

Care and the Shadow of the Fourth Age: How does home care get caught up in it and how does it stay away from it?

Abstract

This article examines how care encounters at the elders' homes are forged, and how the way these encounters are forged avoids or evokes the social imaginary of the fourth age. Data was gathered in Portugal from elders receiving home care (16 cases), their care workers (8 cases) and family carers (6 cases), through participant observation and informal conversations (conducted at the elders' homes), as well as focus groups. The collected data was analysed according to the procedures of Framework Analysis. This study found five forms of care encounters – marked by conflict, infantilization, burden, harmony and indifference - the harmony form being the only one found to maintain the fourth age at a distance. It concludes that home care has a Janus-like nature in relation to the fourth age, and that the way home care encounters are forged depends on the conditions of the care settings and the actions of all participants in care encounters. It also concludes that it is difficult to maintain the social imaginary of the fourth age at a distance when the elders exhibit high levels of infirmity. Finally, it concludes that family carers play a crucial role in the way care encounters unfold. Implications for practice and policy include vocational training regarding the relational component of care and information and educational programmes for family carers.

Keywords: fourth age; home care; care encounters

Introduction

The provision of long-term care at elders' own homes is expanding in most countries around the world (Fujisawa and Colombo 2009), and the care arrangements tend to be mixed, including formal care workers and informal carers, mainly family carers (Saraceno and Keck 2010).

Care has a relational dimension, as it implies a relationship between the care-receiver and at least one care provider. The care relationship itself has been one line of research on the topic of home care for older people. In parallel, during the last decades theoretical work on care has proliferated, and recently we have witnessed a theorization of later life that differentiates the third age (later life without care, associated with consumption and agency) from the fourth age (later life with care, associated with loss of agency and decay). However, to the best of my knowledge we do not have empirical evidence about how care relates to the fourth age. More precisely, we do not know to what extent care maintains the social imaginary of the fourth age at a distance or, in contrast, makes it a conspicuous presence.

This article reports a study conducted in Portugal that purported to understand how care is deployed at the elders' home, as well as to examine to what extent the way care is deployed protects the participants in the care encounters from the ignominy of the fourth age or, on the contrary, exposes them to it.

Theorizing the fourth age and care

The fourth age paradigm

Paul Higgs and Chris Gilleard (2015) argue that in late modernity, particularly in affluent societies, we have witnessed a fragmentation of later life. This fragmentation is translated into the emergence of the third age as a ‘cultural field’, characterised by autonomy, choice and leisure, and the emergence of the fourth age as a ‘social imaginary’, associated with the ‘real’ old age, i.e. decline and decay. The third age and the fourth age are inter-connected, as the more the third age with its ‘anti-ageing’ narratives and ‘age-denying’ practices expands in a given society, the more the fourth age is darkened and pushed to the ending point of later life (Higgs and Gilleard 2015; 2016).

The fourth age does not correspond to a stage of life neither to a chronological category, but rather to a ‘collective representation of all that is feared and found most distasteful about old age’ (Higgs and Gilleard 2016: 121). The fourth age is constituted, according to Higgs and Gilleard (2015; 2016), by four elements: frailty, abjection, care, and loss of agency. These authors conceive frailty as both mental and physical infirmity but also as a status associated with a sense of ‘otherness’ (being different from us) and ‘lessness’ (being less than ourselves). In this vein, frailty entails both material and social vulnerability. In turn, abjection refers to those aspects of frailty that are socially constructed as the most distasteful and repugnant. It is associated with the inability to look after oneself and it foregrounds a social category, a class of abject people which may also include care providers. Frailty and abjection are accompanied by the need for care. It is in and through care that the fourth age is ‘socially realised as both narrative

and practice' (Higgs and Gilleard 2016: 74). Finally, loss of agency means, in general, losing the power to think and act autonomously and independently.

It is important to add that Higgs and Gilleard (2016) conceive care as having a 'Janus-like' nature, i.e. as being like a 'double-edged sword' in relation to the social imaginary of the fourth age. They claim that this social imaginary, although inevitably present in any care relationship, can be kept at a distance or be brought to centre stage through the narratives and practices of care. In other words, care has, paradoxically, the potential to protect older people from the ignominy of the fourth age, promoting, amongst other things, what Lloyd and colleagues (2014) designate by 'relational autonomy', and, on the contrary, to expose them to it, producing an erosive effect on agency and identity. In this vein, Higgs and Gilleard (2016: 138) advocate for an understanding of 'how those deemed frail are frequently further failed and how (...) we can learn to 'fail better'.

The same authors suggest that the greater the infirmity that afflicts older people, the lower their capacity to exercise agency, reflexivity and reciprocity (Higgs and Gilleard 2016). When a relationship has little or no reciprocity from the part of the care receiver it becomes a "relationship of one", and consequently some narratives and practices of care, such as for example the narrative of compassionate care and its associated practices, become difficult to sustain (Higgs and Gilleard 2016).

Higgs and Gilleard (2016) call our attention to the fact that the concept of personhood, in which the person-centred care approach is based, is connected to the concept of the fourth age, given that it purports to combat frailty and abjection. Tom Kitwood (1997: 8), a leading theorist on personhood on the context of dementia, defines personhood as the "standing or status that is bestowed upon one human being by others, in the context of relationships and social beings". According to Higgs and Gilleard (2016), the

Kitwood perspective on personhood confounds its metaphysical aspects (personhood as agency, consciousness, rationality and second-order reflexivity) with its moral aspects (personhood as a moral status, demanding certain rights), and advocates that the personhood of adults with dementia is dependent on the relationships established with them rather than on their own capabilities. Following the same authors, Kitwood's assertion places the responsibility of preserving the personhood of those with dementia - both in the sense of demonstrating moral concern for them and sustaining their capabilities - only on the shoulders of the care providers. However, Higgs and Gilleard (2016) call our attention to the fact that many people with dementia and others in need of care do not have the necessary capabilities to constitute metaphysical personhood, and that these deficits increase with time. Furthermore, they emphasize that most care providers demonstrate moral concern for people with dementia but "their care practices may either deepen or lighten the darkness of the fourth age" (p.133). In this vein, Higgs and Gilleard (2016) advocate that we need to base a "philosophy of care" on the fourth age perspective rather than on the concept of personhood, because keeping the social imaginary of the fourth age at a distance "requires no assertions about the 'personhood' of people with dementia, but simply the recognition of a common humanity and the taking of due care by carers as moral agents" (Higgs and Gilleard 2016: 26).

