinction between the positive or privileged aspects of her life such as her fulfilling professional life as a singer and teacher, and relatively good health, and the negative or difficult aspects such as her miscarriages, the loss of her family and friends. These experiences have taught her that she is not able to control the events of life, but must cope and/or accept them. She takes this strategy in relation to her current health. She talks about the way that she is not able to change her current situation—instead of resisting she accepts it, tries to keep busy and tries not to complain.

> *I'm so lucky, you know, that I'm still here. (268)..I have to watch them all go, you know, and be here by myself. God's been good to me. I'm on my two feet [laughs]. (297-298). Well, the only thing that I'm, I'm very happy the good Lord let me live all these years, but I'm so, unhappy about the fact that I'm alone so much. (503-505). And all my contemporaries have passed away, not one is living. I've outlived them all. Life goes on, eh? (598-600).*
>
> *No, I'm unlucky, I had two miscarriages, so unlucky. I love children [oh] but I was unlucky, too, because thirteen years after we were married my husband died. Overnight. Wasn't sick or nothing. Blood clot stopped his heart like that. *** So I've been here all these years by myself. But I kept busy, busy. (256-260)*

Reviewing her past experiences, Ella's story highlights the uncertainty within life as well as how experiences shift over time. It shows the changes she has experienced in many areas of her life, the meanings of these changes, and the way the changes have altered her life. In particular, she has experienced change in relation to income, perceptions of others in relation to race, and health. Although Ella lived a life of privilege—*I just happened to be fortunate, I don't know, I can't tell people, when my father came to Canada he had money, I can't tell you where, how or when (806-808)*, she now lives on restricted income. This restricted income has an impact on the way she experiences certain events—she is now always concerned about the cost of activities and resources, but she doesn't usually share this information. *I have, uh, a lady comes in twice a month and she cleans for me. And it's very reasonable, it's something that they do for senior citizens and it's very reasonable so that I can afford to have her (539-542).*

She also talks about the way that her financial privilege protected her somewhat from negative experiences of racism, yet had implications on the way she was perceived by the coloured community. Although she doesn't often talk about her experiences of financial privilege and the connections with race, her examples show how her social location and identity had a strong impact on her experiences and the way she lived her life. She talks about the way she was perceived by others, as well as her first experience with segregation in the Southern United States:

> *At the time you're talking about, [yeah] the black population in Montreal was very small, the black population in Montreal were, well very...well, a lot of them were poor. A lot of them were comfortable. And my family was very, very comfortably off.... When I went to ---- High I was the only black girl in there....when I went to meetings and things...you know, and I used to get this thing "oh well, you don't know, you don't live here", you know? ...I usually don't discuss the question because it doesn't sound good, you know. But it happened, it happened (782-798).*
>
> *It didn't, colour never bothered me, you know. Well, I shouldn't say never bothered me, 'til I went with the U.S.O. ..down to the Southern States ... And when I got in... Washington, they took us out of one train and... put us in another one, that was my first experience...they segregated down there, yeah. That was something different for me, for us. Of course ... the U.S.O. looked after us for everything we wanted so, you know, we didn't really miss anything. But it was something that I experienced and, of course, when we got back, all of the segregation was thrown out, you know...So I wasn't down there very long...it didn't bother me that much, 'cause I knew the unit I was with, we got everything we wanted, you know, but it must have bothered a lot of people. (827-864)*

This identity and experience shifted however, when she became involved as a teacher in a community school. Her examples highlight how knowing in one context or at one point in time may change both that persons' experience and the way they are perceived by others.

> *So, the only time that I really became very familiar was when I started teaching at the Negro Community Centre and then, I had loads of black friends and I loved my children and they loved me, and they came to my*

> *house and I went to theirs. And, I think I became very popular with them then, but they didn't know me before [right]...(798-803).*

Her narrative also includes the shifting nature of her health and how she has come to accept her changes and make meaning of her life. She is no longer able to do the things she used to do. She has difficulty getting around, and doing the daily activities such as cleaning. This is compounded by minimal resources that do not allow her to continue her life as it was before. She tries to do things as she did before, but her changes mean that she has to do things differently and rely on other people.

> *Well, I look at a lot of television. And, uh, I cook my meals, and um, I was doing my own housework but it got so hard for me..otherwise in my, I go to the grocery store, I take a bus at the corner and it's only four, I go to the grocery store, and then I sit out on the bench and wait for it 'cause it's twenty-five minutes between [oh yeah], so I wait, sit on the, on the bench outside the grocery store and come back home my four blocks. I do that and then maybe once a month or twice a month, ******...comes in and she takes me grocerying and then I get a whole lot of stuff...Yeah, I get, she helped me get toilet paper up that high [right], hand towels and things like that, so that I'd have a good supply for a week or so, so. (538-552)*

She does not seem to be bothered by her physical changes and needing to do things differently. Her story shows how it is not necessarily the decline that is difficult, but the meanings of these changes and the loss associated with this decline. The loss of her license for example, means that she has to rely on other people and is no longer able to socialise as before. These losses mean that her life is altered in major ways. Again in her discussion, she does not attempt to resist these changes, but recognises and accepts them.

> *I don't drive anymore, up until three years ago I had my own car and I was driving, then after my eyesight, was losing my eyesight, I wouldn't take the chance. They didn't have to tell me you can't have the license, I knew. I was noticing how hard it was to drive in the dark. (522-525).*

Although Ella's account makes reference to the emotional and social loses associated with her physical decline, she struggles most with the loss of her family and social network. Her struggle is related more to her outliving others as opposed to coping with decline and disability. *I try hard and I try not to complain because I'm alone. Sometimes I do* (692-693). Her strategy is to accept the loss and loneliness, by balancing them with the privileges that she has had throughout her life. It seems that reviewing and appreciating her past experiences give her the perspective on her present and future.

> *The thing that bothers me most of all is all my very, very good friends have all passed away. One by one I watched them go. We used to call each other every day. Vera my girlfriend used to come here and I'd go back to her place, I watched her mother and father die, and then she and her husband we used to always, she had dinner here, at her place or my place and, we, it was just fun living. She died. Her husband re-married so I don't see him very much. And, every friend I had has passed away. Close friends. And I can't make friends with, well, the new ones are all too young. So it's a lonely life for me (435-444)*

Ella's strategy to negotiate and make meaning of her life is a personal strategy. Although she doesn't see herself as frail, she has accepted the realities of decline and loss that seem to accompany age. In this sense, the concept of frailty doesn't clash with her experiences or situation, however, her strategy of acceptance may mean that she is perceived by others, including service providers as weak and frail. Here her discussion of the shifting nature of experience seems to be especially hard-hitting—the way she was perceived in the past as a professional entertainer would be very different from the way she would currently be perceived. The implications of both the classification of frailty and her strategy of balancing her present life with her past meaningful events, means that Ella's life history of accomplishments and opportunities are overlooked in relation to her current age and health status. Instead of seeing the many experiences and lessons that she has to share, the label of frailty may mean that Ella is seen as weak and compliant in relation to services.

Kumiko's Story: Balancing Optimism with Realities of Taking One Thing at a Time

Kumiko balances activity and a positive outlook with a realistic strategy of taking one thing at a time. She has always been involved with her church and community and maintains these activities today. Her outlook on life has always been to "*make the best of things*". She addresses the uncertainties of life with an optimistic strategy of enjoying good times. She uses a metaphor of travelling to illustrate this way of living. Her strategy implies the reality of difficult times throughout life, as well as the temporary nature of life itself. In addition to her optimism, she emphasises the importance of community, especially in difficult times. She distinguishes herself from seniors according to her age and health status—she doesn't have any heath problems yet. After her retirement she made a conscious choice to take things one thing at a time. This strategy allows Kumiko to both enjoy and make meaning of her present life.

> *We, ah, manage. You do one thing at a time. You're asked to do something, you do it one- but you look at it [and say] "Oh, I gotta do all this!" y'know? This week we gotta do this, this, [and] we do it one at a time, and it gets accomplished. [Okay]. You don't overwhelm yourself with projects. [So that's your strategy: one thing at a time]One thing at a time, that's right. (264-271)*

Throughout her story she discusses the uncertainty of life and takes the optimistic strategy to make the best of things. She uses the metaphor of travelling as a way of understanding life. She talks about the way you may lose luggage, you never know what will happen or the location may not be what you expected. In these circumstances she insists on making the best of it. Life to Kumiko, is similar to travelling—you have to enjoy what you have and except the changes that happen along the way. Her strategy is to enjoy the good times, take responsibility and make the best of it.

> *But, ah, you take one step at a time; if you have to go here, you go there, you enjoy- you don't crab about what- you don't harp about the bad things...You look forward, and make the best of every situation..I think you have to look on the bright side...If you, if you're down, you think, "Well, I can work myself out of this."...So that's what I always think...We go on vacation and we- some people [say], "Oh, I don't like this, I don't like-" Well, enjoy what there is- [Right].Make the best of it!...Don't harp on the bad things...So every vacation, we always say to ourselves, "Look on the bright side."...And we go, we have a very good time..(656-679)*

She admits that life brings difficult experiences that people have to cope or negotiate. In relation to difficult times she relies on community and a strategy of hope. Her examples here include racism of the internment camps for the Japanese after the attack on Pearl Harbour and seniors at the community centre that have health issues. In both examples, being social and having a community are important ways to deal with loss and sadness.

> *No, well, you see, uh, I was born in Victoria, 1928, and then1941 there was the, ah, Pearl Harbour attack, eh? And all the Japanese had to go into camp, so I spent four years in camp. (605-607). ...Uh, we had, ah, only- we had to give up the farm- my father was a farmer- and we all had to go to Hastings Park, which was, ah, a pooling, ah, centre, and then from there we were shipped over to, ah, Ghost towns, and we spent four*

> *years- was it four years?- 'til '47. '46- I think the war finished in '46, and '46- '42 to '46, that's four years that we spent in, ah- (609-614). ...Yep. And then, ah, since we didn't know what to do, we all gathered at the church- we had a Japanese church- (619-620). ...Yeah. But for me, it was fun because I was still young, but for my parents, or my brothers, who were working, I think it was quite traumatic, because, ah, you had no money and, ah, they had to think of "How are we going to live" and, when we came here the wages were very low for our, for the Japanese- they wouldn't hire us at the beginning. (642-647).*

> *He dragged his feet a bit. And then another fellow who had colon cancer and- it's sad, all in our age group. [How do you- how do you deal with that?] Well, we have hope, I guess, and encourage the other people to come to the Centre. That's why I think we go to the Centre, have these nice meals together and talk and "How was your week?" and "What are you doing, what do you look forward to?" and we have activities going on at the Centre for the seniors- or anybody. [I see. So, that's, that's your role, to give what you can.] Yeah, not, ah, not to discourage anybody, just to encourage them to come out, and if they don't have lifts, we pick them up and take them to the Centre...Then we have our church, and we sing in the choir, and- we have fun. (500-515)*

She makes a clear distinction between herself and the seniors. This distinction is mainly about health and age—she is young, independent, does not have any major health problems and therefore does not consider herself a senior. She provides the services—the persons who receive the services are the seniors. That is, she cooks for the centre, she doesn't go there to get a lunch. In this sense, her way of seeing herself and others is connected with notions of independence and dependence. In addition, Kumiko is young—many of the seniors at the centre are 90 or above. Her responses however show how experiencing health and 'being a senior' will arrive in her future. She says that "so far" her health is good and she does "not yet" consider herself a senior.

> *So, together, even though we're not working, we're both retired, we're still keeping ourselves very active. We have no health problems, so that's why I consider myself young! (191-193)... Oh yeah. Well, if you can't move, and you have arthritis or something, you feel your age. (200-201)...But, ah, since we don't have health problems, we're still very active. (203-204) [And, you consider yourself non-frail and not a senior] No, not yet. [So, being a senior to you- I should ask this more clearly- has nothing to do with age?] No, I think it has more to do with frailty and, ah, health problems. Then you would feel old. (430-439).*

Her active lifestyle distinguishes her from being considered frail. Her strategy for her life is to maintain activity, yet at a slower pace—to take things one step or one thing at a time instead of trying to rush to finish everything. Throughout her life she has been involved with volunteering, specifically with the church and the community centre. She talks about the way her and her husband do things together. This helps her to negotiate her everyday:

> *But we go for long walks every day, and ah, we do all our own- we don't have any help to clean or paint or- when we have to paint a room, ah, we do it together. [laughs]...And projects we do together. Well, I mean, he does the heavy work but I'm there to help him if he needs any help... And he helps me inside the house, too, y'know. I do the cooking he does the- washes the dishes. There's co-operation...And ah, we're always together, we go shopping together, church together, community centre together. (439-450)*

Yet, a story to her doctor (something she rarely does) and her retirement was the turning point where she adopted her strategy of slowing down. The doctor said that her blood pressure was too high. She realised that she was taking on too much, and began to place limits on herself. She realizes that she can't do everything and has began to take responsibility. Although she is active and enjoys her activities with the community and the church, she has places some limits on the amount of things she will get involved in.

Kumiko's story exists outside of the frail boundary. She is not someone who would be classified as frail. Her story however, highlights the balance of an optimistic attitude with a reality of taking one thing at a time. She does not deny the realities of aging. She is involved with seniors, and has learned about the reality of decline and illness from her mother and mother in law. Her story incorporates how she has made the best of her situations without losing track of the social networks of community and church that are important to help a person through bad times. She lives with an appreciation of the present. To have a meaningful life, she has decided to balance her strategies of activity and involvement with slowing down. These are strategies that will guide Kumiko in her present and future.

Dorris's Story

Better Get Used to It: Tensions between Resisting and Accepting Uncertainty

Dorris's story negotiates the uncertainty involved with illness and decline. It is a story about the difficult emotional coping and forced adjustment that accompanies physical decline. It is also about the strategy of getting used to the way she is no longer in control. Her story represents a particular location of someone currently negotiating illness and decline—her experience is not yet a past event—she is uncertain whether it is temporary or permanent. Her story is partially located within what Frank (1995) would call the "illness narrative". That is, her story of her life is dominated by the vivid details and emotions associated with her illness experience. The structure of the illness narrative reveals her struggle, the physical and emotional impact of illness, and the way she perceives both herself and is perceived by others. Her narrative tries to accept the physical changes, yet this is a struggle best characterised by the phrase "better get used to it". Her narrative reveals a tension between resisting the required coping and accepting the realities and uncertainty associated with decline.

