

CHAPTER

TWO

RESEARCH

METHODS

INTRODUCTION

This study used three main methods of investigation. Firstly, a review of relevant literature, secondly, qualitative analysis of fieldwork interviews with a sample of 34 older co-resident carers and thirdly a small amount of quantitative analysis both of statistical data emerging from interviews and from official data sources. This chapter provides a discussion of the methodological strategies utilised in this research and is structured around the broad stages of the research design, which Bryman (2001) identifies as incorporating the following components: original idea; literature review; design; data collection and organisation; analysis and findings; dissemination. Having discussed the research origins and aims in the introductory chapter, the first part of this chapter will explore the way in which these aims and methods utilised were formulated and modified in the light of a literature review and methodological considerations. The second section explores issues of sample selection and gaining access to participants and this is followed by a discussion of questionnaire design and data-collection. Subsequent sections incorporate a consideration of ethical issues relating to the research and methods of data analysis and the chapter concludes with a reflective discussion of the research process. However, as Bryman (2001) observes, the research process is not usually a linear one, moving progressively through respective stages but more of a spiral. Consequently, respective stages are not mutually exclusive and this is reflected in this chapter in which the subject matter of separate sections is, by necessity, interrelated.

METHODOLOGICAL ISSUES

Positivism and the costs of caring

Before going on to fully discuss the methods used in this research, this section begins by considering some of the methodological issues involved in researching informal care, issues that have, in turn influenced the choice of research design and the methods subsequently utilised. As Harding (2000) observes, such methodological issues have tended to be confused with more general discussions of research method. However, they

are in fact distinct with 'method' referring to techniques for gathering evidence, while 'methodology' is a theory and analysis of how research should proceed and this is itself influenced by broader theories of knowledge or 'epistemologies'. In accordance with this, the methodological focus of research into informal care has reflected British sociology's so called 'wars of religion' (McNeill, 1989) over the relative merits of the epistemological perspective of 'positivism' as adopted by sociologists such as Auguste Comte (1839) and Emile Durkheim (1938). According to this perspective it is possible and desirable for the study of the social world to achieve full scientific status along the same lines as physics, biology and chemistry. As such, positivists believe that, like matter in the natural world, human behaviour is a predictable and measurable response to external stimuli which can be quantified by means of systematic and objective observation and measurement through the utilisation of methods such as surveys and experimental design.

This positivist perspective can be seen to have had a great influence on early research into the costs of informal caring. Such research tended to take the form of quantitatively orientated attempts to measure 'objective' costs such as financial sacrifice, which could in turn be alleviated by the input of material support to the family involved. The work of Grad and Sainsbury (1968) provided an influential example of such research attempting, as it did, to objectively compare the burdens experienced by various families of psychiatric patients in receipt of institutional or home-based care (chapter 4). Like much subsequent research into the area, this research developed an overall rating of family burden by evaluating the degree of hardship experienced in various aspects of the family's life, all of which were rated as 'none', 'some' or 'severe'. Thus, it can be seen from the below chart, that there was a greater relief of 'burden' after two years in the Salisbury region which favoured institutional care, than there was in the Chichester region, which favoured home based care. In spite of the apparently conclusive correlation found in this and other research between informal caring involvement and the associated costs experienced by carers, subsequent research into the area has revealed contradictory findings. Thus, Pasamanick (1967), Stein (1975), Hertz (1976) and Test (1980) found that, contrary to the claims of Grad and Sainsbury (1968), alternatives to

hospital care produced no significant differences in the impact on families or that home based care actually resulted in less strain on families than did hospital care. This lack of consistency in research findings can be seen as ultimately driving from the numerous methodological problems involved in attempts to objectively measure the costs of informal caring by means of quantitative methodology.

Table 2.1: Percentage of families affected at referral and at the end of two years

AREA OF LIFE	CHICHESTER	SALISBURY		CHICHESTER	SALISBURY
Household routine	25	36		13	6
Social life	32	32		22	14
Income	27	25		20	10
Mental health	53	77		38	19
Physical health	17	8		6	4
Employment	8	7		13	9
Children	36	37		40	32
Total	198	222		152	94

Source: Grad and Sainsbury (1968: 271)

As such, unlike matter in the natural world, which is subject to universal and unchanging laws, such as the law of gravity, social phenomena tend to be more ambiguous. Thus the ambiguity of the central concepts of 'informal care' and the 'costs' of such care combined with corresponding variations in defining these concepts have led to a lack of standardisation and consistency between research projects. For example, the research of Grad and Sainsbury (1968) was largely based on an artificially manufactured 'ideal type' scenario of community care, bearing little resemblance to actual provision at the time. At the same time, the costs of caring have themselves been defined and subsequently measured in numerous different ways (Platt, 1985). Thus as Braun (1981) points out, relevant studies are of differing designs and are set in different countries with diverse groups of patients and carers. They are also conducted over a large time-span, with follow-up periods varying from six months to five years. These methodological problems have been exacerbated by the occurrence of extraneous variables serving to undermine the examined causal relationship between community care and the costs of

informal caring. Thus age, diagnosis, social class and type of support have all been found to have an independent impact on family burden (Perring et al, 1990). For example, contrary to the suggestions of Grad and Sainsbury (1968), Challis and Davis (1980; 1986) found that frail older people could be cost effectively supported at home through the innovative and efficient use of community services. Similar problems in identifying causality are apparent in straightforward attempts to establish the impact of caring on just one aspect of the carer's life. For example, although many carers have been found to suffer from ill health, it is not clear that this is as a direct result of their caring role. Thus, while almost half the carers in the research of Charlesworth (1983) reported ill health, this compared favourably to national statistics of morbidity for their age group. Similar problems can be seen in the association between caring and psychological strain. For example, Namyslowska (1986) found that families not caring for a dependent relative showed the same characteristics of strain as the families, which were, thus highlighting the possibility that families involved in such caring may unjustly attribute their pre-existing tensions and problems to their 'deviant' relative in a process of scapegoating as outlined by Vogel and Bell (1968).