The Ethics of Care

Tronto (1993; 2013) clarifies the nature of care, arguing that it is both a disposition (e.g.: being concerned) and an activity (e.g. feeding). She also emphasises that care is inherently relational, involving interactions between two or more persons, and that it is put into practice through a complex process. Tronto (1993) initially identified four

phases of the process of care: caring about (recognizing unmet needs), taking care of (taking responsibility for meeting the needs), care-giving (undertaking concrete actions in order to meet the needs), and care-receiving (responding to the care received and making judgments about it). In addition, Tronto (1993) identified the ethical/moral qualities necessary to carry out each phase of the process of care. They are, respectively: attentiveness (being attentive to unmet needs), responsibility (taking responsibility for meeting the needs), competence (providing skilful and appropriate care) and responsiveness (evaluating the effectiveness of the care provided). Tronto (1993) advocates that “good care” is achieved if each phase of the process of care is carried out according to the respective ethical quality. Later, Tronto (2013), when developing a Theory of Caring Democracy, added a fifth phase to the process of care: caring with. In this phase, care needs should be ideally met in accordance with democratic commitments to justice (assignment of care responsibilities and other responsibilities in a non-dominated way), equality (having equal voice) and freedom (absence of domination). According to this author, solidarity and trust are the ethical qualities necessary to accomplish the ‘caring with’ phase. Tronto (2013) also suggests that “good care” requires knowledge about the care-receivers’ lives, and that, in turn, this knowledge is only acquired with sufficient time and proximity.

Care as ‘body work’ and ‘dirty work’

Julia Twigg (2000; 2011) also contributes to the clarification of the nature of care, arguing that providing health and social care is an activity but with a special nature: it is a form of ‘body work’, which is commonly ‘dirty work’. Body work consists of working on the bodies of patients/users and it incorporates two dimensions, an

instrumental dimension (being a practice) and an expressive dimension (involving emotional work). In turn, body work is dirty work in two senses (Twigg 2000). First, it deals with the ‘negativities of the body’ (Twigg 2000: 7), such as faeces, urine, and the like. The presence of odours, sights, and textures produce a feeling of disgust in care providers and a disruptive effect on close relationships (Isaksen 2002). It is also suggested that in the most extreme cases the care-receiver’s home may also be dirty, and a “dirty workplace” may have negative impacts upon care workers “through unofficially increasing their workload, further devaluing their work and risking their wellbeing” (Wibberley 2013: 156). Second, body work is dirty work because it is pushed to the realms of institutions and private homes by a society that put a high value on youth and success and has aversion to decay, failure and death.

The empirical study of the care relationship in the context of home care

Research on home care for older people has addressed several themes. Higgs and Gilleard (2016: 106) identified four themes: a) - “the social policy issues of funding and organising these sectors of domiciliary care (...)”; b) – “the motivations and moral identities of care workers”; c) – “the tasks, challenges and stresses home care workers face”; d) – “the care relationship itself, whether contrasted explicitly with informal, family care, or explored directly”. Considering the aim of the present article, only the literature that focuses on the theme of the care relationship will be reviewed, in particular the literature which includes not only home care workers, but also family carers.

There is a set of studies which do not focus directly on the care relationship, but rather on how the materiality and meaning of the “home” contributes to shape the care

relationships, in specific the power dynamics between care workers and care-receivers (e.g.: England and Dyck 2011; Trojan and Yonge 1993; Twigg 2000). Nonetheless, some of these studies emphasize that home care is also shaped by factors beyond the home, namely by the culture and rationality of organizations and services (e.g. England and Dyck 2011).

Studies which have focused more directly on the care relationship have privileged three issues: negotiations between the elders and the care providers (Valokivi 2005; Breitholtz al. 2012; Vivian and Wilcox 2000; Spiers 2002; Sundler *et al.* 2016); quality of, or satisfaction with, the care relationship (Eustis and Fischer 1991; Karner 1998; Fujiwara *et al.* 2003; Graham and Basett 2006; Chon 2015; Ayalon and Roziner 2016); and factors associated with (in)dignity in care (Trojan and Yonge 1993; Tadd and Calnan 2009; Stewart and McVittie 2011; Moe et al. 2013; Lloyd *et al.* 2014). Studies which have focused on the first issue converge on the idea that care relationships involve complex interpersonal negotiations and exchanges imbued with important issues, such as dependency and power. This has been underlined by other authors (e.g.: Rummery and Fine 2012; Walsh and Shutes 2013). In turn, studies which have explored the second issue show that there are positive and negative perceptions about the quality of, or satisfaction with, the care relationship, and that in some cases these perceptions/evaluations diverge between those involved in the care relationships. Finally, studies which have addressed the third issue identify several factors associated with (un)dignified care. Respect, trust and elders' autonomy are the most mentioned factors associated with dignified care. Some of these studies also show that feeling like a burden also compromises dignity.

In sum, this literature has called our attention to the fragile, dynamic and fluctuating nature of the care relationship in the context of home care, which derives from several

underlying negotiations, ambiguities and ambivalences. This literature has also explored the issue of quality and satisfaction in care relationships and the factors which promote, or undermine, dignity.