Dorris's strategy of '*getting used to it*' is used to negotiate both the physical decline and the uncertainty, which accompany many of her experiences. She talks about her hospital illness in the past, yet it is still temporally close—she is not certain what repercussions this serious illness will have on her health. She talks about the difficulties that she had at that time and the way that this has influenced her life. She says*: It'll either go away or I'll have it for the rest of my life I guess, huh, better have to get used to it* (lines 81-82). This influence is also evident in her narrative—in her account, it is as if the illness experience has taken over any other experiences in her life. Her discussions of the past, framed as illness narratives (i.e., *..to go swimming and, um, I did that, you know, even when I was going home for the weekends...but then um, the river became polluted,* lines 102-105) provide contrasts between how she used to be able to do things and now has major limitations. Her discussions of the present involve the changes since the illness—the new ailments that she has developed since the incident. These issues are discussed under a cloud of uncertainty—she is not sure whether they are temporary or whether she will have them forever. Her strategy of getting used to it therefore, reveals the way coping is imposed on her as well as the tensions between resistance and acceptance. On one hand, she resists the messages about coping—she was weak, didn't want to cope and felt that she was dying. On another, despite trying to accept or "get used to the changes", she wasn't ready for these to become permanent issues. In this sense, her strategy of 'getting used to it' seems to protect her from the disappointment of accepting changes—these changes were forced upon her, she did not accept them. Dorris realizes that hoping the signs of decline will go away is not enough—she realizes that they may not.

Dorris's way of making meaning for herself is about trying to regain some control over her life. Her strategy of 'getting used to it' seems to address the feeling of being out of control and uncertainty. This strategy seems intricately connected with her self-perceptions and the way she wishes to be perceived by others. It seems that she avoids others when she is out of control—she is worried about the way that others may see her, and does not want to be considered a burden. She had several people including family, friends and neighbours that would check in on her, but she didn't want to impose. When the services were not what she expected she decided that she would be better if left alone. Consider the examples about being out of control.

> *I had a very healthy garden in my house and they, when they built my house they bulldozed my garden out [laughs] that was very sad, to go by and see all the garden gone, however, uh, they, uh, that was in the past and I had to, to realise that wasn't my house anymore and, uh, they could do what they wanted with that garden [laughs]. (13-20)*

> *I came home on the 19th of December even though it wasn't uh, I knew I wasn't uh well, but I just felt a little so uh, and I had a friend that stayed with me one night and I said I don't need you to stay with me anymore because I didn't want to impose on a friend...(580-586). Diana came and, Diana came for ten days and Kathy came for ten days, and um, I was very sick when they were here and I, had that you know, and when I had that happen I decided I'd rather be alone. (906-910)*

> *I thought I might just as well be alone and so it was bad [unintelligible] I did have to have somebody else come out after that. But all they did was get your meals, get your meal and sit and I didn't feel right sitting, if I was here, that person would just here, I was watching television and they'd sit beside me and I didn't really feel like talking to anyone so I decided I'd just as soon be alone (897-906)*

Getting used to the physical decline and living with uncertainty is emotionally difficult for Dorris. She talks about the things she could no longer do such as going to church, socialising and travelling. Her illness resulted in a social isolation and forced emotional coping.

> *It was one thing that bothered me, you know, I've always been churchgoer and I didn't go to church, but the minister was very good, he came several times and he phoned an um, and um, what else. (925-930)...And in Montreal West we have a travel club, it's like a seniors club, and they have a travel club where they do a lot of things uh, they go out to dinner, I haven't been going you see, because I've been sick and I haven't been able to eat, but now I can go and uh, they have a diner's club, theatre club, (386-393)*

The most difficult part for her seems to be 'not knowing'. In this sense, she uses a strategy of the worst case scenario (i.e., they will not go away). Her strategy highlights how her lack of control over her physical health is accompanied by forced adjustments. Getting used to it, reveals the difficult choice between resisting and accepting. In Dorris's case, it shows that this is not really a choice. Dorris does not really want to accept these conditions—but feels that she is forced to accept them. *Um, it's that way and it really bugs me [mumbles] occasionally I'm on screen but [clears throat] it'll either go away or I'll have it for the rest of my life I guess, huh, better have to get used to.* (79-83) Dorris has come to a tough realisation that she is not invincible—her illness experience has forced her to accept that things can happen and they do. Life doesn't always work out the way it is expected. In this sense, she commonly makes contrasts before and after the illness.

Getting used to it however, was not always a strategy that worked for her. Dorris's illness experience show how during her illness she was unable to negotiate neither her self-perceptions nor the perceptions of others. Dorris was sure that something serious was happening to her body, yet she was not taken seriously. Although they later discovered she had a serious illness, she was told by many that this was in her head and was a result of her grief for her daughter—she was referred to a psychiatrist and prescribed anti-depressants. Dorris was unable to convince the professionals around her that she was ill—instead she was seen as someone who was not recovering well from her knee surgery and no longer had the will to live. Her story emphasises resistance against messages of trying. She was uncertain about what was happening to her. Unable to negotiate the perceptions and messages of others, she would cry out of frustration.

> *I think I was just weak from not eating and having diarrhoea all the time. This is what I tried to tell people, that I'm weak, I'm not uh, I'm, I'm, well, you know, perhaps there was a bit of depression too, because when you're sick and I thought the disease was killing me and I said, I asked both uh, Dr. ..I said is this disease going to kill me and he said no, it's not going to kill you but it's going to take a long time to get better (994-1003)*
>
> *and for some reason or other while I was sick I thought a lot about the daughter that died, ----, and everybody thought that I was mourning over ------ and I said to ----- one day, I'm not, I said I think of ---- a lot naturally I said, even when I'm not sick but I said, I'm really sick, 'cause of everyone kept saying you have to try, you have to try, you just have to put more effort into getting better. And so I was beginning to think there was really something wrong with me because they wouldn't you know, * but I didn't have any energy you know. I would go from the chesterfield, you know, to the bathroom and that, that was it, that was all I could do. And um, they uh, a girl by the name of ----- came in from the CLSC and she was a psychoanalyst, and she used to make me make up stories about places I'd like to go and she put me through these drills, and they helped a lot and uh, you know, imagining things, imagine you're in happier place, happier time and um, because you know, I wasn't getting out, there was no sun, it was actually a terrible winter and uh, for anybody that didn't have an easy time outside [yeah] and um, and um, anyway, when I went to this new doctor on March the 30th he changed everything and just, but the vacamiacin was very expensive, it was uh, it was uh, five hundred dollars for ten days worth of medication and um, [you're only covered a certain percentage right?] yeah, yeah, well I ...didn't care much about the cost at that time. (618-651)*

Her account describes in detail her struggles with frailty (not eating, losing weight, being at-risk, thinking she was dying), self-blame, and emotional difficulties. She talks about how she felt out of control and how this brought her depression. She talks about the way she looked and felt frail.

> *I had a hard time getting across to them, because I would cry but I would cry because I was weak whenever they were here I would start to cry and it seemed to me that some new ailment or some new ache or pain every time Joan came, I'm sure she lost patience with me a few times but uh, but other than that it was all. Now if I can just get rid of this problem with my face everything'll be fine so um, so I start my swimming next week and but um, back to frailty. It's uh, if you have never been that ill before, and you feel, especially when I dropped so much weight you know, that I'd look in*

> *the mirror and my face was hanging down and my, I seemed to be hollow here and, and uh, you, you look frail, I used to look in the mirror and say, my gosh, you are so old and you are so frail [laughs] and my friends used to say that, oh you look so frail. (931-950)*
>
> *The feeling of frailty is, was so foreign to me that um, that I think that's, that's what depressed me too. And then, at one point, the GP, thought maybe it would be a good idea if I would take an antidepressant, I took it for three days and [unintelligible] and I had a terrible time. I just wanted to crawl up these walls and I wanted to go out and I can remember one night about eight o'clock getting my jacket on, 'cause I couldn't, I couldn't stay here, I had to get out, you know, it was the medication making me do that. And I, you know, I stopped at the door and I thought I can't go it's too cold, and besides I can't walk outside, oh. So I said I'm not taking this antidepressant, it's not for me. So I stopped taking it and uh, that was a pretty bad two week, too, now that was really frailty when all I wanted to do was get out of the house and I didn't have the energy to go out and I knew I shouldn't have gone out and I, I don't think I would have got back in if I'd gone out. Now if I'd got down the front steps I don't think I would've got back in. [sigh] anyway, uh... (968-670)*

Diagnosis was a turning point in her story. From here, she was able to get better, convince people that she was actually ill and move beyond this experience with illness. At the time of her illness Dorris was not able to use her strategies—she was weak and not sure what was happening. It was as if she had no strategies left to use. She was weak, frustrated, tired and frail. The messages about her 'not trying hard enough' and having no will stopped with her diagnosis. Although this diagnosis brought relief in this sense, it also brought the uncertainty of not knowing whether she was really better, whether this would come back or she would have problems for the rest of her life.

> *...He didn't tell me, he didn't bat an eye after that, he just sat down and um, wrote the, wrote the prescription then said you know, whatever, whatever the side effects are, you're gonna have to grin and bear it but there were no side effects [mm] and um, yeah, and I was on, then he gave me another medication that I was on, uh, for two months, which helped me a lot too. And I think I'm better now, I hope I'm better anyway ... (661-670)*

The imposed classification of frailty has particular implications for Dorris. She herself uses the term to describe herself during her illness episode. Although she is still struggling with physical decline and adjusting to these issues, she would now consider that she is beyond this experience. Her narrative highlights the illness and uncertainty associated with illness. Classifying Dorris as frail would mean assigning her an identity and experience that she feels is associated with the end of life. During the time that Dorris was ill she was severely at risk and felt that she was dying—she had no strength to eat, get around and was completely isolated. Although Dorris is in need of public services, she is not in the same state that she was in at the time of her illness. Assigning Dorris a frail identity would fail to recognise the severity of her previous illness, and the way that she is attempting to move beyond it—it would be as if she would be placed back into one of the worst moments of her life. Further, her narrative raises questions about the level of responsibility placed on persons who are sick or ill and do not feel like accepting the messages about their efforts nor the realities of their situation.

Annie's Story: Making this Life Count

Annie's story is about how she negotiates and makes meaning of her life. On a personal level her story is about getting to know herself and 'making this life count'. On a more political level it is about challenging the messages about health, informing older women and health prevention. Although she has not had any serious health issues, in the past, Annie has had sorrows and experiences that have caused her to question her purpose and way that she lives her life. Her story is about the way she has changed her perspective and way of living. Her strategy to 'make this life count' is best characterised by her words: Annie's Recipe for Having Fun. She qualifies this statement however, by saying it would be good if you started it earlier. This statement refers both to the way she discovered this strategy late in life as well as the recognition that life is temporary.

In her narrative she makes distinctions between her past and present life—she talks about how she was raised in a traditional family and carried these roles into her own family. These illustrations show the differences between her way of doing things then and the way she would do them now, her perspective on the worlds, the sacrifices she has made as well as how she is coming to understand herself later in life.

> *The men in our family were gods and so that's the background I came from, I remember when I was young ironing my brothers shirt....old, much older brother...he said.... "You've got creases there...if you don't do that better I won't let you do my shirt and do you know what? I tried harder! ... So, I'm telling you this because I think it's relevant to um, the way that I lived my life see, I came to Canada where you don't have such an attitude*

> *as much {mm..] and yet I'm still living this idea that the man is the centre of the house and you do everything to make the time at home for him as peaceful as possible and um, even the idea of the children being quiet when father comes home...(85-96)*

> *I [worked] when everyone was asleep..then, I could go into his office which was ...at one o'clock or two o'clock in the morning and do the work and come home. So, um, it didn't interrupt, uh, like the family routine..um, I did my studies in much the same way which I think is really dumb ...a very dumb thing to do..she laughs...I mean today I would do it very differently...(59-70)*

She now describes herself as free and has recognised how she may put her priorities first. In this sense, her divorce was a major turning point in her life. Annie's strategy is a strategy for enjoying life. She is coming to see who she is, getting got know herself and being true to herself. Part of her personal development began through connecting with other women.

> *..So, I find now I'm sixty-seven, I'm so lucky and I'm , I have such freedom....and, and um....freedom to try different things and , and uh, not feel, I think I used to feel very responsible for people and it was probably even inappropriate [hmhm..] and this whole idea coming back from when you put your priorities....well they're the last ones [hmm]...and um, and....so....on of the, I used to volunteer, um visit shut-ins and used to help out at school a bit, but I never thought of becoming part of a group... it was at the time of the Green Energy Conference, um at that I became more socially active (97-107)*

Annie's narrative includes two major turning points: her divorce and her daughter's death. Her daughter's death made her realise the temporary nature of life, and as a result, make changes in her own life. One of which was to move toward community and creating social networks. These turning points taught her that it is important to be yourself and enjoy life for every moment. She talks about the way that she was socially isolated and talks about the importance of a community and having good friends. She discussed how she was never involved with women's groups until recently and how her involvement changed her experience. Another was to recognise the value of life and make everyday count. This connection seems to imply that her daughter got it right—her daughter knew how to live.

> *In November of 93 she was coming back from the skihill, she had a car accident and she died. [Long silence] So it makes me feel apart from anything else a desire to, um...really make this life count! If, uh, she were not here and I was still here...to appreciate, um....appreciate the beauty and people...and do something about..what am I doing with my own life. (162-168)*

> *Its not that I'm doing the same things as what she was doing and I wasn't an unenergetic person before but I think that, it not [stumbles over words] I have been so concerned about making ends meet, all of those things that I had stopped doing a lot of things I used to do, you know the active things and yeah, yeah. I, the work I was doing, I worked long hours so it didn't leave me much time, um, but um, I, I feel, I feel that, uh, maybe it's a gift she's given, uh...laughter. (197-206)*

> *..That's another thing! I met..I became to know women more then I had in the past. [hhm] and that was, uh...that was exciting for me. Laughter. So, I think to see women um, pursuing their own goals and um, and, feeling strong in what they're doing (118-122)*

She talks about how her good friends helped her to cope through her difficult times, and how having a social network may assist persons who are ill or isolated. She talks about the different kinds of networks, and the importance of having each. Her understanding and suggestion for others is based in her own experience. She uses her example of the way she was socially isolated before her divorce and how her friends were a community of support after her daughter's death.