It is perhaps a reflection of the socially pervasive culture of the nuclear family 'norm' and of the accepted roles of the family and the state within the 'welfare partnership' (chapter 1), that the role of the family in caring for an adult dependent is seen as being a deviation of traditional roles and therefore inevitably costly as compared with the more accepted familial role of childrearing which is generally regarded as being a positive experience. As such, the experienced costs of caring may be socially or culturally mediated and reflect society's expectations about what carers should or should not be expected to do (Parker, 1990). These expectations may vary, across time, between classes and genders and between generations, affecting perceptions of carers, service providers and researchers alike of what is and what is not 'costly'. For example, Ungerson (1983) has identified caring tasks, which in Western society are designated female, and those which are designated male and service providers have been found to be more willing to provide formal support when these 'normal' boundaries are crossed. Similar value judgements can be found in the way that research is carried out with the fixed interview schedules

and closed-ended questions used in quantitative methodology serving to impose the researcher's own values and meanings onto the study by, for example, confining carers to a range of largely negative responses when questioned on their experience of their role. This role of social norms and expectations in shaping the way in which researchers, service providers and carers themselves perceive the costs of caring serves to undermine the claims of positivists of the possibility and desirability of a value free social science. Thus, as Kuhn (1962) maintains no knowledge can exist independently or objectively for it is the product of its social context being constructed and created within a framework of assumption or 'paradigms'. Moreover, as many feminists have observed, much of this research, in focusing on the costs incurred to the whole household, ignores the existence of social divisions within the household, which leaves some members, especially women to carry most of the caring 'costs' (Lewis and Meredith, 1988). Further distortion can arise as a result of 'reactivity' or interviewer bias brought about by the presence of the researcher. For, according to phenomenologists, all information gained in interaction situations is highly subjective, influenced as it is by the respective values and expectations of the participants. For example, Fennell et al (1988) observe that older people in receipt of formal provision are unlikely to express dissatisfaction with this provision due to such things as their sense of loyalty to the staff or due to the fear of negative repercussions on their service input if they were to voice any criticisms.

Phenomenological, interpretivist and participatory approaches

In spite of the problems of validity associated with quantitative research into informal caring, supporters of this type of methodology claim that such problems will eventually be overcome through the pursuit of greater sophistication in research techniques. It is thus maintained that such methods are potentially superior to other methods, in terms of their reliability as a result of the accuracy and replicability of their findings, in terms of their validity due to the integrity of these findings and in terms of their representativeness due to precise sample selection (Bryman, 2001). However, adherents to 'phenomenological' and 'interpretivist' perspectives in sociology (chapter 1), as advocated by writers such as Weber (1949), believe that the techniques of positivism are inherently unsuited to the study of the social world. Thus, it is argued that the attempts of quantitative research to

isolate variables for the purpose of hypothesis-testing is not only very difficult in social settings but it also potentially acts as a barrier to understanding which can only be overcome if the researcher adopts a holistic perspective encompassing the totality of the situation being studied. This, it is claimed, can only be achieved by means of qualitative methodology. Positive techniques are further criticised for their superficiality in that they focus on the outwardly observable aspects of human behaviour rather than on its inner meaning. Thus it is argued that, unlike matter in the natural world, human behaviour is not a predictable and measurable response to external stimuli but is intrinsically meaningful and is the role of the researcher to explore these meanings rather than attempting to copy the methods of the natural sciences.

This meaningful aspect of human behaviour is apparent in informal care which as Qureshi and Walker (1989) observe does not only involve the performance of tasks but also takes place in a relationship normally involving kin and as such unlike formal care is closely related to such feelings as emotion and obligation. As it was seen in chapter one, this distinction between formal and informal care is further emphasised by theorists such as Parker (1981), Ungerson (1983) and Abrams (1978) who have argued that, not only is informal care uniquely expressive in nature but it is also characterised by its idiosyncrasy and spontaneity arising from arbitrary factors such as the individual social contexts and life histories of those involved. As Blau (1964) stated, in any longstanding relationship in which social exchanges are involved, a set of shared values will have been built up as to what constitutes 'correct' performance of roles. Some of these values will reflect pre-existing general value beliefs but others will be unique to that particular relationship. This growing awareness of the importance of subjectivity, meaning and motives in the understanding of human experience, in addition to the numerous methodological problems associated with quantitatively orientated attempts to measure this experience, has led many researchers to entirely reject positivist approaches in favour of qualitative methodology. As Webb (1996) observes, this development has been very apparent in feminist research, it being argued that qualitative methods help to empower women by exploring their previously marginalized perspectives. Such a trend has also been apparent in research into informal care, which has increasingly taken the form of

qualitative studies focusing on the subjective experiences of caring rather than its objective costs. These subjective experiences are difficult to measure with quantitative methods and may have little relationship to the objective costs of caring but, as Parker (1990) observes, are of prime importance in influencing the way in which the caring role is managed and experienced.

In spite of the merits of qualitative research into the costs of informal caring, in focusing on the individual meaning and motives of carers, such methods overlook the way in which these meanings and motives are themselves constrained by objective social forms (Williams, 1992). For example, the spontaneous and expressive nature attributed to informal care by some theorists could itself be undermined by material constraint, having a subsequently negative impact on the quality of the experience for both carer and care recipient alike (chapter 1). As such, the instrumental-expressive divide drawn by theorists between formal and informal care is debatable and is likely to be less clear-cut than is commonly portrayed. Moreover, in focusing on the individual, such research, unlike positivist methodology, ignores systematic differences between individuals such as those arising from class and poverty (Webb, 1996; Graham, 1984). As it was suggested in chapter one, cultural factors may also have an important systematic influence on the role of carers and these may be particularly significant for older carers within the spousal relationship, due to such things as traditional views about marriage (Gladstone, 1995). This role of social structural factors such as class, culture and poverty in shaping the delivery and experience of informal care serves to undermine the interpretivist concept of the individual as being the source of all meaning and action. Thus as McNeill (1989) observes, while people's actions are the result of their interpretations of a situation, their interpretations and choices are themselves limited by structural factors which are external to them and beyond their control.

This dual nature of human experience, incorporating social constraint as well as individual intent, suggests the need for social research to take account of this duality in the methodology utilised. This need has been recognised by some researchers who are increasingly adopting a pragmatic rather than dogmatic approach to methodological

choice and using a combination of both qualitative and quantitative methods with the strengths of one method helping to compensate for the weakness of another. For example, Bryman (2001) observes that quantitative research can facilitate qualitative research by such things as helping to uncover the generality of phenomena observed. Thus it has already been seen in chapter one that statistical data provided by authors such as Arber and Ginn (1992) and Milne et al (2001) have served to highlight the previously neglected class and age dimensions of informal caring. On the other hand, qualitative methods can complement quantitative research by originating initial hypotheses to be subsequently explored by quantitative methods. It can also 'look behind' pre-existing statistical data and explore the relationship between variables uncovered by this data (chapter 1). In accordance with these observations, this research has adopted this dual methodological approach incorporating open-ended, exploratory questions, yielding a large amount of qualitative data, some closed-ended questions yielding a smaller amount of quantitative data and the secondary analysis of official data sets with the Statistical Package for the Social Sciences (SPSS).