Considering that the theoretical work on the fourth age is recent, it is not surprising that the issue of the fourth age is explored, albeit partially, in only one of the studies reviewed above (Lloyd *et al.* 2014). This study emphasizes that social relationships play a key role in maintaining the elders' identity and, consequently, the fourth age at a distance.

Home care for older people in Portugal

Formal home care in Portugal is provided mainly by the voluntary sector, although the care market (private for-profit sector) has been growing during recent decades. The state has a minor role in home care provision, being mainly a regulator of the care sector as a whole and a funder of the voluntary sector.

In most countries of the world, home care workers have low qualifications and earn low wages (Bettio and Verashchagina 2010), and this is particularly true in Portugal. With respect to qualifications, the Ministry responsible for home care in Portugal establishes that vocational training is a prerequisite for the practice of the home care, but local services may exempt the worker from the frequency of a training action. Moreover, training programmes neglect the relational component of home care, that is, the relationship between care workers and service users. It is also important to add that there are no educational programmes for family carers in Portugal.

In Portugal all people who need care and support with activities of daily living are eligible to receive home care provided by the voluntary and public sectors, and in the case of the voluntary sector the services are paid according to the income of the users and their families. Home care includes services such as personal care, meals, laundry, and house cleaning. Personal care includes incontinence care and assistance with feeding, dressing, bathing, toileting and the like. In the voluntary and public sectors, each care visit takes about 20 minutes.

Methods

Research questions and methodological approach

The present study purports to answer the following research questions:

- How is care forged by older persons and care providers at the elders' homes?
- How is the social imaginary of the fourth age resisted or, on the contrary, reproduced by the way home care is forged?

The first question seeks to gather a deep understanding regarding how the giving and receiving of care is deployed in the context of home care, taking into account the contexts under which care encounters take place. The second question seeks to examine how the way home care is forged protects both the older persons and their care providers from the social imaginary of the fourth age (by not exacerbating frailty, and not producing abjection and loss of agency), or exposes them to it (by exacerbating frailty, and producing abjection and loss of agency).

Considering the research aims and questions, a qualitative approach - with its emphasis on studying "things in their natural settings, attempting to make sense of, or interpret,

phenomena in terms of the meanings people bring to them” (Denzin and Lincoln 1994: 2) - was used to collect and analyse data.

Research participants and sampling

The participants in the present study were elders who were receiving home care, their home care workers and, in some cases, also their family carers. The elders were selected according to the following criteria: aged 65 or older; receiving formal home care; able to maintain a conversation in Portuguese; and able to provide verbal informed consent. No criteria were used to select the care workers and the family carers, as they were automatically selected through the selection of the elders.

A not-for-profit institution that provides social care services for older adults in the region of Algarve participated in the process of selection and recruitment of the elders. This institution identified the elders who satisfied the study criteria and granted formal access to elders and respective care workers. There was concern about ensuring, as much as possible, a diversity of cases in terms of the socio-demographic characteristics of the elders. Convenience sampling (Ritchie *et al.* 2014) and theoretical sampling (Glaser 1998) were used to select the cases.

A total of 16 cases were included in the final sample. In ten of these cases the care encounters had the participation of the elders and care workers (always two care workers), while in the remaining cases they had the participation of elders, care workers (always two care workers) and family carers. In the former cases there is a clear predominance of women (eight women, all over 80 years old, and two men, both under 80 years of age), while in the latter cases the opposite is true (five men, all over 80 years old, and one woman under 80 years of age). Some social characteristics of the elders are

presented in Table 1. The group of care workers is composed of eight women, all over the age of 40, and with nine years of schooling. In turn, the group of family caregivers who participated in the observed care encounters is composed of one daughter, one son, one daughter-in-law and three wives. The first three are over the age of 40 and have ten years of schooling, while the last three are over the age of 70 and have no more than four years of schooling.

<Insert Table 1 about here>

Data Collection and Analysis

The data were collected between 2014 and 2016 through participant observation, informal conversations and focus groups. Only the author of this article undertook the whole process of data collection and analysis. The observations and informal conversations were conducted in the elders' homes. The researcher accompanied the home care workers on their visits. The observations aimed to capture "what is going on" in home care encounters, that is, what the elders and care providers say and do during the care workers visits (including non-verbal communication). In turn, the informal conversations (with the elders, care workers and family carers) aimed mainly to clarify some aspects of the observed actions and interactions, as well as some analytical puzzles. Together, participant observation and informal conversations allowed capturing the properties/features that give shape to care encounters. It should be noted that more or less every two months the cases were distributed to other pairs of care workers (there is a rotation mechanism between the teams of care workers). This means that the same pair of care workers conducted more than one visit to all the elders who participated in the study. Finally, focus groups were selected as a method to collect data, as during the

observations and informal conversations at the elders' homes the care workers expressed sometimes their conceptions about what is a "good home", a "good user" and the like. It was considered that these conceptions deserved to be better explored in a systematic way through the focus group method, which is particularly suitable to capture the culture or shared understandings of a group (Bloor *et al.* 2000). The focus groups took place at the premises of the institution that collaborated with the study. Two focus groups were conducted with the participation of the researcher and eight care workers (the same care workers who had participated in the observed care encounters), both lasting about one hour.

The data collected through the observations and informal conversations were recorded through jotted notes and later these notes were converted into more detailed notes via word processor. A total of 248 observations/home visits were carried out (an average of 16 observations in each home), each lasting, on average, 20 minutes, complemented by a large number of informal conversations, altogether producing 245 pages of typed notes. Data collection ended when theoretical saturation (Glaser 1998) was reached. The focus groups were recorded and transcribed verbatim.

Data analysis was performed according to the procedures of Framework Analysis, a technique of thematic analysis described in Ritchie and collaborators (2014). Constant comparison between cases and categories (Ritchie *et al.* 2014) was conducted to enhance the quality of the analysis. A typology of forms of care encounters was constructed on the basis of the emerging categories. Data analysis was conducted with the help of NVivo9 software. The credibility of the findings was explored through the technique of member checking (participant or respondent validation), but only with the care workers. Considering the content of the findings, it was considered that the

inclusion of the elders and their family carers in member checking could be disturbing for them.