> *I'm, I'm very fortunate to have friends and I think, um, I think that's crucial, that's crucial to have relationships, to have close relationships and also to have secondary and whatever you call it tertiary. One of the things is with the secondary that's relationship where you belong in a club or something like [right...] uh, I think that's very important, very important type of relationship, uh, because no matter what's going on in your life there could be all kinds of chaotic changes however with that particular group you're going there say if you're going there to play squash..you know, you don't form a very close relationship, but if you do than that becomes a part of your very close relationship but with the others its just squash people and you're friendly and everything and no matter what's going on in your life, that remains the same after you. I think that's very important to have that kind of relationship, 'cause I used to visit people who are so-called shut-ins and I know people now who I see who complain about being bored and lonely and people who are bored and lonely are less active and I think that leads to frailty....(571-589)*

> *And after, after my daughters accident I, I just, I didn't work, I, for months and months. I'd lost all my confidence, I didn't think I could do anything and I feel, I had never had an experience like that before...And, so at that time I think, like I had wonderful friends, that's why I keep saying this, which is very important um, to someone's life [laughter] because if I didn't have to see them, and it didn't matter to them...That was something very very special. Yep, for me, yeah that they were like that. They just seemed to understand how to be and um, I think, um you know not having friends, I think that's how someone gets sick. You know, you have something happen like that and your health goes down, your immune system goes down and you catch colds and pneumonia and things like that. And as you get older, you lose people you love very much, don't you? [yeah] (705-724)*

> *Now I talk about anything that, but at that time I had wonderful friends but I didn't really feel like opening up about those things so it meant that I isolated myself unnecessarily [hmhm] which that's not a good idea, especially when there are wonderful people...community, community to me is very important and uh, and uh....so, now that I'm older.. and, uh, so I hope now I'm getting it right...laughter...I hope that I don't die! I always think, that I always think that , you know, the way it is I keep trying to change and learning and everything and than when you've got it all right, that's when you die! [laughter from Annie] (135-148)*

Part of getting to know herself was also getting to experience and know herself through her body. Her recipe for successful aging is a combination of yoga, salsa and weight training. Although she has hang ups about her age, and admits that she was intimated to become involved in some of these activities, her strategy of making life count helped her to get involved. Through her practice of yoga, salsa and weight training she discovered a quiet power and strength that have given her confidence in her body and in life. These strengths help her to negotiate her everyday life and have assisted her in particular situations such as a car accident. This strategy however, is not only a personal one. Annie is currently involved in teaching women of all ages weight training at her gym. She would like to share her strategy of prevention with older women. She believes that getting to know their bodies and become comfortable will assist them in preventing decline. There is also a component of community that is involved in getting older women involved.

> *So, how am I feeling? I am an older lady and I'm going to go this club. I was mortified, I thought oh my god, now no one is going to ask me to dance, and what will I do then? I'll feel terrible......to have all this*

> *wonderful music and anyways ... they're absolutely wonderful, they don't mind. Everyone wants to learn how to do this. It's the only place where I've seen such concentration on the dance...(519-526). I confess though that I would like to have an older man, partner a dance partner. I still feel they are doing me a favour if they dance me with so I would like to get past that. [okay..] So, I still have some hang-ups about my age [okay] yeah....and, its probably coming from me even though I don't see it. You're not as old as me dear. I'd be foolish not to do it. (543-549)*

> *So, the trainer you have to listen to your muscles you know, you have to isolate those muscles and so in isolating muscles that's what I found, it was like a meditation and so you are getting the power and the strength, the confidence in your body ...whatever you do now, whatever I do, I have a knowledge that I have the power there ,I have the power which I didn't have before and that does a lot for your self-confidence ...but that is the knowledge on how to use your body, how to use what you have so um, uh, I think its wonderful and really I would like to teach it to older woman yes, I'd like to do that and um, I think it's a wonderful for, even people who have um, you know can only use the upper part of their body or the lower part because once you get moving you, you'll be moving those fluids all around your body, your increasing the blood, your circulation improves...It's obviously one of my hobbies, yeah it's like um, it's exhilarating, it gives you this quiet power and that's the strength yeah. (440-463)*

In addition to getting to know herself and teaching women weight training, Annie is also involved in community organisations and activism. She extends her strategies of 'making this life count' into a political strategy. Just as her strategy of yoga, salsa and weight training challenges the current conceptions and expectations for older women, so does her collective action which uses common images of older women as resistance. A frail identity would not in any way apply to Annie at this point in her life—this characterisation is very far from her current reality. As such, she is able to use the image of the little old lady or granny image as resistance. She talks about the success of the group as being the way they play into dominant notions and offer the media a so-called "hook".

> *What , uh, the Grannies do I think, is they like a little hook, its colourful, they're funny, they're um, wild hats, they're a group of old ladies, but they're colourful above all. And so, its something to introduce the, the, sub-subject and because of that I think, um well, if the Raging Grannies are going to be in an event, they get media coverage and so it enables the real message to come across and they'll do a short article on the issue whatever it is and I think that's whatever it is, it's a media thing really. A*

> *little colour and um, however the lyrics [right] ...And I haven't ever seen Raging Grannies trivialised, or made fun. So, people do hear the message and um, what else is about them? These are the comments I get, and more and more, because more people know us um, people...um, people come up and say they're very, they're really pleased that these, we're old women and we're doing this kind of thing and some younger people say " I can't grow, wait 'til I grow up and get old and I'm going to be a raging granny!". [Laughter]. Yes, so we're benign, you know, we're old, you don't have to worry about us, right? You don't think of us as doing any violent action. But we have been thrown out of hotels. (315-325)*
>
> *So, they should be careful because we're not going to give up. [Laughter on both parts]. And, uh...perhaps we're uh, perhaps we're a bit too polite. [How so?] Well, we might be too sweet. I mean the lyrics are very good but uh, perhaps we just need to be a little more um, confrontational yeah...we could try that, yeah...(396-400) Yeah, but we want to give cookies, we want to bake cookies! [yeah] but we want to bake cookies for everyone, we don't want people being killed and uh, oh yeah. [hmm] (405-407)*

Annie's story shows how she was able to get to know herself and make changes as a result of the sorrow in her life. It shows how she has negotiated changes and made meaning of her own life, how she uses these strategies within her everyday life and the way that she extends these personal strategies into establishing community. Her story makes connections between experience and the body—she has located her strength within her body. In addition her involvement with women's groups and activism in relation to globalisation, health care and older women's issues stresses the importance of community and involvement. Her activism seems connected to her strategy of getting it right and making the moments count. Her story about the way she lives her life provides an example of prevention—which could be modified for women who may have certain health limitations. Further, her involvement with activism show how the common images may be flipped into powerful concepts within society. When used as a tool of resistance, the notion of the granny can be a powerful and non-threatening way of challenging social issues. As such, her story challenges many common conceptions: the social devalue of older women, the role of older women as weak and complaint, as well as messages about older women as bodies in decline.

Carrie's Story
Moving from Strength & Resistance to Acceptance & Preparation for Death

Carrie's story is a story of the way she has made meaning of her life and the way she uses these experiences to guide her present life. It is a life review, which discusses how she has used her identity in the past to negotiate the perceptions of others, the messages she has to teach others, and how these experiences have led her to an acceptance of her life and preparation for death. Carrie's story has not always been about acceptance. Many of the lessons within her story are about recognising the strength and/or accomplishments of women and/or providing the needed support. Others are about the way she has negotiated racism, sexism and general life events. Despite her modesty, she is proud to share her accomplishments with me, both as a testimony of how she got to where she is today and as a lesson for a younger woman.

> *They'd go down for a cup of coffee, and so, this first day this girl said to me, girl said to me, "Are you going down for coffee?" I said "No, but if you're going down for one, would you bring me up a cup?" "Oh I thought you were going to, you were going to." On my way home, that night, that first hardware store I went across, I went and bought myself a thermos bottle. And made my own coffee at home. (1181-1187)...When it came up, he said, "well he said it's a woman's work," he said, "I'll let you, you go down to get me a cup of coffee." I said, "Look, I'm getting paid to prepare the work for the operators, if you're too lazy to get it yourself," and by then I'm screaming, "then your wife or your children can." So he said, "I'll have, make you go down." And I said, "Well, you must be God Almighty. 'Cause that's the only one that's going to make you go down for me." (1190-1197)...So they found out they couldn't fight me. (1214)... But you know, um, if you have to, as I said, if you let people get away with something once, they'll do it every time. (1219-1220)... the colour of the skin means a lot. (1258)...Any, anyhow, uh, I've always had to fight my way, the colour of my skin. I had to fight for my children, and so, I even fought for my daughter. So, I'm just, and I'm not afraid to speak up. And to, the principal of the high school that I went to said that I was the sauciest girl. It wasn't that I was so saucy, but they used to pick on us. (1279-1284)*

> *And I said to her, "Are you going to this party?" "I have to ask him." I said, "Are you crazy? You, does he ask you?" But there are some people feel they have, that the husband is still the boss. And, ha, when one time my husband did that thing to me. "Did you ask me?" I said, "Ask you?" I said, "They freed the slaves years ago." But you know, life is what you*

> *make it. Life is what you make it. And if you make yourself a doormat to anybody, they will use you as a, as a doormat. (1170-1177)*

She carries her skills of strength and resistance into her current everyday life. Her story reveals the realities of being more vulnerable than before, but still being able to stand up for her rights. She talks about how does not discuss her private information to protect herself. Further, how her resistance to answer questions is one of her strategies that she uses to protect herself.

> *Like, live alone. And I don't tell my business over the telephone. I had my phone to ring, that what do you do.. some sort of survey. How many's in the family, all that kind of stuff. Then they end up at, at how much is your income?...And I said to one of them, my income is my business and none of yours. And I heard them, * before they hang up. But so many people, and here's another bad thing. We get the family allowance and the old-age pension, now. As soon as they give it right to the bank, there's people, guys there that will follow the people home, there was, peep, like this guy had followed this woman home and choked her, don't know if she died or not. To steal her money. I never, do you know one time, had a couple of pensions that I hadn't cashed that was in the house, my hus- my husband's father in law. But I never, as soon as I get my pension, I never run to the bank. These guys that follow you home, I know where she lives alone. (974-989)...But I know how to protect myself. (992)...And I don't answer questions. I don't even answer questions. I don't even bother opening my door. And I, I have a bolt, because you can pick locks, you can't pick a bolt, I, I have a bolt on my door. (994-996)*

Carrie's story also reveals her respect for hard work and perseverance. There seems to be a parallel between the story of a work colleague and her story. She respects the hard work and determination of her colleague who *when she came to Canada she had $8 in her purse, a sick husband and a baby..*(505-506)...*now she owned her own house...she had it just the way she wanted.* (1120-1122). Carrie never says that she herself has made it—she does not credit herself for her achievements. She says that she came from a poor family, worked hard and bought her own house, and will talk about the way that she was able to achieve things in interdependence with her husband, and the support of others (e.g., friends, colleagues). Consider her account about buying her home. This example highlights how she is strong and determined, but also makes a distinction between the interdependent relationship that she had with her husband, and other women's marriages where the wife was dependent.

> *And .. uh, and I bought a house, and uh, I helped my husband. He always said he would never buy a house. And I said, "I'll buy a house." "Well," he said, "we're going, we, we..." No, he said he wouldn't. Well, I said, "With, or without you, I'm buying a house. So, would you believe it?.. we couldn't, have joint property if you're not married in Quebec...and we were married in Nova Scotia, if you're not married in Quebec you can't buy, a joint property. So my husband said "Your house * better than mine, you put it in your name." Which I did, oh, my husband passed away (1131-1142)*

Several stories of resisting racism and helping others are threaded throughout her account. In her story she tells me how she has learned to be generous and do good things for others. *it doesn't cost anything, to be fair, to smile, it doesn't cost anything, but it's worth a million dollars, but doesn't cost a cent.* (280-281). This lesson is provided through a motto of life which focuses on being good to others because *See, you never know what your world may bring.* (221). She gives examples where women she knew helped each other out in relation to lending money and providing care. In each case, there was a risk involved, but as each person took the risk they found that they later needed assistance. Her stories highlight the interdependence and support she has both given and received from other women. Doing good things for others means that although she may not have close relationships with her neighbours she feels that she could count on them for help. *uh, I like it here, they're nice neighbours, I find I'm not friends with the neighbours and I'm not enemies, there's not a neighbour here that I couldn't go and say I'm in trouble, give me a helping hand* (354-357).

Although Carrie's past stories talk about how she used her identity to negotiate the attitudes and perceptions of others (racism/sexism); her current story is about the lessons she has learned connected with her perception of death. In this sense, her current story is more about the way she makes personal meanings of her experiences. She uses her past experiences to frame the way she sees death. Her perception is that everyone has their time. For her, the Halifax explosion was not her time to die. This is both her way of making meaning of the past, and accepting the uncertainty connected with death. She uses this philosophy to negotiate the uncertainty in relation to death. She gives many examples where it was not her time. Yet, she is prepared for death and lives her current experiences as through they may be her last. She actually started her story with: this may be the last time I go home. *I imagine this will be my last time because I'm sure after that* *the angels will come and get me* (53-54). Carrie's story however, reveals how she is ready for death.

> *So, I always feel, I'm not saying, maybe that I'm right, but that's my point of view. That's my belief. That, we, they say, we're born to live and we're born to die, but I do feel that our days are numbered for us. (863-866)...But, oh, I don't mean that you can stand up and let a car run over you, because it's not your time. But I mean you can be very sick, or you could be in a fire, or you could be something, but oh, uh, you die when your time comes. (876-879)*
>
> *But I, this is how I feel. That when we're born, we're allotted a certain time space, because you'll read there's a plane crash, everybody dies but once. Why didn't that one die? Wasn't his time. And uh, we had, um, in our church, it was a family and their house caught on fire. (826-830)*

Aside from her involvement in the Halifax explosion, Carrie has not had many illness experiences throughout her life—she is in good physical health. Her health places her outside of the concept of frailty, yet the referring worker considered Carrie frail as a result of her beginning memory loss. In this sense, Carrie's position exists outside the category of frailty. For her the implications are not related to physical issues. Her stories about others and her motto about sharing provide her with a past meaningful existence that carries on into the future. These meanings provide her with the sense of who she is today—the way she lives her life today. Within the context of her life, it is clear how Carrie's discussions of death are the results of her life review—they are a peaceful acceptance of her situation. Carries' discussions of death and repetition of meaningful accounts may be viewed by some as morbid or confused. However, when considered within the context of her story and the way she makes meaning of her life through review, her discussions of death and way that she has accepted death seem to reveal the way that services are not prepared to talk about these issues. In this sense, even her acceptance of her life and preparation for death become resistance.