Recent methodological trends towards qualitative research, parallel the adoption of post-modern perspectives in welfare which, as it was seen in chapter one, adopt a 'bottom up' approach to assessment and intervention aiming to promote the participation and empowerment of service users by allowing them to exercise choice and express their individuality (Williams, 1992). Accordingly, there is now a growing interest in more participatory approaches to research and evaluation, particularly in the areas of health and social care (Kemshall and Littlechild, 2000). Barnes (1994) observes that this user participation is currently being given a high profile in research through the facilitation of users' involvement in its orientation, design and development as well as in its subsequent dissemination. Such participatory approaches have traditionally been associated with qualitative methodology which has been regarded as being intrinsically empowering, serving to minimise the existence of hierarchy in the research relationship and aiming to emancipate respondents rather than simply describing and documenting their situation. However, the adoption of such a methodological approach has tended to be uncritical with discussion of 'user involvement' in research focusing on the practical issues of

method, such as how to access 'hard to reach groups' rather than on the overall effectiveness of participatory approaches and the methodological and ideological assumptions underpinning them (Beresford, 2002). In recognition of this neglect, Beresford (2002) has identified two distinct models of participatory research, 'consumerist' and 'democratic'. He maintains that consumerist models have been most commonly associated with the political right and its concern with maximising profitability and effectiveness in the welfare market, a concern, which has also been adopted by New Labour's 'remix' of state and market interventions. This approach is framed mainly in market research terms of 'improving the product' and in promoting efficiency, economy and effectiveness, through market-testing and feedback. As such, this approach generally starts with policy and the service system and focuses on external input with which the state and its agencies themselves decide what to do. In contrast, the democratic model of participatory research aims to be rooted in people's lives and aspirations and is concerned that participants are 'empowered' and have the direct capacity and opportunity to make change.

However, in spite of the widespread acceptance and advocacy of such participatory methods, as Beresford (2002) observes, serious concerns are increasingly being expressed as to the effectiveness of these methods. For example, issues of 'consultation fatigue' and 'tokenism' are being raised in which user involvement is frequently being treated as a 'box-ticking' exercise and regarded as meaningless 'nuisance' both to participants and researchers alike. Moreover, there are concerns that the nature and focus of participatory research encourages the 'abstraction of participation from its political and ideological relations' (Beresford, 2002). For example, Swain (2001) maintains that user participation lacks meaning when it is the researcher who defines the terms of this participation, originates the research focus and controls the funding, analysis and dissemination of this research. Adherents to participatory approaches may maintain that such problems could be overcome by ever-greater levels of user involvement, methodological sophistication and funding. However, such methods are more fundamentally flawed. For, like criticisms of the postmodernist perspective and qualitative methods, such participatory

approaches can neglect the wider context of inequality within which the research takes place. For example, as Oliver (1996: 143) observes with regard to disability research:

If the category of disability is to be produced in ways different from the individualised, pathological way it is currently produced, then what should be researched is not the disabled people of the positivist and interpretative research paradigms but the 'disablism' ingrained in the individualistic consciousness and institutionalised practices of what is, ultimately, a disablist society.

In response to these observations, Beresford (2002) advocates the adoption of an 'emancipatory' research paradigm, which takes account of wider social structures. Such an approach, he maintains, is distinct from other research paradigms and does not necessarily incorporate participatory methods but aims for reciprocity, gain and empowerment in the research relationship. While this research does not claim to conform to this emancipatory paradigm, it does in accordance with the recommendations of Beresford (2002) take account both of the structured and meaningful aspects of human experience.

SAMPLE SELECTION AND GAINING ACCESS

As Burgess (1984) observes, field research takes place in a social setting and it is never possible for research to study all relevant people in a given situation. Sample selection is therefore a necessary precondition to the commencement of research. There are two main types of sampling strategies: random or probability sampling, in which every unit in the universe of study has the same likelihood of being selected and non-random or non-probability sampling, in which there is no means of estimating the probability of units being included in the sample. Random sampling is commonly associated with quantitative research methods and, while it is often believed that such sampling methods serve to enhance the validity and generalizability of subsequent findings, as Bryman (2001) maintains, this is not necessarily the case. Indeed, it was seen in the previous section that 'scientific' research into informal caring is potentially strewn with methodological problems serving to undermine this generalizability. Consequently for the purposes of this research, non-random sampling was felt to be preferable to the types of random sampling commonly used in quantitative research because such methods were not appropriate to the small-scale of the study or its broadly exploratory aims. There are

several types of non-random sampling and for pragmatic reasons, this research can be seen to have utilised a number of these. ‘Purposive’ or ‘judgement’ sampling involves the researcher, selecting respondents who conform to a number of preset criteria. In accordance with this, all respondents selected for this research had to be ‘older’, retired and performing a co-resident caring role. While there are many ways of defining what is meant by ‘older’, for the purpose of standardisation, in this research the age of sixty and above was chosen. In order to achieve standardisation in the broader caring context, carers also had to be living in the Sheffield area, the location of my base university. Not only has this area been one of relative deprivation since the decline of the steel industry (Beattie, 1986) it has also been found to be one of the four areas in the country with the largest number of carers per capita (BBC, 2003). However, sample selection can also be seen to have been ‘opportunistic’ in that, providing they met this preset criteria, respondents were selected, as they were available and willing to participate in the research. As fieldwork progressed, ‘theoretical’ and ‘snowball’ sampling were also used. The former involves reviewing sample selection in the light of emerging theory and analysis (Glazer and Strauss, 1967), while the latter involves asking respondents to suggest others in a similar situation, thus following the pattern social relations in a particular setting (Coleman, 1958). It will be the purpose of the rest of this section to outline and illustrate the practical implementation of this process of sample selection and gaining access.

Negotiating access

As a precondition to sample selection, an appropriate source or sample frame had to be identified and access to it negotiated. One possible sample frame was the patient list of general practitioners, a method that was described by Qureshi and Walker (1989) in their book *The Caring Relationship*. However, while such lists have been found to cover the vast majority of the local population (Isaacs and Neville, 1976), they have also been found to include high proportions of deceased former patients (Seyd, Tennant and Bayley, 1985). Gaining access to such lists would also have involved possibly lengthy negotiations with NHS ethics boards. Moreover, it would have been virtually impossible to identify from these lists all of those involved in co-resident caring. For, as many

researchers have observed, the performance of such caring especially between older people is often ambiguous and difficult to define (Arber and Ginn, 1995). In order to overcome these problems, the large number of carer support groups in Sheffield were used as an initial point of contact, the members of which had, by their participation, already defined themselves as carers. Access was negotiated via relevant 'gatekeepers' who in this case were the staff of the Princess Royal Carers Centre in Sheffield, who help to coordinate the City's complex network of carer support groups and publish a regular newsletter. Staff were given a summary of the proposed research and its aims together with assurances of the anonymity and confidentiality of respondents. The second main gatekeepers, the carers themselves, were then contacted via an advert in their newsletter, a poster in the Carers' Centre and by visits and letters to relevant carers groups. Such contacts passed on details of the research as well as an appeal for participants. Unfortunately, as there were no carer groups catering specifically for older carers, more generic groups had to be targeted. In spite of my efforts, only two older carers were gleaned from my contact with carers groups, Mr Cicourel and Mrs Reid. Two others, Mrs Hudson and Mrs Hacker were accessed via personal contacts and these four carers formed my pilot sample, which took place in the summer of 1998.