Ethical Considerations

In Portugal, and in the domain of social sciences in particular, there are no research ethics committees at universities, research organizations and social care services, although this situation is changing. Hence, the study was conducted in accordance with the code of ethics of the Portuguese Sociological Association and the ethical sensitivity of the researcher. The initial step was to obtain formal permission from a not-for-profit institution to undertake the fieldwork at its home care services. Afterwards, an oral informed consent was obtained from all research participants. The initial informed consent from the elders was updated during the fieldwork, especially at times when the investigator was present when intimate care was provided. Nevertheless, the observations at the elders' homes were conducted with discretion to protect the elders' privacy. During the fieldwork, the researcher witnessed some episodes of elders being neglected by their family carers. Faced with this, the researcher suggested to the care workers that they should report the situation to the coordinators of the home care services. They agreed with the suggestion and reported the episodes to their coordinators, who made the necessary interventions to prevent negligence in the future.

Findings

The presentation of the findings is organised according to the two research questions. The findings of the focus groups with care workers, in particular those related to the

social constructions/representations shared by the participants, are presented throughout the description of the forms of the care encounters. Nonetheless, it is necessary to note another finding of these focus groups. The care workers revealed that they only had initial vocational training, but this training did not include the relational component of care. In addition, the care workers said that they do not receive specific guidelines from their coordinators as to how they should relate to the elders.

Forms of care encounters

In order to account for the different ways through which care is forged, the concept of social form, as defined by Allan (2009), was used: “A form is a patterned mode of interaction through which people meet personal and group goals” (Allan 2009: 240).

Five forms of care encounters were identified, which are marked by conflict (2 cases), infantilization (3 cases), burden (3 cases), harmony (3 cases) and indifference (5 cases). It is important to note, in advance, that there is no clear association between a particular form of care encounter and a particular team of care workers. In other words, each form of care encounter maintains the same basic characteristics regardless of the teams of care workers.

Conflict

The care encounters included in this form are represented by two cases. In each case, these care encounters have the participation of the elders, two care workers and one family carer (in one case, a son and, in the other case, a daughter). The elders, both male, are bedridden, and exhibit some physical strength and memory. Although they are able to talk, they do it only when they are questioned about something. They receive personal care, including incontinence care and bathing.

In both cases the care encounters take place in the elders' bedrooms, which are very dirty (walls with faeces, garbage on the floor, intense odour), underfurnished and depersonalised (they resemble a prison cell, completely empty of personal possessions).

The care workers express aversion in relation to the conditions of these care settings:

It is really difficult to work here (accompanied by non-verbal communication showing difficulties in withstanding the strong odour) (Care worker n°3, during a home visit).

The objects and utensils that the care workers need to undertake their work are also scarce in these care settings. On the whole, these care settings fit the social construction of a "bad home" which is shared by the care workers who participated in the focus groups. A "bad home" is a home that is dirty and that does not have the things that the care workers need to undertake their work properly, such as towels, soaps, diapers, and the like. Apart from this, the elders are also often "full of urine and faeces" when the care workers arrive at their homes (urine and/or faeces in several parts of the body, as well as in pyjamas and bed sheets, due to the overloaded diapers that were not changed). This contributes to reinforce in the care workers the feeling of disgust and the idea that the family carers are negligent. In this respect, the care workers expect that family

carers are attentive to and responsible for the incontinence care outside of the periods covered by the home visits.

When we look at the way the care encounters unfold in these settings, we find that the actions taken by the care workers and the family members are task-oriented (although the family members neglect most of the elders' needs, as we will see later), that is, they are focused on the practical care tasks rather than on the elders themselves.

It is also observable that the care workers, while performing the care tasks, tend to ignore the elders, given that they talk with each other as if the elders were not there. Furthermore, the care workers, and also the family carers, do not protect the elders' privacy. For example, the care workers do not knock on the door before entering the bedroom and do not ask for permission to take off the diaper. The care providers (care workers and family carers) also do not promote the elders' autonomy, as all the decisions about care are taken without the elders' participation.

However, the most important feature of these care encounters is that they are substantially marked by conflict. There is a harsh relationship between the care workers and the elders and also, although with lower intensity, between the family carers and the elders. On one hand, the harshness between the care workers and the elders is revealed by interactions with the following characteristics: the elders do not cooperate with the care workers (e.g. not complying with the care workers' requests, making the body rigid) and they often show aggressiveness. In turn, the care workers ask them to do (or not to do) certain things with an authoritarian tone of voice, touch the elders' bodies in a brisk manner, and sometimes even make threats (e.g. that they will put them in a nursing home). These interactions seem like a "fight" between two opponent parts. This was explicitly recognised by one of the care workers before entering the elder's home

when she said that she was going to another “battle”. On the other hand, the harshness between the elders and their family carers is found mainly in the sour tone of voice they use to talk with each other and their non-verbal communication (indicating mutual impatience and annoyance). It should be added that the elders’ behaviour is in line with the social construction of a “bad user” that is shared by the care workers. Not cooperating, being aggressive and not manifesting trust in the care workers are the characteristics of a “bad user”.

Conflictual relationships are not limited to the interactions between the elders and their care providers. The interactions between the care workers and the family members are even more problematic, as in several occasions they were fraught with bitterness. In one home visit there was a disagreement between the care workers and the elder’s daughter about the best way to change the elder’s diaper, and this disagreement ended up in an overt and strong dispute. In this respect, it should be noticed that the care workers, in both cases, have a negative image of the family carers. They think that they neglect the elders’ needs and that they do not help them in the care provision. Regarding the issue of family negligence, a care worker, while providing care, emphasised the following:

This is a case for the intervention of Social Security, this is very serious, and something should be done regarding this situation! (Care worker n°2, during a home visit).