Katherine's Story: This Has to Change—This is Not a Rehearsal

Katherine's story is about how she negotiates and makes meaning of her life. On a personal level, her story is about the way she makes meaning of her current life and circumstances—her story is about trying to motivate herself to make changes in her life.

On a political level, it is about how she uses the notion of the little old lady to resist. Although she has not had any serious health issues, in the past, Katherine admits that she has placed limits on herself. *My frailties are the things I have failed to do (511).* She makes clear distinctions between her past and present life—and although she now describes herself as free, she has a desire to makes changes in relation to certain parts of her life. In particular, she wishes to be less shy. This desire for change is best characterised by her statements "*this has got to, this has to change" (256) and "this is not a rehearsal*" (253). In other words, it seems as if she is saying to herself, this is the real thing—I have to get it right.

Katherine is trying to make changes in her life and find out who she really is—before it is too late. Her major turning points were her divorce and her involvement in the peace movement—both of which seemed to release her from her former life.

> *While I was still in that relationship, I had seen people demonstrating, in New York, you know when that had that huge rally in Central Park, and I thought, boy, I was very much admiring of people that would get out there and, you know, put their feet on the line, and not just talk about it, but really be there. And, uh, but I guess, there was no way I could have done that at that time with this partner I had, who was, say, quite controlling. So after we had broken up, just that same year I think... sitting at my sewing machine, just as, I was doing a lot of dressmaking, designing, and, um, I heard about this, uh, demonstration that was to take place in Montreal. A human chain between the US Consulate and the Soviet Consulate. At the time, I thought well, that sounds wonderful, really, I think that's a terrific thing to do. And then I sort of said to myself, well, 'why aren't you going to be there'? And then I answered, 'well I will be there'! It was the next day. So I went down without knowing anyone there and got into this huge crowd, and we, wind up. Someone had a walkie-talkie and came along and said, 'we've just made the connection', people holding hands between the two points. Um, it was really quite an electric moment, especially for my very first entry, there was a very electric moment. (61-81)*

Although she is more comfortable talking about her political self than her personal self, her narrative shows how the two are intertwined. Her involvement in activism is very personal. She went from being controlled to free. Her activism both developed out of her personal desire for change and is the location where she tries to be less shy. *I often refer to my Raging Granny costume as my protective uniform because it makes me want to, bolder and move. Ready to get out there and [laughter] raise a fuss*

(Katherine, 44-46). She uses her new strategy of seeing life as the main performance to negotiate her personal limits and her shyness. Her involvement therefore is not only about making a change in her own life, but making larger more global changes. However, her narrative includes the tension between hesitating to make the changes and actually making the changes. In the following paragraph she talks about moving to Vancouver to be closer to her two children:

> *It's a little bit of a struggle. Montreal is incredible, city, and it's familiar, and I've never moved farther than a half an hour drive away from my previous home, so I can't manage to stay with the same friends, and keep in touch with the same friends. However, I do have a beginning of a network of friends, uh, in Vancouver... I keep saying, or talking about it for years, so people get fed up hearing it, but say I should do it while I'm still fit and active, so that I can get established, make connections. [Long pause] Haven't done it yet. (296-308)*

A frail identity would not in any way apply to Katherine at this point in her life. Although she admits that she is beginning to "see the dotted line" and may have different views in the future, this characterisation is very far from her current reality.

> *I always refer to my Ohio family ancestors [Okay], having pretty strong constitutions. No, I'm very lucky, very lucky. I don't have arthritis, or, I don't have, anything that holds me back. Although I, last year, when I turned 70 I, I said, I'm beginning to see that little dotted line behind my heels, I suddenly felt not quite so full of energy, it depends. I mean, when I go to conference or a demo, or a summit in Quebec, we were, I could just keep going forever, morning till night, ...because I'm full of adrenaline...but, uh, sometimes I can't keep going as long as I expect to. But very often I'm, sort of, able to go at a better pace than much younger people [laughter]. (483-496)*

Katherine's good health and strong constitution allows her to use the image of the little old lady or granny image as resistance. Her strategies therefore move from the personal to the political. As part of an organisation of older women, she challenges the notion of older women as frail. Using humour and song, she and her granny colleagues negotiate the perceptions of older women as burdensome and fragile.

> *With the Grannies, uh, because we looked so funny and, uh, sound pretty weird, they stop, and sort of look puzzled, long enough to listen, and then are very often, you know, quite on our side and, and encouraging. And, uh, so it, it, uh, keeps us energised. (163-168)*

> *We sang some nice songs. I don't think they knew what on earth to make of us. And then after we did our presentation, went around to each of the commissioners with a cookie tin and all the cookies. [laughter]. Um, so, whatever we do, it's on a very light-hearted level with a little message underneath. (538-542)*

This serves to both challenge messages about older women as well as confront real social issues. In this sense, the image of the little old lady becomes a legitimate position of social critique and activism. The notion of older women as respected, burdensome and fragile becomes a way of being heard. Policy makers, police and media are more likely to view older women in a sympathetic lens. *We are taken quite seriously by the a lot of the media, Quite often the CBC will phone and say, "We're talking on, on a phone-in program today we're talking about such-and-such. Will you call in?"* (183-187). As such, Katherine and her colleagues are able to challenge social messages. Further, their status as 'old ladies' lends safety and legitimacy to other social movements and protests within society (Grenier & Hanley, 2002).

Within and Between the Stories

Older women's experiences exposed the differences between the ways of negotiating and common themes, which were experienced differently. Women in my sample seemed to negotiate in one or a combination of accepting decline and/or death, resisting dominant messages and the equipment such as canes, walkers and wheelchairs, and making general changes in their life. Older women's ways of negotiating shifted between these options—at times they would resist, but at others they would accept the conditions. Older women's positions however, were intricately connected with both their perceptions of themselves and the meaning they associated with the circumstance or equipment. Older women's ways of negotiating were intertwined with the contrast of having and not having choice. Many of the older women in my sample gave examples where they had come to accept something but only on their own terms.

Similar to older women's understandings of frailty, women's negotiations were different within and outside the frail/non-frail binary. Older women without health issues were not required to make the same adjustments in relation to their physical limitations and/or the meaning that they associate with this loss. The strategies used by older women in the frail category seemed to be about adapting and/or resisting. These strategies reflect how health problems bring a forced sense of dealing with it or coping. Illness or decline is in a sense imposed upon older women. Older women are not given choices about the types of illness or decline they will experience, nor the severity or duration. In this sense, older women are forced to 'deal with the card they are dealt' so to speak. Older women who are experiencing illness or decline are thus faced with an uncertainty and finding a strategy to cope. Older women's stories highlight the extent of these changes and how that each change has both practical needs or issues as well as emotional issues associated with the loss. Older women must find a way to integrate these changes into their lives which is both meaningful in relation to the way they have lived their lives in the past, yet also provides them meaning in the present and future. Older women must adapt in one way or another—even if this adapting means resisting.

Women in my sample who did not have current health issues seemed to be making changes, modifications and/or making mental preparations. Although these older women have very different issues, it seems that there is also a reality of aging. All of the older women however, seemed to have a wake-up call experience where they realised that they had to change their lives: Elizabeth had her hip surgery, Martha had her session with cancer, Kumiko her high blood pressure, Annie her daughter's death, and Katherine had her 70th birthday. Although not all of these were related to health, each woman had something that had made her change the way she was currently living her life. This event could be an experience with loss or a close call—older women spoke about how at a certain point they realised they were not invincible. In each case however, the older women realised that they won't live forever.

ACT VII

The Moral of the Stories for Policy, Research, Practice

A conclusion? This dissertation represents both an account in itself, and an account that interacts with several others. In this sense, although story is forced to come to an end—to make the connections of why I have told you what I did, this conclusion is not really a point of finality. Considering the account as rhetorical and performative, it was told for the purposes of making contributions to a field and to obtain a degree. This powerful purpose however, leaves me with both a feeling of uncertainty, guilt and interconnected choices about which path to pursue. Have I done enough with the stories and experiences that I have been told—I have had to leave out so many details and particular ideas that would seem to extend beyond this account. But do they? The women may not say so—instead, they may say that they are all a part of the story that makes them who they are. I remain uncertain whether the woman's accounts contain the complexities that I understood from their stories. At the same time as I am uncertain about my choices, I also wonder how to pull the account together—How can I possibly sum up the story? How may I embark on such a task? Do I focus on what I have learned, the contributions to the field, the challenges of writing such an account, and/or the implications for practice? Just as I was faced with a major challenge in the beginning, I also face this challenge at the end. I will make a compromise which is connected to the way I started the story. I will focus on the tensions between the diverse older women in my study, myself as a researcher, and the policy and services based on binary conceptions of risk. Although I cannot anticipate the way you have interpreted this account in light of your experience, I will share some of the ways that I have made meaning of the account on both personal and professional levels. I will attempt to make the connections between women's local experiences, stories told about them and the meaning this may have for social work practice.

The stories of diverse older women provide personal, theoretical, and practical insights. That is, they inform us as persons, academics and practitioners. Narratives of diverse older women located within and outside the frail/non-frail binary expose the interplay between language, power, diversity and change. Women's stories reveal the complex tensions that exist within and between professional accounts and personal stories. That is, they make known the intricacies that exist between constructions such as frailty, personal and collective stories and experiences, and the underlying perceptions and meanings given to each of these accounts. In doing so, they expose values and underlying assumptions that operate within practices, and therefore raise questions about the current organisation and practices within public home care. Specifically, they make known the different ways that policy, research and women conceptualise frailty, raise questions about the individual medical binary and the way that this binary shapes services, needs and experiences, and the resulting gaps in service.

Hearing women's stories not only exposes the power relations that exist within and between these constructions, but how attention to the local level permits an in-depth understanding of power through experience, meaning making and negotiation. Their stories highlight the importance of identity, the implications of language, the way older women make meaning of their events, and the way their interpretations are key to their negotiations of their life, illness or disability and their needs. As such, the insights and details that emerged from women's accounts also justify the relevance of both a narrative methodology focused on storied accounts and a critical perspective focused on how power operates at a local level. Their stories however, cannot merely be attributed to the purposes of exposing contradictions and justifying a methodological and theoretical approach. They also question our personal and professional practices with diverse older women, allow room for stories previously untold and reveal the spaces between accounts which allow for change.

Exposing the Tensions between Accounts

Diverse older women's accounts expose contradictions that exist between policy accounts and the personal stories that women tell about themselves, as well as the challenges that these tensions and contradictions may pose within policy and practice. Above all, women's narratives about frailty expose how the dominant notion of frailty is based on a binary classification of disability (i.e., frail or not-frail) and the subsequent lower social value assigned to the classification of 'being frail' or having a disability. That is, women's accounts reveal how the policy account is primarily medical, whereas their accounts are more about the connections between medical and social experiences, and therefore may be better characterised as social and/or personal. Their narrative accounts of identity and experience challenge dominant classifications through contextual, temporal and personal experiences of frailty. That is, instead of frailty being a synonym of “breakable”, “fragile” and/or “weakness”, women’s narratives show that experiences of ‘being frail’ depend on the situation, the timing of events, other experiences in their lives, and the resources and supports available to them. Women’s stories expose the importance of context. Particularly potent was the way that women from both within and outside the classification of frailty spoke about health, housing, transportation and income as social components or resources that influenced their experience. Women’s stories about their experiences demonstrate how these four notions have more of an impact on women’s lives than the assigned experience of ‘being frail’. In this sense, the tension and/or contradictions that exist between accounts raise questions about the way the current binary of frail/non-frail shapes public home care service into individually medically-based services as well as the impact that current trends such as standardization and managed care have on meeting women’s needs.

Organisation of Services

Women’s accounts, which expose the contrast between policy, practice accounts, and women’s experiences, question the current organisation and approach of public home care services. Specifically, their complex narratives illustrate how frailty is socially constructed in the interest of both medicine and public services. The binary classification of frailty constructs a treatable problem—a problem located on a physical body. At the same time, frailty is a concept used to classify, prioritize and respond to particular needs deemed acceptable within the current organisation of services. In these senses, frailty is a powerful concept which reflects the medical lens of aging, as well as the larger interests of managing care and restricting public costs—only the most frail are eligible for available services. The interest of restricting eligibility to the most vulnerable therefore, positions older women as bodies at risk, and imposes an individual and medical view of older women in public services. Medical organisation of services means that social experiences and meanings attributed to physical and social experiences are reduced to binary classifications relevant to the provision and receipt of public home care services. Under a system which sees only medical decline and/or functional impairment, older women's experiences are considered only as individual and medical needs—the social experiences and meanings of these experiences remain outside of dominant accounts.

In addition to revealing the way services are organised, women's accounts point to the implications of such priorities. Medical organisation and current notions of managed care (i.e., restricting eligibility) mean that emphasis is placed on medical intervention and acute care. The shift toward acute level care (e.g., Quebec's Policy of Virage Ambulatoire) means that community-residing persons with everyday social needs (e.g., cooking/cleaning, home maintenance, socialisation, and/or transportation) are not eligible for services. Focus on managed care means that only medical needs may be recognised—those outside of these classifications either have to be re-classified or will receive little or no response. Cost restriction also means that even those older women who would be classified as frail are rarely eligible for services—in a sense, diverse older women compete for services—those with less need receive a lower priority and therefore, less care. However, meeting only acute medical needs means that the program does not in fact reach its desired goals of maintaining or improving the situation of community residing individuals, but rather provides medical care in crisis situations. This medical organisation and acute care provision have grave social and personal costs. Failure to recognise and respond to the connections between the medical and social needs seems to create greater risk through unmet needs. Partially meeting older women's needs also raises the possibility that they may be maintained at a poor quality of life. For example, the absence of housing and transportation as social needs identified by the women in this sample mean that a woman who has a physical issue that makes her eligible for care may become isolated within her home. Without the necessary services to allow her to keep her house in good living conditions or to get out for exercise for example, the home may become a location of isolation. Failure to recognise the various connections between needs may mean that the older woman does not actually live within their community but isolated within her home.