In order to contact carers for the main body of my research, I pursued a variety of statutory and non-statutory agencies in the subsequent academic year. My first point of contact was Sheffield Social Services Commissioning Officer for Older People. Through her I contacted two further carers via field social workers and obtained a list of eight carers from a home care service manager, six of whom agreed to take part while two refused. As with all subsequent gatekeepers who helped me to gain access to carers, I wrote to thank them for their co-operation. I also adopted a standardised way of introducing myself to carers, which was continued throughout my fieldwork. This involved obtaining their telephone numbers and addresses and writing them a letter of introduction, outlining my research and contact details if they had any queries. In order to provide evidence of my authenticity it was typed on university-headed paper. Around one to two weeks after I posted the letter, I followed it up with a phone call to the carer to ascertain their willingness to take part in my research, to answer any questions and to

make an appointment to see them if they were in agreement with this. Following the completion of my interview, I asked carers if they were willing to take part in a follow-up interview - all agreed. I also provided carers with a signed guarantee that their interview would be confidential and used only for the purpose of my research, as well as promising to provide them with feedback on my findings, if they so wished. Due to the sporadic nature of my sample access, interviews throughout the fieldwork took place on a phased basis.

Reviewing and supplementing the sample

The first phase of interviews, showed a tendency for the carers referred by the social services to be very highly involved, caring for severely disabled people. I felt that this was probably due to the sample frame: such carers being more likely to be highly burdened and in receipt of social work or home care services than their counterparts from support groups. In order to increase the diversity of my sample and the size of the pool from which I could draw respondents, I began to write to a number of voluntary agencies, in accordance with the principles of 'theoretical sampling'. These agencies included the Crossroads Sitting Service and organisations run for older people in general such as Agewell. This was because previous reading and experience had suggested that many older people may be involved in caring without defining themselves as carers especially those involved in reciprocally caring spousal relationships (chapter 1). I also put up posters in agencies such as Age Concern and placed an advert in the national journal, *'Community Care'*. I often found these attempts frustrating, experiencing little success in gaining access, either due to a refusal of 'gatekeepers' to provide access or due to the failure of carers to respond. Indeed, as Bytheway (2002) notes, gaining access can not only be a time-consuming process in which success is not always guaranteed, it can also be fraught with traditional attitudes of 'ageist protectionism' on behalf of gatekeepers. Nevertheless, I did eventually gain access to three carers from the South West Area Sitting Service, Miss Howard, Mrs Flude and Mr Davis, all of whom had already taken part in another research project. The Chinese Community Centre also put me in touch with a carer but unfortunately she died before I had a chance to interview her. Snowballing via my existing sample also yielded little success with only one carer in

my first phase of interviews, Mr Caplow, being able to put me in touch with another in a similar situation, Mr Tunstall. I feel that this lack of success in snowball sampling can be largely explained by the social isolation of most of the carers I interviewed.

As a result of these problems in gaining access, by the time I was well into my second year of research, I had still only seen eighteen carers. In view of the fact that I hoped to carry out quantitative as well as qualitative analysis of my fieldwork findings, it was clear that my sample size needed to be increased. I eventually achieved this by negotiating access with Sheffield Social Services Home Care Service. This negotiation was quite a lengthy process involving the obtaining of initial approval of the Head of Older People's Services in Sheffield. I then had to negotiate access with a local Home Care Manager and her supervisor, who herself raised initial reservations over issues of client confidentiality. Once access was eventually granted, problems were experienced by the Home Care Manager in tracing older co-resident carers in receipt of the home care service. This was because their computer system did not categorise carers in terms of their age, unless they were 'young carers', thus rendering older carers effectively invisible. As a consequence of this she had to resort to asking each area home care supervisor to provide her with a list of all the older co-resident carers on their caseload. These lists, comprising a total of 44 carers were forwarded to me in June 1999. As the lists held only names and addresses I was then faced with the task of attempting to locate carers' phone numbers and post-codes through local directories. Once their phone numbers and post codes had been traced, as with the previous phase of interviews, I wrote to them to introduce myself and then rang them up to make an appointment. I eventually managed to trace and contact 30 of the initial list of 44 carers. Of these, seven refused to take part, largely due to ill health, two were too deaf to understand me speaking on the phone, two had phone lines which were cut off and in three cases the carer or care recipient had recently died. Consequently 16 were eventually interviewed, bringing up my total sample for the main body of interviews to 34 respondents. While this is a relatively small sample size, it is not unusual for qualitative studies to utilise small samples. Indeed, many influential studies have been based on much smaller samples than this (Glendinning, 1992).

The process of gaining access for follow-up interviews was similarly tortuous. For while all respondents in the initial sample had agreed to take part in a follow-up interview, in attempting to contact respondents in preparation for these interviews, it was discovered that many of them were no longer living at their former address. In some cases, I was able to ascertain what had happened to them. Mr Tunstall, for example, had died, while Miss Howard and Mr Davis had moved house following the death and care home admission to a care home of their respective mothers. Another respondent, Mrs Phillips said that she would find participating in a follow-up interview too upsetting as her husband had recently died. However, in the majority of cases I could not contact respondents and could only speculate on their whereabouts. This high incidence of death and disappearance serves to highlight an important problem in carrying out longitudinal studies with older people. The number of respondents taking part in follow-up interviews was therefore limited to nine. This small number, in turn, served to undermine the possibility of conducting a focus group after the follow-up interviews in which emergent themes could have been further pursued. For only three of the follow-up sample of nine said they would be able to participate in a focus group. This was due to the 'restrictedness' placed on carers as a result of their role, or due to lack of transport and mobility problems (chapters 3, 4 and 5).

Sample characteristics

As the profile of respondents below shows, eighteen of the carers were women and sixteen were men. Their ages ranged from 60 to 94 years, all were retired and lived in two-person households with the cared for person. The majority, 27, were caring for their spouses, 5 were caring for adult children with disabilities and 2 were looking after their aged parents. In accordance with the 'social relations of power' polyhedron (Williams, 1992) alluded to in chapter one, diversity in disability, age, class and gender was to a certain extent achieved in this sample and was taken into account when analysing findings. However, sexual diversity was not achieved: with the exception of Miss Howard, all of the respondents were currently or had previously been in heterosexual marriages and issues of sexuality are not explicitly dealt within this thesis. Neither was the sample ethnically diverse: most of the respondents were white and part of the

indigenous British population, indeed, most were also indigenous to Sheffield. The exceptions to this ethnic homogeneity were a white Italian man, Mr Cicourel and Mr Denis, a black Jamaican man, both of whom had migrated to Britain during the 1950s in search of improved employment opportunities. As a consequence of this largely white, British sample, ethnic minority issues are not comprehensively covered. The main characteristics of the respondents in the sample are outlined in the table below and are described in more detail throughout chapters three, four and five and in the pen portraits shown in the appendix.