Not providing the necessary conditions so that the care workers can do their work properly (supplying the objects and utensils needed for the provision of care), as well as not having the house and the elder clean, are the characteristics of a “bad family”, a social construction shared by all the care workers who participated in the focus groups.

Participant observation revealed many indicators of family negligence. Apart from the dirtiness of the bedrooms and many occasions in which the elder had not yet had breakfast at the time of the home visit (around 11 a.m.), the researcher witnessed an episode in which the elder was lying on the floor, completely naked and covered with faeces and urine, while his daughter was dealing with other household chores.

Most likely as a consequence of these patterns of interaction and the conditions of the care settings in which they take place, the elders express sadness through verbal (e.g. saying that they feel sad) and non-verbal communication (e.g. having a sad look in their eyes). They even say that they want to die:

I'm very sad with all of this, I want to die, please give me death... Life does mean anything to me anymore! (84-year-old man).

Infantilization

In this form of care encounter - represented by three cases - there is no participation of family carers, although they exist. The care workers have the idea that the family carers neglect the elders in two cases. The elders, two women and one man, are bedridden and their physical strength and memory is very low (e.g. they would not be able to make their bodies rigid in order to make the care workers job more difficult, and they are not able to remember the last meal they had). In addition, one elder is not able to talk and the other two have great difficulty in talking. Regarding this, it is important to underline that the higher levels of physical and mental infirmity are found in this form of care encounter. These elders receive personal care, including bathing and incontinence care. The care settings are the elders' bedrooms, all of them pleasant (clean, with natural light, not under or over furnished), although one has an infantile decoration.

As in the first form of care encounters, here the actions of the care workers are also task-oriented and they also sometimes ignore the elders, do not protect their privacy and do not promote their autonomy. However, contrary to the conflict form, in the infantilization form, the care workers display tenderness while providing care. Some examples of this tender care are caressing and smiling. Yet, while providing care they also use “baby talk” (using diminutives, shortening sentences, simplifying vocabulary, childish tone of voice) and in general they interact with the elders as if they were babies (e.g. neglecting what they are trying to say or devaluing their wishes). Let us look to the following field note:

The care worker said: My little girl, how are you today? Next the care worker asked the elder if she would like to have baby formula using baby talk. While this care worker was feeding the elder, the other went to get a teddy bear and used it to play with the elder. She said: People of this age like to have a teddy bear. After this, the care workers laid the elder in bed and began to undertake her personal hygiene. When I asked the elder if she would prefer that I leave the room, one of the care workers said: She does not care about that anymore (Visit to a 91-year-old woman).

During another home visit, a care worker addressed the elder by “little baby” several times, using baby talk:

Come on my little baby. Open your month... Do you want some more my little baby? You are a baby; yes, you are my little baby (Care worker n° 4, during a home visit).

In these care encounters the elders adopt a passive posture in relation to the care workers, as they fully cooperate with them (accepting the requests and orientations of the care workers) and they are not demanding (usually they do not even make requests to care workers, which can be explained, in part, by the difficulties they have in talking).

Burden

This form of care encounter - represented by three cases – has the participation of family carers (the elders' wives in two cases, and the elder's daughter-in-law in the other case). Two elders, both men, are bedridden, and the third one, a woman, is not bedridden but she is confined to home. All of them still have physical strength, good memory, and they communicate without difficulties. All receive incontinence care and assistance with bathing. In the cases of the men the care encounters take place in the elders' bedrooms and in the case of the woman it takes place in the bedroom and the bathroom. One of these care settings is pleasant, while the others not so much, given that one is over furnished (something about which the care workers complain) and the other has no natural light.

The interactions between the elders and the care workers are marked by tenderness, although the care workers' actions are task-oriented. In contrast, the interactions between the elders and their family carers exhibit some coldness and insensitivity, particularly visible in the family carers' actions and attitudes, and also some impatience/intolerance mainly from the part of the elders. The following interaction between the elder and his wife is illustrative of coldness and insensitivity from the part of the latter:

Elder - I have here my saint (making reference to his wife). Elder's wife – There are no saints here, saints are in heaven. Be quiet, don't talk nonsense (75-year-old man).

In turn, the following interaction reveals some impatience or intolerance from the part of the elder towards his wife:

Elder's wife - That's not good at all (the position in which the care workers leaves the pillow). Elder – No! How do you do it? (making reference to the way the wife accommodates the pillow). Say it (using an impatient/intolerant tone of voice) (81-year-old man).

In addition, there is another pattern of interaction between the family carers and the elders that distinguishes this form of care encounter from the others: on one hand, the family cares emphasize the elders' physical and mental infirmity and, on the other hand, they make them feel like a burden. They systematically emphasize, in the presence of the elders, that they are a “dead body” or that they do not have “mental sanity anymore”, and they complain that providing care implies a lot of work and that they do it unaided most of the time. The following testimonies are illustrative:

My husband no longer feels his body (75-year-old man).

This is too much work! (making reference to the care provided to her husband). I'm eager for this to end, because this is too much for me! You come here for a few minutes (making reference to the care workers), but for the rest of the day I do everything myself, without anyone's help (81-year-old man).

Certainly as a consequence of these actions, the elders feel, in fact, like a burden, and this also makes them feel bad and sad:

You see the work that is needed! I need two persons to get me out of my bed. It's a lot of work! Researcher - How do you feel about that? I feel bad and sad as you can imagine, I feel that I demand a lot of work (75-year-old man).

It should also be underlined that the elders abdicate from exercising autonomy, letting their family carers decide for them.