Underlying Values & Assumptions within Concepts & Services

Diverse older women's accounts also reveal the role that expectations, values, and assumptions which operate within the classification of frailty and the medical organisation of services play within the current system of public home care. Specific underlying values and assumptions which seem to operate within public home care include compliance, emphasis on risk as opposed to care, and an overall striving for standards and certainty. Current classifications of frailty and the organisation of services mean that older women are expected to play a certain role—that of the passive 'little old lady' who accepts what is given to her and does not 'raise a fuss'. That is, older women are expected to accept the eligibility criteria and follow the requirements of the services offered to them. As older women's stories have indicated, this expectation of compliance is less a problem if you are in a crisis situation where you are likely to receive services or where you know the system and are willing to play the 'frail old lady'. The expectation of compliance however, is problematic for those who have lower level of need, those who do not know the system as well, or those whose identities (e.g., strength and perseverance) clash with notions of passivity and/or compliance. Take for example, the older women who spoke clearly about fighting racism and sexism throughout their lives. How do they reconcile their sense of self when faced with seemingly competitive identities such as a 'strong coloured woman' and passive service recipient? How may a woman be both strong and independent and passive and compliant? Categories such as frailty which are packed with such strict expectations of compliance seem to leave little room for women to receive care on their terms. They seem to leave little room for unique needs, the way that needs may differ according to social location, nor the importance of identity and/or past experiences. At the same time however, diverse older women's accounts demonstrate how women negotiate and/or resist within these small spaces. Women use their identities and strengths to negotiate the values and expectations placed upon them, and as such make meaning of their experiences.

In addition to divergent expectations and experiences, when stories of policy are compared and contrasted to those of diverse older women, there is a clash between the way that older women, policy and service practitioners use the word frailty and talk about needs. These differences in discourse reveal how professionals and service recipients seem to speak different languages and how these differences represent a clash between the underlying values, assumptions and expectations of service providers and women receiving public care. Although at times older women's responses reflected dominant notions of frailty, especially in relation to physical descriptions (e.g., petite and breakable), the meaning and use of frailty and experiences of 'being frail' are very different. In general, policy and service accounts reflect standard and measurable notions of medically-defined risk, while older women's accounts represent complex social experiences inseparable from their identities. While service planners use the concept of frailty to assess risk and target services according to medical criteria, women use it only when asked, in relation to others, to describe a very difficult situation in their life and/or in relation to particular contexts or death. While professionals talk about needs as standard and measurable, women's accounts reveal the complexity of their accounts and the connections with social experiences. The twelve diverse older women's perceptions of frailty best connect with social care notions—their definitions and experiences would foresee that the issues of housing, income, and transportation are considered alongside and interconnected with frailty. As such, these contradictions between the way professionals and older women talk about needs reflect the major tension between social notions of care and managed care that exist within current public home care services.

The divergent discourses of policy and diverse older women's accounts expose the degree to which current home care services contain underlying assumptions of managed care and medically defined risk-based services. This is not to say that there is a clear distinction between social and managed care—policies which guide home care service contain both notions of social care and managed care. However, the contrasts between policy and older women's accounts reveals the extent to which current services are preoccupied with managed care at the expense of social care. Women's accounts contain interconnections with social issues, access and care as emotional work, while policy accounts are more closely aligned with risk-based models of managed care which place emphasis on effectiveness, efficiency and cost-restriction. For example, policy may speak generally about health, but exclude the interconnections that exist between health and social issues such as housing and transportation. Women's accounts in relation to frailty expose how current services are moving farther away from the consideration of varying types of needs into crisis-based or risk-based services accompanied by more standard methods of implementation, which overlook the connections between the physical and the social (e.g., Virage Ambulatoire). Women's accounts provide the opportunity to question taken for granted notions such as frailty and the subsequent organisation of services according to these medically defined classifications of needs. Women's accounts highlight how current conceptualisations of need and the values and assumptions within the accompanying organisation of services represent moves toward standard notions of risk and from more flexible understandings of need.

These contrasts in language, assumptions and underlying values within public home care have implications at a conceptual level, service organisation and care delivery. Despite the service changes as a result of the retreat from the welfare state over the past 10 years, home care policy maintains evidence of social notions of care. Home care maintains an image and an intention of helping people to live at their homes. It could be argued that idealistically and publicly, home care maintains a social value of care. However, looking through the lens of language, the use of frailty provides glimpses of the shift happening within home care at this moment—services are implemented according to risk, persons in need are prioritised according to the severity of their situation, and more priority is being given to post-hospital and crisis-based patients. Values of social care which remain present within the public home care systems compete constantly with notions of managed care such as cost restriction and efficient management of services. These competing tendencies between care and risk create a large gap between the intention of policies and services and the actual implementation of service. Further, despite the development of new provincial and national home care initiatives, the context remains fixed. These policies will be implemented within a context of hospital discharge, residual services and cost restriction. As such, the age-old discrepancy between community care and services based on functional impairment, risk and priority is likely to continue. Despite ongoing intentions of social care, services may not actually meet older women's needs if they are implemented into a context of restriction and management. This failure to integrate complex social and community needs means that the policy is unable to meet its intentions and is therefore, not attaining its stated intention of effectiveness. The twelve diverse older women's accounts raise serious questions about the underlying values and assumptions within care as well as the reliable achievement of policy intentions at the local level. Older women's stories expose policy rhetoric and highlight the need to clarify intentions of policy, provide services consistent with stated intentions, integrate social needs, as well as recognise how including diverse social locations may make policy response more relevant to older women's needs.

These women's accounts expose the contradictions between policy intention and the actual implementation at the service level. At the policy level, home care policy aims to maintain persons at home within their community. At the service implementation level, services are administered according to medical criteria and under the current context of service restriction whereby only the most in-need receive services. Herein is the current contradiction between the policy intentions of meeting the needs of older persons within their homes and responding to those at the greatest risk. On one hand, women's social needs would fit within the ideological notions espoused by home care programs such as Maintien à Domicile (Quebec, 1994). Yet, social components are being neglected within the current system. Providing services to only those with the highest level of needs means that persons who would require maintenance level supports would not be eligible for services until crisis. Frailty therefore, as an individualistic and medical notion is best connected with the service level based on high level of need or risk. Yet, even those that meet these medical criteria are not considered to have a high enough priority. If the outcome of policy is based only on physical location, then it is possible that it achieves its aim of maintaining people at home for as long as possible. However, if social notions such as isolation and quality of life are included, it would seem that the policy does not attain its goals. Within the current system, women become isolated and confined to their homes as a result of their individual medical and physical issues. If the intention is to provide only medically defined and risk-based services, this should be stated clearly at the policy level. Current contradictions mean that there are significant gaps in service—especially where women's social needs do not correspond with recognised medical definitions and priorities based on severe risk-based criteria.

These contradictions between risk and social care call into question the current priorities placed on financial resources and call for a shift back to social notions of care.

Provision of care is expensive—yet, this debate within home care should move beyond the financial cost into the social or moral reasons for providing such services. Balance should be struck between the professional classifications necessary to provide services and the social value of caring for older persons. Effectiveness of services should not only focus on the cost of the service, but the policy ability to meet its intentions and the extent to which policy meets older women's needs and provides them with an acceptable quality of life. Services that older women may actually use—those that meet their actual needs—may be more effective in crisis prevention and enabling the best quality of life. Medical intervention and medicine are expensive and currently consume a large portion of the health care budget (Armstrong, 2002). Rethinking priorities may create a system, which is more effective. In general however, policies and services must be explicit about their intentions—do they intend to provide services that help people to stay at home within their community or risk-based services for those most in need. To address this, I would advocate for what Armstrong (2002) has called a return to the social models of care. In a social model of care, older women's social needs may be recognised and their actual needs may be considered as opposed to those that are related to disability and decline only. That is, policy and service accounts would be able to reach beyond notions of frailty and medically-defined risk and into the interconnections between varying social locations, social needs such as housing and transportation, and the life experiences of diverse older women. A social model of care would take into account the social and preventative types of services which would permit women to live at home and in their communities in the ways which are meaningful to them.

In addition, women's accounts illustrate the extent to which current classifications and organisations of services contain embedded assumptions of standardisation and certainty. It is not that the women in my sample spoke directly about certainty or standard methods of service provisions. Rather, diverse older women's stories packed with discussions of uncertainty revealed the various ways that similar events could be lived differently. These stories provide stark contrasts to the clear-cut binary classification of frailty which play a key role in the conceptualisation of need and is therefore a key example of a standard objective measure which classifies truth (i.e. frail or not frail). Their accounts reveal the level to which current policy and practices strive for certainty—

certainty in organisation, implementation and results. This struggle for certainty is best reflected in the standardized instruments being implemented into current services. The stories of the older women I spoke with directly challenge the certainty within the standard conceptions of frailty and reveal that the social experience of aging is far from certain. Their stories went beyond information that could be collected by standard forms. Older women's responses, illustrations and stories show that frailty seems to depend on context, shifts throughout time and is relative to death. Their accounts show the variability within frailty, and how it is not possible to standardise across accounts—each woman lives, understands and experiences her life differently. They show how frailty involves the combination of social components and emotional adjustments. As such, older women's stories provide strong messages about the need to relinquish certainty within the medical organisation of services and move toward a service delivery approach which recognises and accounts for complexity and variation within and between accounts.

Listening to the narratives of twelve diverse older women reveals how women address, negotiate and/or resist the values, assumptions and expectations within classifications such as frailty and the organisation of services. Clearly, classifications which create such expectations of compliance and represent moves toward standardization and certainty should be questioned on a larger level. At the same time however, by listening to the stories which exist within these classifications, a space of resistance and negotiation is revealed. In this sense, the stories of diverse older women allow us to witness how older women negotiate and make their experiences relevant to the way they see themselves and interact with the powerful constructions within service on a daily basis. Accounts told by and about diverse older women show us how older women refuse to accept the labels, define their experiences differently, or may use such strategies such as 'playing the frail old lady card' to exert strength, control and choice. Their accounts are vivid examples of the clash between expectations, taken for granted assumptions, and the way that women lead their daily lives.

Service Priorities: Balancing Common Needs & Diverse Locations

The tensions within and between policy and women's accounts reveal the types of unmet needs that exist and provide insight into the commonalities and differences that may inform policy and service decisions. The accounts of diverse older women who have experienced illness or physical disabilities exposed the types of needs not being met by policies and services (i.e., the services gaps). Specifically, diverse older women's unmet housing needs seem to exist in relation to home maintenance and repair, advocacy for tenant rights, and home modification to accommodate physical needs (i.e., disability). Older women's unmet transportation needs seem to exist in relation to available, reliable and safe methods of transportation. These needs surfaced most often for older women with disabilities and/or illness. The unmet needs were discussed as difficulties or challenges and would resurface often throughout the interview. Although the women I spoke with would not say "I could use transportation", they spoke about how they were no longer able to drive, could not afford a taxi, or the difficulties with taking the bus. Various stories revealed how the existing services were not appropriate for their needs. Interesting however, was the way that these issues of housing, transportation, and resources crossed various situations regardless of being classified as frail or not. The differences between stories therefore, were not the main elements, but the way that women were able to have their needs met in a way that was consistent with the way they see themselves (e.g., their identity) and the resources they perceived available (e.g., children). The contrast between the common issues of need (i.e., housing, transportation, and income/access) and the different experiences of the frail and non-frail, therefore highlight the implications of service priorities based on risk as opposed to care.

In this sense, the stories of older women with disabilities or illness highlight how women classified as frail have more unmet needs within the current system. As much as this finding could be simply due to the fact that women who are determined eligible within the current system have greater needs, it also highlights the realities for a group of older women who have experienced illness or disability. Their stories highlight how having their needs met could drastically alter a situation, as well as how not having their needs met has an impact on their daily lives. Continuing with the same example, older women discussed the implications of their unmet needs. For some, this lack of transportation meant that they would have to rely on services that were not safe, did not meet their needs, or that they would stay at home. The implications of not having proper transportation highlight situations, which place the woman at greater risk. For example, the woman may fall on the bus, or be socially isolated at home. Gaps within these types of services exist within both the public and private system. Some services may exist in relation to these needs, yet for many older women this may be a question of having the resources to purchase services or knowledge of the system. Stories about older women's unmet needs therefore, question the effectiveness of the current risk-based model and suggest a return to social model based on common needs of health, housing and transportation and the way these may be experienced differently based on social location.

The common elements between women's stories highlight the need to strike a balance between similarities and differences within services. On one hand, there were striking similarities between the stories. All twelve women's stories included common themes of housing, transportation, health and income or access. These common connections that transcend, yet influence the boundaries of health, highlight the potential for an alternative way of targeting services. As opposed to common focus on individual and medical or physical decline, housing transportation and income or access provide common social grounds for organising services. Diverse older women's needs may begin with a health issue but become more or less complex or difficult depending on their situation and resources. Commonalities between older women's local accounts could therefore unite services decisions and/or areas for service development. By doing so, services which connect experiences of health, housing, transportation and income better reflect way older women speak about their needs as social as opposed to the approach focused only on their physical needs. Building on women's discussions, it would seem that a starting point would be to recognise the social aspects such as housing and transportation that are interconnected with health. This would mean that it would not merely be the physical or medical issue as the identified problem and target for intervention, but the way that the health issue interferes with social aspects and the ability of the woman to conduct her daily activities and live her life in a meaningful way.

Yet at the same time as having overarching commonalities, the diverse older women's stories revealed how the common experiences and unmet needs were experienced differently depending on social location, identity and past life events. Older women's accounts demonstrate how diversity and difference may change needs, experiences and therefore the receipt of services. Although these commonalities reflect grounds for an alternative social organisation of services, they also highlight how policies and services should be flexible enough to incorporate difference. The common needs, experienced differently, highlight the potential for strategic claims-making as well as the need to recognise and incorporate diversity and difference into policy and practice. Diverse needs highlight how 'recognised needs' or service packages may not be suitable for older women's needs. The best example here is that needs for adaptation and cleaning are recognised, yet 'getting around' (i.e., transportation) and 'getting out of the house' (i.e., socialising) are not. Services which reach beyond the scope of available services or are slightly different from what is recognised are not available. Woman's accounts call for recognising diversity and lived experience that exist between accounts. In this sense, older women's stories highlight the need for a balance between the "thin" and "thick" needs (Drover & Kerans, 1995). That is, women have both needs common to their status as older women, as well as within group differences which depend on their social location. Diverse older women should be able to have their needs met without having to sacrifice their identities. Policies and services may explore how to build flexibility into their assessment and implementation at the service level so that they may more appropriately respond to common social experiences and the different ways that a woman may experiences her social needs.