Table 2.2: Profile of respondents

GENDER	MALE	16
	FEMALE	18
AGE	60-69	9
	70-79	10
	80-89	12
	90 PLUS	3
CARED FOR PERSON	HUSBAND	14
	WIFE	13
	SON	4
	DAUGHTER	1
	MOTHER	2
MARITAL STATUS	MARRIED	27
	DIVORCED	2
	WIDOWED	4
	SINGLE	1
ETHNIC ORIGIN	WHITE BRITISH	32
	WHITE ITALIAN	1
	BLACK JAMAICAN	1
SOURCE (how initial contact was made)	SOCIAL SERVICES	24
	VOLUNTARY	5
	ORGANISATION	
	PERSONAL CONTACT	3
	ADVERTISEMENT	2

QUESTIONNAIRE DESIGN AND DATA COLLECTION

As discussed in the methodological issues section of this chapter, the analytical duality of informal care, involving both subjective feelings and objective tasks has been reflected in research into this care. Thus, as Graham (1983) identifies, studies have typically been divided into two categories: quantitative surveys, which focus on the objective elements

and material basis of caring and qualitative accounts, which explore its subjective and psychological meanings. However, as Bulmer (1987) has observed, in order for the informal caring role to be fully understood, research must explore both the objective structures underlying this provision and the way in which these structures are subjectively perceived and rationalised. Consequently, in order to benefit from the potential advantages of qualitative and quantitative methodology and to compare the relationship between the objective and subjective experiences of carers, a combination of open-ended and closed- ended questions were incorporated in the questionnaire which was used in the first stage of data collection and which aimed to evaluate the way in, which the material circumstances of carers interact with their caring role. The questionnaires used in the pilot, main and follow-up interviews can all be found in the appendix.

The piloting phase

In order to avoid the disempowering or 'top down' approach commonly associated with research into older people, it was felt that carers' views and perceptions should help to shape the design and implementation of the questionnaire. One way in which this might have been achieved was through running a focus group prior to the design of the questionnaire schedule so that older carers themselves could identify issues to be incorporated. However, there were many practical problems potentially involved in achieving this arising from the inability or unwillingness of highly involved carers to participate in such a group due to their caring responsibilities and mobility limitations. Indeed, as subsequent interviews showed, for these reasons, only three carers in the sample of 34 were a member of a carer support group. As a result of these considerations, a compromise was therefore made with the compilation of the main questionnaire being preceded by a pilot phase involving four carers. This aimed to evaluate the design of the questionnaire and its administration including the appropriateness of the questions and the clarity of the instructions, so that amendments could be made prior to the commencement of the main body of research. One significant area of modification was on questions relating to finance. Thus, in an attempt to evaluate the material circumstances of respondents, in the pilot questionnaire, carers were asked if they experienced problems with debt. This question drew on my knowledge of research on

younger carers in poverty amongst whom credit and debt has been found to be widely utilized (Ford, 1991). However, to my surprise, none of the respondents in the pilot sample claimed to experience such problems (chapter 3). As a consequence of this, in the main body of interviews, this question was dispensed with and was replaced with questions probing respondents' ability to 'make ends meet', their actual level of income and the way in which this income was distributed within the household. Another modification made following the pilot questionnaire was to a question relating to the age of respondents. For while the pilot questionnaire asked respondents to indicate their age band, it was subsequently discovered that all the pilot sample were willing to give their exact age. This practice of age-banding was therefore dropped in the main body of interviews with carers instead being asked their date of birth. It was felt that this was slightly more tactful than asking people their precise ages, in addition, my experiences as a psychiatric nurse suggested that those with poor memories were more likely to remember their date of birth than their current age.

Just as questionnaire design was adapted in the light of carer responses, so was its administration. For example, it was originally intended that, rather than incorporating all of the questions in one questionnaire, quantitative data would be obtained by means of a short questionnaire completed by the carer which would then be followed by a semi-structured interview eliciting the qualitative component of the data. The rationale behind this decision was that, in accordance with the findings of Brooks et al (1993), carers would find it easier to disclose sensitive issues such as details of their income through the relative impersonality of a self-completed questionnaire format rather than in a face-to-face interview. However, contrary to expectations, all of the carers in the pilot sample preferred me to 'talk through' the questionnaire with them rather than complete alone. Moreover, all of the pilot participants had problems in answering some of the closed-ended questions 'cold', finding it easier to answer them when they were delivered within the context of the semi-structured interview. This was because the interview allowed them to clarify their thoughts and feelings and also enabled me to reflect back on what they had previously said, if they were in any doubt on how to answer a particular question. For example, without guidance and clarification, pilot respondents had great

difficulty in answering questions on the impact of caring upon various aspects of their lives, not understanding what was meant by such things as 'household routine' and 'emotional health'.

The main body of interviews

As a consequence of the above considerations, in the main body of interviews, all questions were delivered by myself in the form of an interview. The findings were both tape-recorded and noted manually. All but six carers, Mr and Mrs Thompson, Mr and Mrs Lane, Mrs Harris and Mrs Phillips were interviewed alone, obviously such sole interviewing can be associated with ethical problems (Marsden, 1987), however, dual interviews can be equally problematic (chapter 4). Interviews lasted from between one and four hours and took place in the carer's own home. These great variations in the length of interviews were attributable to the semi-structured and exploratory interview format, which allowed respondents to help to guide what issues were covered. The first section of the questionnaire elicited the personal details of the carer including their age, gender, ethnicity, marital status, living arrangements and their relationship to the person for whom they care. This information helped me to gain an insight into the impact of social divisions, such as age and gender, on the caring role. Moreover, these social divisions can themselves be an important guide to material circumstances. For example, widowed women who are over sixty-five have been found to be particularly vulnerable to poverty (Arber and Ginn, 1991). The second and third sections of the questionnaire elicited information on the respondent's caring role and material circumstances respectively with a series of closed and open-ended questions. Thus both sections aimed to ascertain the 'objective' income and caring responsibilities of respondents as well as the way in which these factors were managed and subjectively experienced. Arber and Ginn (1991) have observed that carers' material circumstances are not simply the product of their access to income but are also the result of their access to formal and informal support. The final section of the questionnaire therefore aimed to ascertain levels of access to this support and the degree of satisfaction with it.