Harmony

These care encounters include three cases whose participants are the elders and the care workers. Although these elders also receive care from family members who were not present in the observed care encounters. Nevertheless, it should be noted that the care workers have a very good image of the family carers. As one of the care workers said: "Here there is a lot of family support, they buy everything the elders need" (Care worker n°7, during a home visit). All the elders receive personal care, a bedridden woman receives incontinence care and bathing and the remaining ones, a woman and a man, both not bedridden but confined to their homes, only receive help with bathing. All of them still have some physical strength and good memory, and they communicate without difficulties.

The care settings - the elder's bedroom in the case of the bedridden woman and the bedroom and bathroom in the remaining cases - are pleasant. The elders' possessions (e.g. perfumes, hats, combing brushes) are visible in these settings. In addition, these settings have all the things the care workers need to undertake their work (towels, soap and diapers). These care settings fit the social construction of a "good home", that is, clean and equipped with all the things the care workers need to provide care properly. One of the care workers reinforces this saying the following: "There are houses where

we don't like to go and others where we like to go, and this is one of those where we like to go". (Care worker nº5, during a home visit).

The care workers' actions are not fully task-oriented, as they talk with the elders about their past lives while they are providing care and/or they offer them some time after they have finished their work to talk about their biographies and to offer them some company, although they have strict guidelines about the time they should spend in each visit. The interactions between the care workers and the elders are dominated by tenderness and by total reciprocity regarding tenderness. In addition to tenderness, the care workers show concern about the elders' needs and the elders show gratitude towards the care workers. They also protect the elders' privacy and they acknowledge their presence (they do not ignore them) and they respect their wishes. Furthermore, the care workers promote the elders' autonomy, given that they encourage them to take decisions about their care. Let us look to the following field note:

The care workers talk with the elder with a smile on their faces and with a pleasant tone of voice (a sweet tone but not an infantilizing tone). They touch her body in a gentle way and they ask her if she would like to have clean bed sheets. While they are performing her personal hygiene (washing her and cleaning her), they talk with her about her last profession, something much appreciated by the elder. The elder also asked one of the care workers how her daughter was doing and they talked a bit about her. When the care workers were combing the elder's hair, with the elder's combing brush, they praised her hair and she liked to hear that. At the end, the care workers put some perfume on the elder, something that the elder was used to in the past, and they caressed her hand. The elder reciprocated warmly to this behaviour (Visit to an 82-year-old woman).

Finally, it is important to mention that these elders meet the criteria of a “good user”, as conceived by the care workers, which includes cooperating, not expressing aggressiveness, and trusting the care workers. During a focus group, one of the care workers clarified this in the following terms:

Not all the users are good, some are bad... Those who are good users collaborate with us, treat us with respect and sympathy, and trust our work. The other ones, the bad ones, are aggressive and they do not collaborate with anything (Care worker n° 3, during focus group n° 1).

Indifference

As in the previous care encounters, these (5 cases) only have the participation of the elders and the care workers, with the exception of one case in which a family carer is also present (the elder’s wife). However, all elders included in this form have also family carers. The care workers have the idea that the family carers do the minimum in relation to the elders, that is, they think that they do not neglect them but, at the same time, they do not provide strong support. Two elders, both women, are bedridden and the remaining three, two women and one man, are not bedridden but confined to home. They have some physical strength and good memory, and they communicate without difficulties. All of them receive personal care, including incontinence care and bathing.

The care settings are the elders’ bedrooms, although in two cases they also include the living rooms. All the care settings are pleasant, with the exception of one in which there are cockroaches in the bedroom. This situation generates revulsion in one of the care workers.

The interactions between the care providers (care workers and the family carer) and the elders are task-oriented, and marked by indifference, that is, there is no tenderness but at the same time there is also no harshness. In one care encounter, the conversation between the care worker and the elder was very short and circumscribed to the practicalities of care:

Care worker – Good morning! Elder – Good morning! Care worker – Lift your leg. Ok. Today it's done. Take care. Elder – Bye! (Visit to a 91-year-old woman).

The care providers, in particular the care workers, provide care in a very “mechanical” and cool mode (neither warm or cold): they undertake the care tasks in a quick way, talking very little with the elders, and when they talk the subject is related to the care tasks. The care relationship is formal, with mutual respect, including the respect for the elders' autonomy but, at the same time, with emotional distance/detachment (lack of strong feelings). Let us look to the following field note:

The care workers started doing their work very quickly (incontinence care) and they talked with the elder very rarely. This was the only conversation between the care workers and the elder: Care worker - Today this is bad (making reference to the fact of the elder having a lot of faeces in the diaper). Elder - Heh, today this is bad! Care worker – Let's turn aside, please. Yes, that's it. Ok. It's done. Elder – Don't over tighten the diaper. Care worker – Okay, I'm not going to tighten it too much. There were no smiles and no caresses between the care workers and the elder. The care workers took 12 minutes with this visit. The whole visit was marked by emotional distance and coolness (Visit to a 72-year-old man).

Overall, the care settings, the elders and the family carers do not fit the social constructions of “bad home”, “bad user” and “bad family”, but they also do not fully fit the opposite social constructions.

Forms of care encounters and the avoidance-evocation of the fourth age

As described earlier, the social imaginary of the fourth age is constituted by frailty, abjection, care and loss of agency. Frailty is present in all forms of care encounters, although the components of “otherness” and “lessness” are not present in all forms and when present they are not with the same intensity. Care is also present in all forms of care encounters but the way it is deployed varies according to the forms of care encounter. For example, if we consider the ethical/moral qualities that Tronto (1993, 2013) associated with each phase of the process of care - attentiveness, responsibility, competence, responsiveness, solidarity and trust - we verify that these qualities were not present, or fully present, in all forms of care encounter. With regard to abjection and loss of agency, these elements are not clearly found in all forms of care encounter and when they are they are not necessarily linked to the same patterns of interactions and the same characteristics of the care settings.