Turning back to the actual approach within public home care, it is as if the focus needs to shift more toward the unique situations and special circumstances of each case as opposed to focus on the standard, objective response. Reason for referral within home care is most always about physical limitations and cases seem to receive similar types of treatment—those which have been recognised by the system (e.g., adaptations within the home, assessments, nursing care). This is not to deny the common physical needs that exist however, the twelve diverse older women in this sample have demonstrated how there are similar types of needs which may be experienced differently as well as needs that are not currently recognised by the system. Instead of focusing merely on the identified components within standard tools (e.g., activities of daily living), assessments should focus on the ways these activities connect with the social experiences and personal meanings within diverse older woman's lives. Focusing on some of the complexities within each case is not a new approach. Instead it represents a holistic and more open-ended approach to assessing needs and providing services. In a sense, it is a suggestion to move back to an approach where home assessments included narratives, case histories and self-interpreted needs. That is, a return to more general assessments focused on the way the client defines their needs as opposed to a standard assessment of physical functions and competitive risk-based services matched with interventions of recognised services. Although older women may have similar medical diagnosis and physical limitations, their needs and experiences of these events will depend on their situation (e.g., housing) and resources (e.g., ability to make the necessary adaptations or modifications). In this sense, it is both the connections of the physical and the social, and the diversities that exist within and between cases, which will allow services to be more relevant and therefore more effective for the client. A system based on common social experiences, lived differently would seem to better respond to older women's actual needs.

At this moment I have to jump in and interrupt once again—it seems that I am taking us down a path that makes great statements about the relevance of these twelve interviews. Of course, the sample was small and was intended not to generalise, but to explore. Sure, older women's stories and experiences about frailty and their lives expose tensions and raise many questions about the values and underlying assumptions within home care, the medical organisation of services, the ideological contradiction between risk and social based care and highlighted a potential to re-organise services, but their accounts and the lessons learned were not this straight-forward. Their accounts were complex, performative and layered. At one level, women's stories were an interactive lesson—learning by doing, so to speak. The interview performance and the dialogue between us was filled with lessons and reflections for future research, policy, practice. At another level, it was filled with lessons for a young woman. In this case, I have to ask myself: What have I learned from their accounts? To this, I would respond that listening *to older women's local accounts was like peering through one spot that I wiped away from the steamy window of home care. Similar to Twigg's (1997) study where the bath was the way to understand community care and the response to the body (Twigg, 1997), older women's stories from within and outside the frail/non-frail binary was the location or lens into experiences in relation to home care, lessons about women and about myself.*

Lessons Learned from Women's Stories

Lessons about Myself

Looking back at the project, I feel that I have learned not only about older women, but have learned a great deal about myself. I remember a quote that I stumbled upon from Eleanor Roosevelt. It said: "Autobiographies are...only useful as the lives you read about and analyse may suggest to you something that you may find useful in your own journey through life" (Roosevelt, 1937). Her statement could easily be applied to narrative research and my case of hearing the stories of older women in relation to frailty. I cannot deny that I have learned about diverse older women's perceptions and experiences—yet I feel that in the process I have learned about my own perceptions and experiences. Overall, diverse older women taught me to listen—to listen to the insights they have gained over the years, to the meanings that they have made for themselves, and the way they have used their knowledge and identities to negotiate the way they are perceived by others. In these lessons I saw parallels between what I was trying to become and what they had become. Just as older women negotiated their lives in certain ways, so do I as a result of the lessons they taught me. These twelve older women's stories forced me to re-view, re-think and re-negotiate my life.

While writing about women's resistance, I realised that it was much easier to write about resistance and negotiation than acceptance. Women's accounts made me realise that I had underlying values and expectations that preferred to see people resist, fight and make changes—I less preferred to see women accepting difficult situations. It didn't take me long to admit that until now I preferred to live my life as resistance. The twelve women I interviewed made me see not only how this was not always the case in my own life, but challenged my views. I respected each woman that I met and could see the strengths and resilience in each situation—my expectations of resistance were at times in *contrast with the way they lived their lives. Did my preference for resistance mean that I could not accept the way that they had chosen to make meaning of their lives—was I imposing the expectations of my story upon them? Their stories forced me to confront the discrepancies between my accounts and their accounts. Women's stories about their lives in relation to frailty showed me how although I prefer to fight what I feel are injustices or illness for example, I also realise that I have to accept my limitations and certain conditions. This does not mean that I am a fatalist, but that I have a recognition that some things are beyond my control. This is where I feel that despite our very different experiences, there are parallels and differences in experiences between myself as a young researcher and the diverse older women I interviewed. Thinking about it now, I wonder what stories I would have to tell about my life. What strategies do I take, what metaphors do I use? How did I negotiate my life? Although this is not usually the way things go, it only seems fair. I have taken their stories, reacted, interpreted and presented them to you. Again, I am faced with a power imbalance that my not be resolved. It is not common for the powerful voice to turn back on itself. I suppose I am still only doing so in a limited way—a real answer would be to have each woman interview me and summarises my life in a paragraph with a section on how I understand my life, the way others see me, and the way that I negotiate both of these.*

In this sense I can say that the older women's stories have altered the way I perceive myself and others in the world—they have changed me. I have learned that I can not always be so strong, and it is this lesson that has made me stronger. I have learned that resistance is an important part of how I have arrived where I am today—but I also realise that sometimes I am tired. I realise that I have often chosen the difficult or political choice—I have chosen the one with the largest stakes but also the greatest consequences. Each woman told me a story about herself, but in doing so was sharing the lessons that she had learned over a lifetime. Within each woman's stories are examples of support, encouragement and challenge. Over the years, their lessons have sent me into repeated existential crisis and caused me to question the priorities and way of living my life. Although I had thought that resisting and pursuing all were the way to live, after my interviews, I am no longer so sure. I have learned to live and appreciate uncertainty. Although I was already changed by my past illness experience, the older women taught *me about the instability of health and uncertainty of life—I could say now that I am caught within another turning point, and can not be sure which direction I will resurface. The older women have shown me the importance of maintaining connections while they are still available, how I can seek out the support of others with out compromising my values, and to live each day appreciating the small things. The largest change however, is that the twelve older women who have shared their stories with me have taught me the value of acceptance and creating meaning for yourself.*

But what about the older women? What did they get from the interview? Frank (1995) would say that "storytelling is for another just as much as it is for oneself" (p.19). I suppose that my narrative interruptions are just that—my chance to expand the way the current story is told—insert my perceptions and feelings into an account which at times seems too fixed, too rigid, the illusion of being too true. Following Frank's statement, I would anticipate that being interviewed gave older women a chance to tell their stories, but also to tell their stories in a way that was meaningful to them—a story that would allow them not necessarily to portray things as how they are, but in the way that they see themselves. That is, older women were given the chance to be recognised for their strategies and ways that they have lived their lives. Telling their accounts would allow them to step out of the category of 'older woman' frail or not, into who they feel that they are. In the words of Elizabeth "I feel that anybody can be young...but it takes a certain amount of stamina to get to be old" (lines 109-110). At the least, they had the chance to share their lessons with a younger woman—to teach me how things are—to try and prevent some of the difficulties they experienced through their lives. Take for example, Annie's recipe for having fun—and it would be good if started it earlier! (lines 495-496).

Professional Lessons

Older women's storied accounts teach us about the relevance of a method focused on an in-depth exploration of older women's narratives and lived experiences. That is, they provide an example of how to interview diverse older women. Although policy studies are commonly conducted using statistical or economical approaches with large number of people in order to make generalisations, this in-depth approach with twelve women provides an alternative way of conducting policy studies, which is more relevant to older women's experiences. Gender is a major policy issue, especially for older women (Opie, 1994) – a feminist local analysis of older women within and outside of the binary classifications of home care helps therefore, to understand the micro or lived experiences of the macro policies. Incorporating principles, such as the voice of the researcher and social context, narrative is one example of a feminist methodology used to understand older women's lives (Neysmith, 1995). Local accounts such as the ones provided by the twelve women in this study show how such in-depth accounts have relevance for policy understandings, research projects and social work practice. Admittedly however, narrative is better suited to those individuals who prefer to talk about their experiences in-depth. Some older women were less comfortable with this approach and were more used to a standard questions answer type interview.

Narrative allows older women to perform their accounts in a way that is meaningful to their past experiences and identity. As a method, narrative permits older women to talk about their stories and experiences in a natural way. Older women were able to choose their starting points, and structure their stories in the way that was most meaningful to them. This challenges the traditional research format which is guided by the research/expert. Moving away from structured questions designed by the researcher, a narrative method is an honest attempt to listen to older women's voices and experiences. The space created through critical methods such as narrative, emphasise the relevance of such an approach within social work. Although this space is sometimes criticised as not being enough, considering older women's discussions of the concept of frailty and their needs, the importance of this space cannot be overlooked. There is strength and meaning in allowing someone to tell their story. In addition to making space for participant-directed content, narrative also helps to contextualize the responses and show how experiences and meanings are fluid, shifting and overlapping. This approach therefore allows for the discovery of complex patterns of interactions that would not be possible in a more formal researcher developed interview. However, at the same time breaking down the power between researcher and participant is somewhat deceiving as I discovered that the narrative method did not eliminate my power but created dilemmas and tensions related to my power as a researcher and how I could actually write a reflexive account about women's lives, especially when they are written by a young woman for the purposes of a degree.

Using qualitative research to explore issues at the local level helps to understand the context, intersecting issues and needs that may be overlooked with a larger survey type approach. The embedded context and meanings of frailty were understood only through listening to content combined with the structure of the women's stories. In this sense, their subjective experiences, multiplicity of truths and negotiations gave insight into the actual lived experiences. As such, their accounts raise questions about common policy approaches. They highlight how instead of being imposed from above, policy may be developed from the ground level of micro experiences. In one sense, this approach questions the boundaries of policy studies—it questions the accessibility of policy studies and provides an opportunity to witness how policy is lived at the everyday level. Their stories exposed how local accounts may provide common connections necessary for designing policy as well as the necessary depth to allow for flexibility of the interconnections between policy issues and diversity and/or difference. An in-depth local analysis may offer an alternative way of conducting policy studies, and/or serve as a starting point to select issues for larger studies with a larger sample size.

The narrative method and feminist local level approach is not only helpful to research and policy, but also may also be a form of critical practice. By allowing older women to author or perform their stories, the method challenges the traditional power between the worker and the person receiving care. While the structure of their stories may assist practitioners to understand the context and meaning of the story, listening to the ways older women use their identity may provide insight into their strengths and potential for negotiation. Narrative may also allow workers to witness the constructedness of their own practice. Just as my research interaction with these twelve older women formed a powerful account so does the interaction within services, where the worker is the gatekeeper of service. Both the research account and social work accounts are constructed accounts with particular intentions. Narrative taught me about my power in conducting research. A storied approach may allow workers to reflect on their role in defining and negotiating need, while discrepancies between stories may provide spaces for workers to intervene in critical practice. Within this approach workers may recognise spaces where they may give over some of their power in order to recognise and retain the meaningful identities and strengths that are important to the older women. At the same time, narrative exposes how far social work has moved from the collection of in-depth case histories and storied accounts—how in-depth approaches have been displaced by standard assessments. The insights gained from this narrative approach call for a return to case studies (Sherman, 1991), hermeneutics and reflexivity within practice (White, 1997).

Movements toward Change

The narratives of the twelve diverse older women that I interviewed highlight the need to revise and re-think the stories told about older women, the services offered and the way the services are offered to them. The insight gained through older women's narrative highlights the utility of a critical perspective focused on language, power, diversity and change, as well as the possibility of integrating a narrative approach into practice. Above all, older women's accounts demonstrate the importance of recognising self-definition and accounting for diversity within practice, as well as the need to address the gaps that exist in relation to social and emotional needs. Older women's stories, especially those who were frail highlight the lack of available and appropriate services, that is, unmet needs. There is therefore, a question of connecting older women to the few services that exist and creating new services. Unmet needs may be addressed both by new services, which provide information/education and advocacy in relation to housing or transportation, as well as by revisions in government policies and services. This however, would mean commitment on behalf of government policies to reach beyond current conceptions of health, including social transportation and housing as priorities or components of home care. It may also mean making the commitment to maintain certain levels of care and create alliances between social and health services. Priority however, should not be placed on minimal standards of care according to risk, yet should shift to incorporate social notions of care and a general commitment which is based less on management and more on actual values of care.

Power of Language

Older women's accounts expose the way power located within language may be both coercive and relational. Contrasting accounts from policy and diverse older women exposes how coercive power operates through language, by defining, classifying and regulating older women's experiences. It also shows how women's accounts, phrased in a different language (i.e., social), and intricately connected to their identities allow them to resist, adapt and negotiate. Their strategies of negotiation, adaptation and resistance provide examples of older women's relational power. Listening to the voices present within the accounts helps to recognise both the way that people tell problematic accounts about older women, as well as how older women resist and negotiate these accounts. Hearing diverse older women's accounts teaches us to be conscious of the way that power operates through language, understand the meanings of the differences between accounts, and how these contrasts between the different languages used may be both a site of resistance and a location to intervene.

These twelve accounts highlight how an approach based on language is relevant to social work practice. From this approach, researchers and practitioners may see how language organises and impacts the implementation of services, and may provide a site for change. For example, within dominant accounts, older women's needs are currently discussed as deficiencies. This organises services to respond to these deficiencies and risk. If these needs were seen as temporary difficult times or social requirements that would help the woman to live at home with dignity, respect and the best possible quality of life, the organisation and implementation of services would be quite different. The contrast between older women's and professional use of language teaches us to be conscious about the way we use language, the values and underlying assumptions which operate within our practices, and the impact that language may have on individual experiences of services. Listening to the language used by the persons seeking service, and identifying the gaps between professional and diverse older women's accounts may be a key to finding meaningful interventions.

Importance of Identity & Self-Definition

Older women's narratives about their lives and experience highlights the importance that identity and sense of self plays in women's lives. At one level, women's storied accounts allowed them to make sense of who they are—to create a meaningful existence—and to be recognised as such. On another level, women's discussions of their identities and 'who they are' is active resistance against both a powerful concept of frailty imposed by society and public services, and an interview about this imposed concept. In this sense, their identity claims, achieved through narrative, provide women the space to define who they are in a way that reaches beyond a classification of health and public services. At the same time however, diverse older women realise that identity plays a large part in having their needs met—it is only a question of whether they want to play the game or not.