In order to avoid 'reinventing the wheel' and to fully utilise existing expertise in the area, the questionnaire used in the main body of interviews was provisionally constructed with reference to many quantitative indicators utilised in previous research. For example, questions 17 and 18 of the questionnaire, which aimed to evaluate the nature and duration of the caring role, are indicators used by the General Household Survey (Green, 1988) to determine the degree of caring involvement exercised by carers. Similarly the scales used in question 19 on the impact of caring and question 35 evaluating access to formal provision were adapted from the research of Grad and Sainsbury (1968) and Walker and Warren (1996) respectively. However, these quantitative indicators were not adopted uncritically, for while such methods provide 'hard' data and allowed me to identify systematic differences between carers, differences which as Carr et al (1996) observe are often obscured in qualitative research, such methods can also be disempowering to respondents by marginalizing their perspectives through the imposition of preconceived and inflexible categories (Warren, 1994). For example the questions originally used by Grad and Sainsbury (1968) on the impact of caring reflected their implicit assumption that such caring was an inherently negative experience. Thus, they followed questions on the impact of caring on various aspects of the carer's life with the possible responses of 'none', 'some' and 'severe'. In order to avoid this distortion, this questionnaire allowed for the possibility of positive responses to questions on the 'costs' of caring (see question 19). This decision to modify conventional rating scales was justified in the pilot study with all four respondents maintaining that caring had made a positive contribution to some areas of their life.

My adaptation of quantitative indicators used in the questionnaire in order to minimise the distortion of carers' responses helped to avoid the disempowering approach commonly associated with quantitative methods. This was further facilitated by the inclusion within the questionnaire of many open-ended questions also taken from pre-existing research such as Grants (1995) exploratory study into disability and debt. The exploratory nature of such questions combined with a reflexive approach to questionnaire design enabled me to identify emergent issues to be pursued in subsequent interviews. For example, although not incorporated into my initial questionnaire the issue of car

ownership and access to transportation in general quickly emerged as an important influence on the material circumstances and subsequent caring role of my respondents. Questions concerning this issue were therefore incorporated into subsequent interviews. Not only did this adaptation of the questionnaire and its administration help to ensure that participants' perceptions and preferences had some influence on the research design, it also helped to promote the validity of the data produced by minimising its distortion and ensuring that interviews measured and described what they were supposed to (Denzin, 2000). Such validity can also be promoted by enhancing the scope, depth and consistency of research design through the use of methodological triangulation, which as Flick (1998) recognises helps to transcend the limited epistemological potential of the individual method. Triangulation usually refers to using more than one method or source of data. However the term has been interpreted more broadly by Denzin (1970) to refer to approaches using multiple observers, theoretical perspectives, sources of data and methodologies. For example, the use of multiple investigators can help to detect or minimise biases resulting from individual researcher. The scope of my research did not permit me to use this form of triangulation during my interviews with carers, all of which were administered by myself. Nevertheless, as Booth and Booth (1994) recognise, this personalised method of administration helped to facilitate reciprocity in the research relationship, allowing me to tell participants about myself and my research before the interview commenced. It also facilitated the adaptation and modification of the interview format.

Follow-up interviews

Further depth was added to the research through the use of follow-up interviews. The specific intentions behind conducting these interviews were threefold. Firstly they gave to the research a longitudinal dimension allowing for an exploration of the way in which the carer's life had changed since the initial interviews. This process was further facilitated by the inclusion within the follow-up interview questionnaire of an open-ended section exploring the biography of the respondent. These biographical approaches help the researcher to understand the workings of the respondents' lives, showing how events unfold and interrelate over their life course (Bryman, 2001).

Those who listen to the life stories of older people whom they wish to help, gain markedly different pictures of the person and their needs from those who administer traditional assessment techniques (Dant et al, 1992: 187).

They can also be therapeutic to the older person, since the telling of these stories is often part of their adjustment process and is a commonly utilised therapeutic technique with older people (Lyttle, 1986). A second aim of conducting follow-up interviews was that they allowed for the pursuit of themes emerging from initial interviews and the provision of feedback on these themes to respondents. Thus the follow-up interview schedule (see appendix) was structured quite differently to the initial interview schedule and provided brief feedback on emergent themes such as mobility and financial management. Follow-up interviews were also used as an opportunity to clarify issues of ambiguity. For example, as analysis of initial interviews progressed, it became clear that, due to respondents' financial caution, initial questions probing perceived material circumstances were too 'blunt' an instrument for respondents. For, contrary to expectations, none of the carers claimed that they ever had problems in 'making ends meet'. More sensitive measures of perceived financial well-being such as those suggested by Walker and Maltby (1997) should have been utilised instead. These were therefore incorporated into the follow-up interview schedule. Here respondents were asked to describe their financial position with possible responses ranging on a continuum from 'very comfortable' to 'things are very difficult'.

Responses to questions on the financial allocative systems of households were often unclear in the main body of interviews. This lack of clarity may have been due to their difficulty in expressing verbally the complexity of their financial management systems and because, not surprisingly, they did not neatly conceptualise these systems in terms of the four classifications suggested by Pahl (1984). These problems were further exacerbated by my unwillingness to probe too deeply in view of the relatively sensitive nature of the issue being explored. Thus some carer's responses to this question varied from incomprehension:

Mr Caplow: What do you mean?

To ambiguity:

Mr Hall: We share everything don't we?

Me: Have you always shared responsibility?

Mr Hall: As far enough as it would allow

Me: When you were working, did you put all your earnings together or did you keep your own earnings to yourself?

Mr Denis: I never had any spare cash (Mr Denis)

This ambiguity of response sometimes persisted even after significant probing:

Me: Say, when you were in your forties, did you pay the bills or did he?

Mrs Field: Well it depended. He always paid the utilities but we pay those by direct debit so he doesn't have to trouble about those. I've always paid for everything else really

Me: You often find that men pay the big bills and make major financial decisions

Mrs Field: Oh he's never made financial decisions for me (laughing)

Me: So you've always done the housekeeping?

Mrs Field: I certainly do, he's never done any of that on my behalf. I mean the car belongs to me, not to him

In view of this lack of clarity, follow-up interviews preceded questions on income allocation with an overview of Pahl's (1984) four main allocative systems (chapter 1) and respondents were then asked to identify which one they had used both pre- and post-retirement. However, with hindsight, this may also have been over complex and in addition may have been over-prescriptive in terms of the categories utilised. In view of this, the presentation of various vignettes may have been a preferable alternative.