At a glance, we can see that the fourth age is resisted or maintained at a distance in the form of care encounter marked by harmony, and that it is brought to centre stage in the remaining forms of care encounter, although perhaps in a less pronounced manner in the form marked by indifference.

In the harmony form of care encounter the fourth age is kept at a distance, given that the care settings are pleasant and personalized, that is, they are cosy and have the possessions that the elders need to sustain a respectable self-image (e.g. cosmetics and

clothes). Goffman (1961: 20) designated these personal possessions as “identity kit”. A pleasant and personalized care setting contributes to hold back the emergence of abjection and loss of identity. Furthermore, the interactions between the elders and the care workers are also pleasant, as they are characterized by mutual tenderness and respect. There is connectedness between the care workers and the elders. In addition to this, the care relationship is balanced in terms of power, as the elders and the care workers manifest interest in the lives (or past lives) of each other, the care workers do not make the elders feel as different (otherness) or with less value (lessness), because they do not ignore them, they protect their privacy and they promote their autonomy. We can say that care is deployed with respect for the ethical/moral qualities described by Tronto (1993, 2013). All in all, the care workers focus their attention not only on the care tasks but also on the elders as persons with biographies, aspirations and preferences. This does not exacerbate frailty and does not produce abjection and loss of agency. Using Goffman’s terminology (1971), this form of care encounter preserves some “territories of the self” which are essential to sustain a dignified self-image.

In the remaining forms of care encounter the fourth age is brought to the centre stage and this acquires its maximum expression in the form marked by conflict. In this form, the extreme dirtiness of the care settings and elders’ bodies contributes inevitably to exacerbate frailty and to produce dehumanization and abjection, which affects not only the elders but also the care providers. Frailty and abjection are accentuated by care providers’ actions such as negligence (on the part of family carers), ignoring, not protecting privacy and not promoting autonomy. Care is deployed without attentiveness, responsibility, competence, responsiveness, solidarity and trust, the necessary qualities to ensure “good care” according to Tronto (1993, 2013). Ultimately, this whole picture ends up curtailing the elders’ agency and dignity, although they try to have some control

over the care relationship when they do not cooperate with the care workers. Nevertheless, power imbalance is evident in these care encounters to the disfavour of the elders. We can say that these elders undergo a process of dehumanization and objectification. Hence, the fourth age is omnipresent in this form of care encounter, not only because of what has just been said but also because of the fact that conflict is not compatible with “good care” (Tronto 1993, 2013). Care implies compassion and “tuning in” with the persons’ needs (Heijst 2011), something that is absent in these care encounters, which are dominated by separateness and animosity. The “territories of the self” are seriously violated leading to what Goffman designated as “mortification of the self” (Goffman 1961).

The fourth age is also evident in the infantilization form of care encounter. This form has many similarities with the conflict form, but instead of being dominated by conflictual relationships it is dominated by actions taken by the care workers which infantilize the elders and by concomitant actions taken by the latter manifesting subordination to the former. This kind of interaction devalues the social status of the elders, equating it with the status of babies who are characterized by total dependence on their care providers. This inevitably activates the components of “otherness” and “lessness”, accentuating frailty and producing abjection. Another consequence of treating the elders as if they were a baby has another negative consequence: the erosion of the elders’ agency. In these care encounters “good care”, as defined by Tronto (1993, 2013) is also absent, and the power imbalances which disfavour the elders are also clear.

The exacerbation of frailty and the concomitant production of abjection are also found in the burdensome form of care encounter, although through different dynamics/processes. In these care encounters, are actions, performed by the family carers, such as emphasizing the elders’ physical and mental infirmity and the burdens of

the care situation, which exacerbates frailty and produces abjection. The elders explicitly state that they feel that they have little value and that they demand a lot of work. Therefore, family carers are far away from “good care” (Tronto 1993, 2013), although the care workers maintain a tender relationship with the elders. Another element of the fourth age – loss of agency – is also found in these care encounters, as the elders transfer the decisions about care to their family carers. Therefore, power imbalances are also evident in these care encounters which disadvantage the elders.

Finally, in the form of care encounter marked by indifference the interactions between the care providers and the elders are task-oriented, mechanical and cool. The care providers only take the time that is absolutely necessary to carry out the care tasks. Although there is mutual respect in these care encounters, the care workers are not fully attentive to the elders’ needs and they are not fully concerned about the effectiveness of the care they provide. In this vein, they do not meet all the qualities of “good care” (Tronto 1993, 2013). It is suggested by Tronto (2013) that “good care” requires sufficient time and proximity between the carers and the elders, something that is absent in these care encounters. But perhaps what is more important regarding this form of care encounter is that indifference ends up producing some level of objectification, which affects not only the elders but also the care providers. This objectification ends up producing a sense of “otherness” and “lessness” and, consequently, abjection.

Discussion

Starting with the big picture, the findings reveal several forms of care encounters, being the result of different combinations of aspects related to the care settings and with the actions and interactions of the persons involved in the encounters. Most of these aspects

were already identified by previous studies on the care relationship in the context of home care, such as dirtiness/cleanliness of the care setting and the care-receiver's body (e.g. Twigg 2000; Isaksen 2002; Wibberley 2013), respect and trust (Trojan and Yonge 1993; Tadd and Calnan 2009), ignoring/not ignoring (e.g.: Tadd and Calnan 2009), privacy (e.g.: Tadd and Calnan 2009), autonomy (e.g.: Tadd and Calnan 2009; Lloyd 2014; Valokivi 2005) and feeling a burden (e.g.: Tadd and Calnan 2009). Other aspects less explored (or not explored at all) by the abovementioned studies were also identified in the present study, such as family negligence, task-oriented versus person-oriented actions, and the manner through which the interactions are established (showing harshness, coolness, tenderness).