Older women's accounts highlight how identity claims are important at a personal level. How to negotiate a frail identity is likely connected to the way that the woman views her current and future situation as well as frailty. That is, women's ways of responding are intricately connected with their life identities. Buying into a frail identity, whether on a temporary or permanent basis, may have emotional implications for the older woman. First, take for example, the woman who has used her identity of strength to fight racism throughout her life. Is it fair or even good to ask her to give up her defences for the sake of receiving services? The emotional implications of losing her identity of strength may be greater than any physical need. Second, take as an example a woman who sees frailty as close to death. Will older women associate their involvement with service as evidence of impending death? If so, this association may raise emotional issues that services are not prepared to deal with, as well as result in a refusal of services that may prevent an already risky situation from becoming a crisis. On the other hand, take for example the woman whose refusal to be labelled frail results in her label as a non-compliant client and denial of service, or the woman who underestimates or minimises her needs for fear of becoming a burden. Despite the fact that both older women have legitimate needs, neither are served by the current organisation of service. Although the current system claims standardisation, taking on the frail identity seems to play a large part in the system responding to their needs, while for women, maintaining their identities seem to be key to having their needs met in a meaningful way. Buying into the frail identity and/or acting the part so to speak, seem to be the way to receive services. It would seem that the better negotiators get the most offers of service. Although this is consistent with the move to business notions, it seems an odd way of distributing public services.

Most importantly, this study highlights the interconnections between self-definition and making claims within practice. Instead of insisting on powerful labels created in the interest of practice, working with the way older women define themselves may be more meaningful than the intervention itself. Allowing older women to define their needs yet maintain their identity provides choice and self-determination that the label of frailty may take away from them. Here, workers may intervene in ways that allow the older women to maintain their identity, yet make strategic claims for services. Older women may have legitimate needs that fall within the domain of those recognised under frailty, yet their way of talking about them may be very different from the way that policy makers and service providers talk about the problem or need. In this sense, it is important to sort the need and the perception of need from the way of talking about need. Requiring older women to talk about needs in a predetermined or expected way is unfair. Workers may clients to create ways of talking which will result in their needs being met. If services intend to empower or provide autonomy, practice needs to rethink the expectations placed on older women in relation to the way they talk about needs. We need to recognise the meaningful way of talking about needs and strategic ways for older women to get their needs met. This may be achieved by shifting within and between the dominant languages required to talk about needs. Respect for self-definition and strategic claims may be the key to successful interventions.

Recognise & Integrate Social Needs

Connections between diverse older women's narratives highlight the need to integrate social needs into current policy and service approaches. At the moment, social needs exist outside of the public services and few resources exist to meet these demands. Providing services such as housing repairs and transportation are non-profitable and therefore remain unaddressed by the private market. While community organisations that provide these types of services have recently taken on the overload from the public service providers (in Quebec this is the CLSC) and are unable to meet demands which are less urgent. Current service priorities focused on hospital discharge and medical care mean that community services that have traditionally focused on some of the more social and community needs are now also involved in co-ordinating for the medical system. Older women's stories however, highlight how individual and medical needs do not exist in isolation. Instead, these physical needs create and compound social needs. Take for example the woman who experienced vision loss and is no longer able to drive. Although she has needs related to her immediate situation of vision loss, she also now has difficulties with transportation and the emotional issues that accompany her loss. Further, take the issues of home modifications and access posed by the woman who is at risk of falling. Older women's stories expose the various overlaps which exist between individual medical needs and social needs, and the way that these social needs remain unmet within the current system.

Integration of some of these services however, requires that home care policy reach beyond current conceptualisations of need and risk to incorporate the issues that older women define as their needs. This means organising services so that they are more reflective of older women's needs as opposed to the "official discourse" about their needs (Aronson, 1992). This means that services may focus on the physical, but also the connections between the physical and the social. This may mean making connections with organisations and services who may be providing these services if she has the resources to purchase them, as well as designing new services to assist older women to achieve a better quality of life despite physical decline. Overall, this requires re-thinking the priorities and current organisation of services—looking to innovative ways to meet older women's social needs, a commitment to social notions of care, and an expanded notion of health and guaranteed certain levels of care.

Recognise & Integrate the Emotional

Older women's stories reveal both the way that their understandings of frailty are connected with ideas about death. Their stories and interactions with the interviews revealed the lack of space that older women have to talk about death and the need for services to both recognise and integrate the emotional issues associated with death into practice. There is often an assumption or connections between aging and death. This connection which Gadow (1996) refers to as "aging as death rehearsal" is commonly associated with a silence or taboo about talking about death (Gadow, 1996). Just as older women experience this silence in their daily lives, this silence and the need for space about death was also present in our interviews. The silence I experienced in talking about death reflected the silence that older women live everyday in relation to discussions of death. Older persons needs to talk about death and the common perceptions of taboo were also reflected by Howarth (1998) when she says:

> *"Ageing does not necessarily release people from a fear of their own death or that of others...the assumptions that in old age people have had time to resign themselves to their own mortality..seems somewhat misplaced as the pace and culture of modern communities discourage members from dwelling on what is considered—in old age and youth alike—to be morbid or unhealthy thoughts" (p.687).*

The notion of frailty was often implicitly or explicitly contextualized within life review, impending death and social expectations. As such, older women's stories question the distance from death within current service provision. Once again older women's needs differed from the way the system discusses and provides for their needs. Within the current system, older women's needs are individual, physical and medical, as such they exclude the emotional issues which accompany decline and/or the space to talk about death. Further, the standard practices of risk assessment within managed care mean that social work and home care practice are shifting farther away from discussions of death. This focus on standardisation and risk assessment would mean that these spaces would only be made available if the woman presented as a crisis. Instead of understanding the meanings which diverse older women have so carefully constructed and negotiated for themselves, discussions would be exchanged for a tick beside 'anxious about death', 'resistant', or depressed.

In the same sense, it could be argued that these risk-assessments tools actually set out to create and maintain distance from the emotional issues which accompany physical decline. Current measurements consider objective answers, which are quantifiable and may be compared across persons, but are restricted from exploring the subjective feelings associated with loss and death. As such, standard practices which focus on the functional impairment maintain distance between the older person, their issues of loss, and the worker. The goals of the system intend to assess, standardise in order to compare, restrict service use and monitor the worker. Within this context, it is as if death is positioned as the unacceptable certainty, while knowledge and science are positioned as acceptable certainties. In this sense, distance from sensitive and philosophical issue of death is maintained through standardised assessment and service provision. Asking why this may be so—perhaps it is the old science versus religion debate. Personal values or views about mortality may keep death at a distance. Perhaps this is the silence of the death taboo which I experienced as a researcher. I would guess that workers are restricted by this taboo as well. In one sense, this seems a strange contradiction that in a time of such uncertainty people withdraw from the only certainty that exists—death. Yet, on the other it is understandable in relation to the social values about age, a natural inclination to avoid pain and suffering and/or human arrogance. The stories of older women however, raise questions about how current practices maintain distance from real social experiences such as loss and death.

Stories from older women raise practice questions about the openness of death, the question of 'being with' clients, as well as the implications of the moves toward certainty. My reflections on death and experience as a younger woman with a discourse on death raises questions about how open a service provider may actually be within the current context of care, as well as how open they are allowed to be. The importance of creating space and listening to stories raises questions about how service providers may incorporate 'being with' clients into their practice. How may practitioners work with their uncertainty to accept older women's discussions of taboo topics such as death? However, building on my experience of people's discomfort with death, perhaps the tools assist in creating a distance that would otherwise become too difficult for the worker. Is it helpful to be ready to address issues of loss and death if the service structure is not willing to provide follow-up? Questions now should focus on how workers are able to negotiate agency requirements and older women's needs to discuss their experiences of frailty and impending death. Is the current provision of service willing and/or able to address the issues of loss and death that arise through discussions of frailty? These stories highlight the tension between the distance of death in practice and closeness of death in diverse older women seeking public home care services. Listening and learning from older women would mean selecting a fluid approach as opposed to the certain one, as well as establishing a comfort level with death. These stories highlight the contradictory requirements of social workers who should take into account stories of life and death, meaning and identity, strength and resistance, as well as work within a powerful meta-narrative of managed care.

Integrate Negotiation, Acceptance & Resistance

The twelve women's stories highlight how the local may be a site where older women engage in personal change and acts of negotiation, acceptance and resistance, as well as highlight the common experiences which may be addressed through social organisations and/or advocacy groups in co-operation with and on behalf of older women within public services. Discussions about frailty raise particular questions in relation to negotiation and the possibilities for emancipation. For the most part, frailty seems to be a condition that older women negotiate on an individual level, privately in review of their life experiences and future notions about death. These older women's accounts talk about the personal quest for adaptation or change. Women highlight the ways that they try to integrate changes into their life, while at the same time maintain an identity and activities that are meaningful to them. That is, these women work to create a balance between continuity and change. These changes suggest the potential relevance of a return to theories of continuity and change. Return to these theories however, would not be conceptualised as before, but rather may be incorporated with a critical or structural change. The twelve women's stories of personal change highlight their strength and agency, and suggest that research, policy and practice find new ways of incorporating these strengths into services. This recognition and incorporation of change highlights the radical potential of the local and the potential for a critical social work practice rooted in narrative experience.

Yet, at the same time, the connections between their stories highlight common conditions, which require change. Multiple stories of frailty raise questions in relation to individual and group identity, negotiation and possibilities for emancipation. The multiple and shifting stories of older women in relation to frailty question whether there is such thing as a collective frail identity—a collective voice of older women in relation to health care. In one sense, older women have identified a reality of common needs and experiences, considering that older women do not discuss health matters with their friends, and the difficulties with getting 'out' and 'around', it seems that a collective voice is difficult to achieve. Yet, older women who are considered to be in this category have several unmet needs which require attention. Amongst older women in such uncertain conditions, is a revolt against the system realistic? These older women discuss conserving their energy and most likely do not have energy to be involved in political protest. The collective voice would seem to only exist amongst the socially active who are not restricted by their health status. This raises questions about notions of user-involvement and potential for contesting the organisation of services. How are older women who for the most part are restricted to their homes, have no transportation, or are pre-occupied with maintenance activities such as changing and cleaning able to attend user-involvement meetings? or organise against problems within service? These realities highlight the requirement for organisations and advocacy groups to work in co-operation with older women. This would mean staying involved with how changes affect the everyday lives of older women and organising against problems. Considering the realities of older women's social experiences, they may not be able to organise on a collective political level as before. However, working in cooperation with allies they may highlight their personal adaptation, negotiation and resistance and contribute their experiences to organisations and groups working on behalf of older women's issues.

Taking the Final Bow: Final Words & Future Stories

This story about the way older women understand and make meaning of frailty in relation to their lives and experiences comes to an end. Yet it is not the final story to be told—many parts of our discussion have led me to ask more questions about older women's bodies, stories and health care. Although this represents the end of the dissertation story, this account represents a turning point in my account—an account which is now marked with before and after the older women's stories. Their accounts have led me to question the connections between body image and aging, the *implementation of home care, the way their continuities and discontinuities taught them about life and how to share these lessons with other women. Yet, it has left me with a sense of how to explore older women's experiences, while balancing my own intentions and the power within language. Most of all, their storied accounts have taught me to be more aware of the way that I live through my body. They have taught me to be attentive, flexible, and move through life with fluidity—interesting lessons for someone who thought she knew how to dance.*

Request for Ethical Approval

Please answer each item, using additional space if necessary.

1. Title of Research Project:

Diverse Older Women: Narratives Negotiating Frailty

2. Granting Agency:

This study is funded by a Doctoral Fellowship of the Social Sciences and Humanities Research Council of Canada (SSHRC).

3. The Participants:

The general population for this study is defined by the age-based criteria of 65+ in order to provide a reference point to the larger context of aging in Quebec and Canada. In this sense, the study population refers to women who are commonly referred to under the categories of the 'aged', 'the elderly', or 'senior', in public discourse.

As a result of differences in service terminology in French (i.e., dependence) and English (i.e., frailty), this study population will only include English speaking, Montreal residing women, over the age of sixty-five. However, careful attention will be placed on recruiting participants from varying social locations (e.g., ability, class, ethnicity, 'race', and sexual orientation) in order to address diverse older women's experiences to the greatest extent possible.

This study focuses on 'frailty' as a marginal site or location where women may negotiate notions of age, disability, and decline. As such, this sample also includes older women from varying social locations in relation to service. These locations include both service users and non-service users. Stated simply, the study will include older women considered 'frail' according to service guidelines and clinical criteria (e.g., worker judgement) as well as those who would not be considered 'frail'. Considering these different locations of frailty may assist in understanding older women's experiences in relation to age, disability and decline.

The sample however, is ultimately based on access and identifiable informants. It may be difficult to locate 'frail' and 'non-frail' older women who are not involved with services or community groups (e.g., isolated). Ideally, I will build a purposeful sample that achieves as much variation as possible within the limits of a doctoral dissertation. The inclusion of diverse social locations is important in identifying multiple realties and experiences surrounding frailty.

4. Recruitment of Participants (Attach copies of all written or spoken material used in recruiting subjects, including newspaper ads, posted notices, and verbal announcements):

Sample Selection. This study will involve referrals from a variety of sites in Montreal. Recruitment will take three main forms: referral by health professionals, recruitment through the community (community organizations and clubs), and the snowball sampling technique. (See Appendix B for the letter to referral sites).

Referral by Health Professionals: Informed professionals will be asked to introduce the study to older women known through their agency. Workers will explain that the study is voluntary, that identities will remain anonymous, and that participation does not affect their services. If the woman is interested, depending on the woman's preference, the worker will ask for the woman's consent to furnish me with her contact number so that I may explain the study, or will give the woman my contact information. (See Appendix F: Possible Recruitment Sites).

Recruitment at Community Organizations: Participants not currently involved with services may be located through ads placed at local community centres. Similar to the health professionals, informed community organizations will be asked to introduce the study to older women. Flyers with contact numbers will also be distributed to relevant locations. Recruitment via health professionals and community groups will take place after gaining entry/access to the appropriate organizations and referring staff. The process of recruiting older women through community organizations will be the same as referral by health professionals (e.g., informed consent, contact information).

Snowball Technique: Each participant will be asked if they know of another woman who may be interested in participating. Participants will be provided with additional information sheets for potential participants and will be asked to pass my number to the woman.

Older women referred by agencies, organizations or other older women will first be contacted by telephone. At this time, I will introduce the study to older women and if interested, I will ask for their consent to meet for the interview. At the first meeting, I will review information letters with the older women and interested parties will be asked to complete the consent form (Appendix C). It will be explicitly stated in the consent form that participation is voluntary, their identities will remain confidential and that participation does not affect service in any way.