ETHICAL CONSIDERATIONS

Throughout the fieldwork, the ethical principles of social research were stringently applied as cited in the British Sociological Association's statement of ethical practice (1996). It was ensured that participants knew that their involvement was entirely voluntary and that they could 'opt out' of the research at any stage. Attention was also paid to the protection of the privacy, confidentiality and anonymity of respondents and to ensuring that their well-being was not adversely affected by their participation. In accordance with this, all respondents were allocated a pseudonym drawn from the

bibliography of an introductory sociological textbook (Haralambos, 1980). Another important ethical issue to note is the sensitive nature of the topics, which were explored in interviews. For example, several researchers into poverty have commented on the reluctance of poorer people to associate themselves with such research due to unwillingness to accept their own poverty (Alcock, 1993). I therefore attempted to exercise subtlety in addressing sensitive financial issues and did not ask questions about these issues to the end stages of each interview (Corden, 1996). In fact, the majority responded very well and talked openly and perceptively about issues relevant to my research focus.

A central legal and ethical issue surrounding social research is that of 'informed consent'. My research conformed to this principle and the aims of the study were made clear to potential participants who then decided whether or not to become involved. However, there are problems associated with this approach. For example, qualitative researchers can rarely be completely open about their aims from the outset as these are being continually revised. Moreover, although participation in the study was entirely voluntary, as Berkowitz (1978) observed, some service users may feel coerced into participating in a particular study, in order to preserve the provision which they currently receive, often being unsure about the distinction between the researcher and service provider (Booth, 1983). In order to minimise these problems surrounding the principle of informed consent, my independence from local service providers was made explicit from the start. However, in spite of my independence from local service provision, in accordance with the phenomenological perspective, no researcher can rid themselves of their values or identity, which in my case includes professional qualifications in nursing and social work. These multiple identities gave rise to a certain degree of role confusion and uncertainty. This was because, on one hand I did not wish to unduly influence the responses of carers by admitting to my background. On the other hand, I am proud of all my credentials and it would be dishonest and unethical to deny their existence. As a consequence of these conflicts, while I would obviously be honest about my background if explicitly asked, I was constantly unsure as to how spontaneously forthcoming I should be with carers about this. In addition, I often experienced role confusion, tending to see

carers' situations through the eyes of a social worker and sometimes feeling compelled to give carers practical advice and then, in order to avoid impinging on another social worker's territory, finding myself back tracking and claiming ignorance:

Me: You may be able to get attendance allowance

Mr Hall: Do you think so?

Me: Well I'm not really an expert but it's a possibility

Another significant contrast between my professional roles and my role as a research student was that, as a professional I have developed a large degree of detachment to my clients. This contrasted to my work with the carers in this sample to whom I felt a sense of closeness not experienced in my work as a nurse or social worker, in spite of the fact that I saw many respondents only once. Indeed when I was planning my follow-up interviews and discovered that some respondents had recently died, I was quite shocked and disturbed by this news. This compares to my experiences with older people within social work and nursing when the death of a client is an unremarkable and everyday occurrence. I feel that this greater sense of closeness which I experienced towards my research respondents was attributable to two main factors. Firstly, my professional relationship with clients is governed by an instrumentalism, based on the understanding that they want me to provide them with a service. This compared to my experiences with research respondents who gave freely of their time and apparently expected nothing in return. Secondly, my sense of closeness and empathy to research participants was facilitated by the fact that I spent many hours reading, transcribing and analysing their interview tapes. This contrasted to my work with clients when assessment meetings were, by necessity often rushed and the subsequent writing up of assessments was largely based on preconceived, closed ended categories. In view of this, I would recommend that all trainee health and social welfare professionals conducted qualitative research in order to promote their ability to empathise with service users (chapter 4). Indeed this is upheld by recent focus groups exploring the social work needs of carers in which the need for empathy was given a high priority (CCETSW, 2002).

My multiple roles as a social worker, nurse and research student not only gave rise to dilemmas in my contact with carers but were also the source of much inner conflict. For while my research student role relieved me of the more onerous responsibilities of my jobs and facilitated a degree of academic exploration not possible in my professional practice, it also divested me of the power to which, in the other half of my life, I had become accustomed. I found this process of disempowerment to take place on two levels relating both to my academic position and to the research process. Firstly, with regard to the research process, in trying to gain access to carers I often felt myself and my research to be trivialised by some service providers. It was also apparent in my contact with carers, for as a welfare professional, I am used to having unlimited access to information about clients. In contrast, as a research student I had to pursue a much more subtle approach when attempting to obtain information from carers, especially on potentially sensitive issues such as finance. Secondly, with regard to academic status, research students are perceived as being near to the bottom of the pile, just one step up from undergraduates. This position combined with all encompassing labels such as ‘a student’ and the patronising and erroneous assumptions that go with them, reflect in many ways the ageist attitudes and generalisations experienced by older people. Indeed, this is one reason why, throughout my several years as a postgraduate student, I never fully relinquished my roles as a psychiatric nurse and social worker. For while maintaining a dual professional-postgraduate role was always hard work, like the coping strategies of respondents in this research (chapter 4), it helped me to sustain my own ‘sense of self’ (Tanner, 2001).

ANALYSIS

Interview transcripts

From the fieldwork interviews full transcripts were produced and were analysed with the use of the ‘constant comparative method’ (Maykut and Moorehouse, 1994). This method is closely associated with the qualitative analysis strategy of ‘grounded theory’ as originated by Glaser and Strauss (1967). It is based on the principle that theoretical ideas should emerge out of fieldwork data rather than from preconceived concepts and that a subsequently close connection is maintained between data and its conceptualisation.

Moreover, attention to the procedure of constant comparison requires the researcher to constantly compare relations between categories of data so that this theoretical and conceptual elaboration can begin to emerge. A necessary precondition to this constant comparative method is the use of 'coding', with interview data being broken down into component parts. For the purpose of this research this coding was conducted both manually and with the use of winMAX computer aided qualitative data analysis (CAQDA) software, a package which was selected following my attendance at an introductory course in CAQDA at the University of Surrey. Data was divided into categories all of which were related to the research aims their subcategories. My initial main categories thus incorporated: access to resources, formal support, informal support, resource management strategies and role transitions and caring costs. These categories helped to make my interview transcripts more manageable and understandable and formed the basis of further categorisation and sub-categorisation later on in the analytical process. For example, as research progressed, a further main category of 'health' was added, due to the preoccupation of many respondents with such issues. As Bryman (2001) observes, qualitative data analysis can be described as 'iterative' as there is a repetitive interplay between the collection and analysis of data which itself, starts at an early stage and helps to shape the next steps in the data collection process. Consequently, analysis was an ongoing process which accompanied as well as guided data-collection and the categories outlined above remained flexible with emergent themes such as attitudes of financial caution and the positive benefits of caring, leading to the development and refinement of original ideas and concepts. Both discursive and fine grained/content analysis of texts was utilised. The former pursued emergent themes related to my primary areas of interest, while the latter looked at textual analysis such as the tracing of key words like 'manage' and 'cope', which were widely used by respondents. The experiences of council tenants and owner-occupiers were compared and housing status was recognised as a prime indicator for social class and material circumstances.