Still looking at the big picture, we verify that the social imaginary of the fourth age is brought to centre stage by all forms of care encounters, with the exception of the harmony form that keeps this imaginary at a distance. The fourth age pervades almost all forms of care encounter because conflict, infantilization, burdensomeness and indifference compromise “good care” (Tronto, 1993, 2013) and produce a sense of “otherness” and “lessness”, abjection and loss of agency. The fourth age is kept at a distance in the harmony form, because the attention is not focused on the elders' infirmity, but rather on the elders, as persons with biographies and current aspirations and preferences. There is warmth, respect and trust, as well as reciprocity and a balanced distribution of power in these care relationships.

Looking now at the more specific components of the results, we can verify that the way through which care encounters are forged results from micro dynamics and structures. It was demonstrated that the conditions of the care setting (cleanliness/dirtiness, having the things that the care workers need) play an important role. The homes involved in the conflict form of care encounter fit the social construction of a “bad home” and this

negatively interferes with the care workers' actions. As suggested by other studies, dirtiness produces a disruptive effect on care relationships (Isaksen 2002) and puts at risk the care workers' wellbeing (Wibberley 2013). Regarding this, it is important to underline that in one of the two cases inserted in the conflict form, the cleanliness of the care setting improved during the last months of field work, and at the same time the care workers' disposition and mood also improved with positive repercussions in the manner they provided care. This confirms the importance of the care setting and conditions to the manner in which care workers perform their work.

Still at the micro level of reality, the results also show that all participants in the care encounters have an important role in the way care is done. With respect to the elders, despite the power imbalance in their disfavour that exists in any care relationship (Twigg 2000), this study demonstrates that their actions (or lack of action) contribute to the way the care encounters unfold. The relevance of the elders' actions is particularly evident, for example, in the conflict form of care encounter. Interestingly, the findings also reveal that the elders who have high levels of physical and mental infirmity and that, associated with this, are not able to talk (or who have great difficulties in talking), are involved, exclusively, in the infantilization form. High levels of infirmity, when associated with not talking, seem to contribute to the emergence of infantilization. This also confirms that it is difficult to keep the social imaginary of the fourth at a distance when the care relationship becomes what Higgs and Gilleard (2016) call a "relationship of one". In this respect, Higgs and Gilleard (2015: 1) argue that care "should concentrate less on ambiguous and somewhat abstract terms such as personhood and focus instead on supporting people's existing capabilities, while minimising the harmful consequences of their incapacities".

In what concerns care providers, the findings show that the care workers play an important role in the way the care encounters unfold, and ultimately in the possibility of maintaining, or not, the social imaginary of the fourth age at a distance. This is evident in all forms of care encounter, albeit less decisively in the burden form. However, the findings indicate that family carers play an even more decisive role in this respect, whether or not they are present when the care workers make their visits. This becomes evident when we compare the conflict form and the harmony form. In the conflict form the family negligence towards the care settings and the elders clearly interferes negatively with the care workers' disposition and mood and most likely also on the elders' disposition and mood. This, in turn, interferes negatively with the relationship between the elders and the care workers. The harmony form of care encounter shows us the opposite situation: family negligence of the care settings and the elders do not exist (in fact the opposite is true), which interferes positively with the care workers and certainly also with the elders' disposition and mood, and this might have a positive impact in the relationship between them. But the crucial role of the family carers is also clearly evident in the burden form. Therefore, in the cases here studied the family carers' role is more decisive than the care workers' role, because they can interfere not only with the conditions of the care settings and the elders that care workers encounter when they arrive at each house, but also through the interactions that take place during home visits. In fact, the influence of family carers in care encounters does not even require their presence in these encounters.

Nonetheless, these micro dynamics and structures are embedded in meso and macro dynamics and structures, more specifically in the organizational context of home care and the public policy context. For example, if the care workers had had vocational training regarding the relational component of care, they may not have reacted

negatively to the aggressiveness of the elders, nor have infantilized them or have interacted with them with indifference. Previous studies suggested that the culture and rationality of the home care services are inevitably taken to the home visits (England and Dyck 2011). In turn, if the family carers had had information and education about dignity in care, family negligence (of the care settings and the elders), family insensitivity and family indifference may not exist.

Strengths and Limitations

The prolonged engagement in the field and sustained observation are two strengths of the present study, as a significant number of observations were conducted over two years in each home. This enhanced the richness of data and the robustness of analysis. Nevertheless, the present study also exhibits some limitations. First, the findings refer to social contexts characterized by low incomes and low levels of education (elders receiving home care from private for-profit sector were not selected). Second, focus groups were conducted only with the care workers, as it was not possible to schedule focus groups with family carers. Third, member checking was conducted only with the care workers, which may have some implications for the trustworthiness of the findings.

Conclusions

Care encounters at the elders' homes can take different forms and these contribute differently to the avoidance or evocation of the social imaginary of the fourth age. This confirms the 'Janus-like' nature of care.

The way home care encounters are forged, and the associated presence, or not, of the social imaginary of the fourth age, depend on the conditions of the care settings and the actions of all participants. The present study supports the claim made by Higgs and Gilleard (2016) that it is difficult to maintain the social imaginary of the fourth age at a distance when the elders exhibit high levels of infirmity. It also reveals that in the context of home care, family carers play a crucial role in the way care encounters unfold. However, these micro dynamics and structures are embedded in meso and macro dynamics and structures, among which the lack of vocational training regarding the relational component of care and educational programmes for family carers about dignity in care will play a significant role. These have implications for practice and policy.

This study contributes to developing empirical applications of the theoretical perspective of the fourth age. Nevertheless, it calls for further examination of the role of all participants in the care process, as well as the contexts in which the care process is embedded, in maintaining, or not, the fourth age at a distance. It also calls for further debate about how public policies could contribute to maintaining the separation between the fourth age and home care.

Acknowledgements

I would like to thank the reviewers for their valuable comments/suggestions and effort to improve the manuscript. This paper was partially supported by the Portuguese Foundation for Science and Technology (FCT).

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