5. Treatment of participants (Include a brief statement on the purpose of the research and a summary of procedures and dependent/independent variables);

Purpose of Research:
The purpose of this research is to explore older women's narratives (i.e., stories) and lived experiences with 'frailty', understand the ways older women interpret, negotiate, and make meaning of frailty, disability and decline in their everyday life, and make room for alternative stories or experiences. Central features of this inquiry include (1) older women's voices and experiences as central to 'making meaning' of 'frailty', (2) older women's negotiation of dominant stories, (3) diverse experiences of how older women have arrived at their current understandings (i.e., including diversity), and (4) the creation of alternative stories about 'frailty'.

The following questions guide the study:

How do 'diverse older women' make meaning of 'being frail'?

How do 'diverse older women' negotiate dominant stories of aging, disability and decline in everyday life?

How do 'diverse older women' re-story the 'lived' experience of 'frailty'?

Summary of Procedures:

Located within the narrative approach (White & Epston, 1990), this study uses in-depth un-structured individual qualitative interviews. Grounded in an interpretative approach (Denzin, 1994; Denzin & Lincoln, 1994) and critical feminist theoretical framework (Fraser, 1997b; P. A. Lather, 1991), the overall research design may be described as a critical feminist study aimed to expose 'diverse older women's' narratives. Influences of phenomenology (Moustakas, 1994; Polkinghorne, 1988) have also been incorporated. Together, these concepts guide the exploration of 'local' narratives, 'voice', and 'lived' experiences in relation to 'frailty', including the ways in which diverse older women negotiate the meanings of 'being frail'.

Data collection methods include individual interviews, supplemented by document review of policies and service guidelines, collection of documents such as news clippings and the development of a researcher journal. In general, I propose twenty in-depth individual interviews to expose 'diverse older women's' narratives. Of these interviews, approximately half (10) of the women will represent persons considered frail, while the other half (10) will be comprised of those persons not considered frail according to service guidelines and/or clinical judgement. The number of individual interviews however, is an estimate and will ultimately be based on reaching saturation point. Individual interviews will focus on the concepts of 'frailty', 'meanings', 'lived experiences' and 'negotiation'. That is, 'frailty', will be explored as a social location where older women may negotiate dominant stories. Individual interviews, used to explore a broad topic from a participant directed focus (S Kaufman, 1994), will allow for in-depth explorations of the ways each woman 'makes-meaning' of 'frailty' within her own personal experience.

Interviews will follow a thematic guide to allow for flexibility and participant-directed focus. Questions and probes will be comprised of both descriptive questions to gather data, and structural questions to address the relationship between dominant assumptions and older women's 'lived' experiences. For example, a descriptive question may ask older women to discuss and define 'frailty' in relation to personal experiences, while, a structural question may engage older women in discussions about dominant/societal perceptions and how older women negotiate these meanings in their everyday lives. Props such as news clippings and photos will be used to engage in discussions about societal perceptions and expectations. Older women will be fully informed of the nature of the study and will participate only under the conditions of informed consent. Interviews will be audio-recorded and transcribed at verbatim. (See Appendix E: Thematic Guide)

6. Indicate how the research plan deals with the following ethical concerns:

6a. Informed consent

(Attach written form is any: otherwise, describe what you say to participants):

To inform each participant, I will review an information letter describing the study, procedures, and expectations (e.g., length of interviews) (See Appendix A: Information Letter), my identity as a doctoral candidate at McGill, and contact number's. In worker-referred cases, I will review all information and request verbal and signed consent at the point of first contact. (Appendix C; Consent Form). Participants will be assured that participation is entirely voluntary and that they may withdraw at any time without consequences. Risks and benefits associated with the study will be reviewed, and referrals will be available if required (i.e., distress). Considering the potential for coercion within health care (e.g., power differential, and requirement of service), especially for older persons, participants will be informed that their services will not be affected in any way, nor will they receive services that they would not have otherwise received. Participants will be assured of confidentiality, meaning that their identities will not be revealed. Pending a clear understanding of the study, participants will be asked to sign a consent form. One copy of both the information letter & consent form will remain with the participant, and I will retain the other.

6b. Deception:

Absolutely no deception will occur during the course of this study. Older women and referral sources will be fully informed about the purpose and procedures of the study. Furthermore, older women will be encouraged throughout the study to articulate any concerns they may have and are free to discontinue their participation in the study at all times.

6c. Freedom to discontinue:

Older women will be free to refuse to answer questions and may discontinue participation at any time. Freedom to refuse or discontinue is explicitly stated in the information letter Appendix A) and the consent form (Appendix C).

6d. Physical and mental stress (Attach any medical advice on physical stress)

In the event that issues arising from the study may cause emotional discomfort or distress in participants, contact information for counselling services at their local CLSC will be made readily available to them.

6e. Post-research explanation:

Upon study completion, results will take varying textual formats. Targeted benefactors and locations for results include: participants, front-line practitioners, older women's advocacy groups, as well as service and policy planners. Presentations at the local level, and write-ups within local, provincial and national newsletters/bulletins will increase awareness of study results and implications for practice. Relevant advocacy groups such as the NDG Seniors Council, Older Women's Network and Canadian chapters of the Gray Panthers and the Older Women's League will also receive information. While presentations at scientific meetings (e.g., CAG) and publication of related articles in journals (e.g., Affilia, Canadian Journal on Aging, and the Journal of Women and Aging, as well as International Conferences and Journals) will disseminate information to the scientific or academic communities. Agencies, planners, and decision-makers will have access to findings through both the above mentioned targeted presentations and written report format. Together, it is intended that older women's narratives in relation to 'frailty' will not only be recognised, but become central to the debates, textual sources, and social locations where discussion of diverse older women's experiences circulate.

6f. Confidentiality of results:

Information about participants will be kept confidential and older women's identities will remain anonymous. That is, their comments will not be identifiable, and no information about participants will be released or printed that would disclose their personal identity. To respect anonymity of identities, all recorded interviews will be coded by number and will henceforth be referred to by that number. In the transcription process, necessary for analysis purpose, any identifying information will be removed. To respect confidentiality, participant's identities will be replaced with pseudo names. Only the researcher will know the identities of participants and this information will be kept confidential under lock & key. Formal documents (e.g., dissertation) and/or publications will include assigned pseudo names.

Please comment on any other potential ethical concerns which may arise in the course of the research. If the proposed research involves testing subjects in situations where particular problems might arise, please explain how researchers will be trained to handle matters in a sensitive and professional way:

The sample of older women who may be 'frail', poses ethical issues of true informed consent, burden, and decisional capacity (Kayser -Jones & Koenig, 1994). Kayser Jones (1994) indicates that for older persons, true informed consent may be jeopardised by coercion of powerful individuals, or human contact as a result of isolation. To account for this, I will stress that there is no link between participation and services, that participation is entirely voluntary, and that they may refuse to participate or answer questions.

To decrease potential burden/fatigue, open interviews will be conducted in a comfortable setting of the participant's choice. Here, it is important to state that participant perceptions and concerns for their health will be respected. That is, if a participant feels that the interview is to tiring it will be discontinued.

Finally, decisional capacity is accounted for in both the recruitment and ongoing research process. Recruitment will be based on workers perceptions/knowledge of the decisional capacity of potential participants; it is not uncommon for workers to have administered a cognitive evaluation (e.g., mini mental) at service intake. Further, each interview participant will be assessed based on the level of general understanding. In the event that a participant's decisional capacity is questioned, the interview will be discontinued and/or excluded from study results, according to the situation. To account for further dilemmas, I have a committee with extensive experience in research with vulnerable populations.

7. Names of any research associates, assistants or students involved in the project. (These people act as your agents, and it is your responsibility to ensure that they carry out the research in the manner described on this form.):

Amanda Grenier (Doctoral Candidate)
Student Research Assistant (Responsible for Transcription)

Signature of project director: ______________________________
_____

Date: __________________________

INFORMATION LETTER FOR DIVERSE OLDER WOMEN

As part of my doctoral dissertation in the School of Social Work at McGill & Universite de Montreal, I am interviewing older women on the subject of frailty. Different people mean different things when they talk about frailty. I am interested in talking to you about how you understand frailty and how you see yourself in relation to health and service.

As researchers and practitioners, we often hear terms like frail, dependent and sick to describe older female clients. Yet, we do not know if this is how older women see and describe themselves. This is what I would like to understand through my study. To my knowledge, no research has yet focused on the ways older women interpret and give meaning to frailty in everyday life. My study intends to address this focus.

If you agree to be involved in this study, you will participate in one to three interviews of approximately two hours conducted at a convenient time and place for you. The interview format is flexible and is designed to explore your experience including how you view frailty, and how you view yourself in relation to frailty and service.

Participation in this study is entirely voluntary, and you may withdraw at any time without penalty. Older women who agree to be interviewed will not be identified by name and will be represented in documents through the use of pseudo names. In no way will participation in the study affect services you may or may not be receiving. All recorded interviews will be coded by number to ensure anonymity of your identity. Tapes will be transcribed for analytic purposes; any identifying information will be removed from the transcription. You will also have the right to speak off the record and/or have part or your entire tape interview erased.

I hope that you will choose to participate in this study, since the results may help to understand older women's experiences of frailty in relation to service and contribute to the development of knowledge about older women's experiences. I will regularly be available during the study period and am available to answer any questions you have about the research.

This study is funded by a Social Sciences and Humanities Research Council of Canada Fellowship.

Thank you for your co-operation.

Amanda Grenier, MSW
Doctoral Candidate, School of Social Work, McGill/Université de Montréal
(514) 843-1817 or (514) 398-6347

INFORMATION LETTER FOR REFERRAL SOURCES

As part of my doctoral dissertation in the School of Social Work at McGill & Université de Montréal, I am interviewing older women on the subject of frailty. As researchers and practitioners, we often hear the term frailty used in relation to service. However, little is actually known about how women define themselves, nor is information known about women's everyday experiences with frailty.

The purpose of this study is to gain a better understanding of older women's experiences with frailty. Through individual interviews with older women (65+), I aim to better understand how older women view and understand frailty, what meanings they associate with frailty, and the ways they negotiate frailty in relation to service. To my knowledge no studies have focused on the ways older women interpret and give meaning to frailty in everyday life- this study intends to address this focus. As such, the results of this study may contribute to our understandings of women's experiences of frailty, inform policy and service and ultimately impact health care services delivered to older women.

As someone who is often in contact with older women, I am asking for your help in identifying or informing potential participants. Women eligible for this study include urban (Island of Montreal), community residing, English speaking women, aged 65+. Please keep in mind that I will be including women of varying backgrounds (e.g., ability, age, class, ethnicity, race, and sexual orientation), as well as women who may or may not be receiving a service (e.g., different locations in relation to service and frailty). Keep in mind that although the study looks at 'frailty', I am interested in interviewing both older women considered frail (using guidelines of guichet unique and/or your clinical judgement) as well as women not considered frail, but whom meet the general criteria for the study (English speaking, Montreal residing, 65+). In general, I am asking that each woman participate in one to three tape-recorded interviews of approximately two hours each conducted at a time and place convenient for the woman. The interview format is flexible and will focus on older women's experiences with frailty and how they see themselves in relation to this concept.

In informing women about the study please ensure that they understand the study is voluntary, that they may withdraw at any time, that participation will not affect their services in any way. Further, that only the researcher (myself) will know of their identities and participation in the study. Interested women may contact me by telephone to arrange a meeting or give their consent for you to provide me with their contact information.

I hope that you will choose to participate in this study by identifying or informing older women, since the results may help to understand meanings associated with frailty, and contribute to the development of knowledge about older women's experiences in relation to frailty. I will be available during the study period and am available to answer any questions you have about the research.

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Thank you for your co-operation.

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DIVERSE OLDER WOMEN: NARRATIVES NEGOTIATING FRAILTY
CONSENT FORM (Approved by McGill Ethics I)

Participant:

I acknowledge that the research procedures have been explained to me, that I understand the study, and that any questions I had were answered to my satisfaction. I know that I may ask any questions that I have about the study procedures now or in the future. I have been assured that information about me will be kept confidential and that no information that would disclose my personal identity will be released or printed.

I have agreed that my individual interviews be audio-taped for analysis purposes. I understand that my participation in this study is completely voluntary and that my decision to participate or not, will not influence services I have, nor will participation give me access to services I do not have. I further understand that I am free to withdraw my participation from the study at any time and that I have the right to ask to speak off the record and/or to have part or all of my tape erased. I have been given a copy of the information letter.

I hereby consent to participate in one to three individual interviews.

Signature: ____________________________ Date: ________________

Name (please print): ________________________________

Researcher:

I have carefully explained the nature of the research. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and the demands, benefits and risks involved with participating in this study.

Signature: ____________________________ Date: ________________

Name (please print) ________________________________

DIVERSE OLDER WOMEN: NARRATIVES NEGOTIATING FRAILTY

Guiding Themes:

Theme One: *How do diverse older women make meaning of being frail?*

This theme attempts to explore and understand older women's understandings of frailty (e.g., what is your understanding of frailty?) including the ways in which older women have come to this understanding (i.e., social location-how did you come to this understanding?). This theme looks at older women's images/association with the word frail (e.g., what picture comes to your mind when I say that a woman is frail?). The theme also explores self-perception around the notion of frailty (e.g., would you consider yourself frail? How do you see yourself?) as well as attempting to understand what qualities would be associated with frailty in general (who would you consider to be frail?).

Theme Two: *How do diverse older women negotiate dominant stories of aging, disability and decline in everyday life?*

This theme attempts to understand older women's experiences with frailty in relation to dominant or societal notions. That is, it attempts to explore some of the overlaps and/or contradictions that may exist between dominant discourses about older women and older women's perceptions of themselves (e.g., people may say that you are frail- how do you see yourself?). In these themes, service guidelines, clinical judgements, photos and news clippings will be particularly useful. These props will aid in conceptualising and/or depicting dominant notions, and open the discussion to understand how older women negotiate these understandings in their daily lives (e.g., reflection on service guidelines for determining frailty; use of 'frail' & 'non-frail' photo: what do you see in this photo?). This section includes questions on how others perceive the older women (e.g., how do your friends or family see you?) as well as how older women perceive the expectations of themselves in relation to service (e.g., if you had to request a health service, what would you say about yourself? How would you present yourself?). Further, this theme also includes a subjective focus on functional health/ability and the impact this may have on older women's lives (e.g., what do you do in the day? what does this mean to you? how does this affect you? what meaning to you give to doing these things? not being able to do these things?)

Theme Three: *How do diverse older women 'restory' the lived experience of frailty?*

This theme is comprised of the told stories and experiences of older women, and therefore ultimately depends on the material presented in each interview. Overall, it explores older women's concepts of themselves. It may include discussions on the usefulness of the term frailty, may present new concepts in relation to older women's health and service use.

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