As discussed in a previous section, theoretical sampling was used, in a limited form, with the sample frame of statutory sources being supplemented by non-statutory sources in an

attempt to broaden the diversity of respondents. Like coding and constant comparison, theoretical sampling is a characteristic analytical tool of grounded theory and as Glaser and Strauss (1967:45) describe:

It is the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what to collect next and where to find them in order to develop his theory as it emerges. The process of data collection is *controlled* by the emerging theory, whether substantive or formal.

Due to the iterative nature of qualitative data analysis as well as to avoid being swamped by data, the transcription and coding of interviews was an ongoing process and was largely conducted by myself. While very time-consuming, this procedural standardisation helped to promote the reliability of the data produced. It also helped to promote my own familiarity with this data. In spite of the huge popularity of grounded theory amongst qualitative researchers, it is not without its critics. For example Bulmer (1979) has questioned whether it is possible or even desirable for researchers to temporarily suspend their awareness of relevant theories and concepts as grounded theory recommends. Indeed, researchers applying for funding are usually required to specify the possible implications of their work to existing knowledge before this work commences. Some might therefore take the view that it is not only necessary but also desirable that researchers are sensitive to existing theory so that their investigations are focused and can build upon the work of others (Bryman, 2001).

The inception of my own research was based on certain theoretical preconceptions (chapter 1). However, many of these were overturned by subsequent fieldwork findings and this would not have happened if I had not at least partially suspended my adherence to these preconceptions. A further problem with grounded theory is that the fragmentation of data occurring as a result of the coding procedures used in this theory can diminish the sense of context and narrative flow of fieldwork data (Coffey and Atkinson, 1996). This decontextualising and fragmentation of data has been exacerbated by the growing popularity of computer-aided qualitative data analysis programmes (Fielding and Lee, 1998) and can also add a rigidity (Coffey et al, 1996) and spurious scientificity to qualitative research. Neither can such programmes help with decisions about the coding of textual materials or about the interpretation of findings (Weitzman

and Miles, 1995). In the light of these significant limitations, this research does not claim to adopt a grounded theory method in its 'purest' form (Bryman, 2001). Instead it takes a pragmatic approach, adopting only ingredients of this method but not all of them. For example, in addition to coding, constant comparison and theoretical sampling, 'theoretical saturation' is identified as the fourth main analytical tool of grounded theory (Bryman, 2001). This involves the ongoing collection of data on an emergent concept or category in order to further illuminate or develop that concept. However, the fact that many respondents were not contactable following the initial stage of interviews, combined with constraints of time and resources meant that this was not always possible. Consequently, significant themes such as those relating to the influence of culture on the experiences of carers did not emerge until a late stage of analysis, so obviously these themes could not be fully explored in fieldwork interviews and therefore point to the need for further research to be carried out into these areas.

Case studies

As part of the pragmatic approach to research methods, analytical tools typically associated with grounded theory were supplemented and complemented by other methods. For example, in order to enhance the descriptive, analytical and procedural reliability of data produced as well as to provide carers with feedback, short case studies were written on each respondent. A selection of these case studies appear in the findings chapters and all appear in the appendix. It was my initial aim to return these case studies to respondents for amendments and approval (Laslett and Rapoport, 1975; Wolcott, 1990). However, although a stamped addressed envelope was enclosed there was a poor response to the case studies sent out. Some were not returned and those that were had few or no comments added by the carer. This poor response could have been due to the fact that respondents were happy with what I had written. On the other hand it could have been attributable to a lack of interest or understanding of my research and the consultative approach which I was attempting to adopt. It has already been discussed earlier in this chapter that advocates of participatory approaches to research often assume that potential respondents *want* to participate and are *able* to do so. However, this may not necessarily be the case. I may therefore have initially overestimated the degree to

which respondents wanted to become involved in my research and correspondingly underestimated potential barriers to this involvement, due to such things as lack of time and reading difficulties. Ethical issues of confidentiality might have also contributed to the poor response, for example, the possibility that returned case studies got into the wrong hands may have deterred people from participating. As a consequence of these issues, feedback to carers was given in the form of brief summaries of relevant themes in the follow-up interview schedule. All respondents were also given the opportunity to see a report of my full findings and to read the transcripts of their interviews.

Statistical data

The potential advantages of using quantitative as well as qualitative methods have been alluded to throughout this chapter and it was seen in chapter one that statistical data has provided many useful insights into the poverty and age dimensions of caring (Arber and Ginn, 1992; Milne et al, 2001). Moreover, although qualitative researchers often dismiss the usefulness and validity of quantification, they often practice quasi-quantification through the use of terms like ‘many’, ‘often’ and ‘some’. As Bryman (2001) observes, more precision needs to be injected into such estimates of frequency. In order to help to provide this precision and to identify quantitative and well as qualitative themes arising from interviews, statistical data was also produced. For example, stark differentials in the objective material position of carers quickly emerged with carers aged seventy and over being much less likely than carers in their sixties to be in receipt of occupational pensions or to own their own homes. Equally significant, if unsurprising, patterns were found with regard to access to resources with home ownership being highly correlated with car ownership and the receipt of an occupational pension. Due to the relatively small size of the sample, it was not felt to be appropriate to analyse this data with the use of a computer package such as SPSS. Instead this was analysed manually with the use of a calculator. Unlike, the analysis of qualitative data which was an ongoing process running alongside data collection, this quantitative analysis was a largely distinct phase which occurred at a late stage of the research process. At a similarly late stage, secondary SPSS analysis of governmental statistics was carried out. Two annually produced data sets were selected for this purpose, the General Household Survey, which covers issues such

as education, health, social behaviour and attitudes and the Family Expenditure Survey which focuses on household expenditure and income. The 2000 to 2001 editions of these surveys were chosen, firstly because this period corresponded with the time in which most fieldwork interviews were carried out and secondly, as these were the most recent editions available for analysis during the period of writing up. The findings from this analysis are presented in the tables appearing throughout chapters three, four and five. Although these findings were chronologically preceded and conceptually led by the fieldwork data, they do help to complement and add depth to this data. They also supplement the quantitative studies alluded to in chapter one (Arber and Ginn, 1993; Milne et al, 2001) and help to ‘fill in the gaps’ left by these studies with regard to the specific focus of this research.

Analytical memos

While case studies and numerical data are methods of analysis not associated with grounded theory, analytical memos are. All themes emerging from my initial interviews were recorded in a series of such memos, which were written after each phase of interviews. Strauss (1987) recommends making memos throughout the research process as a means of facilitating theoretical insight and development and to keep a record of thinking on various topics. These memos assisted in my discursive analysis of transcription data and in generally organising my findings. Consequently, just as the process of data collection gave rise to new themes and categories, leading me to revise my initial interview format, analysis of findings gave rise to similar transformations in my initial hypothesis and expectations. For example, in spite of the fact that most of the respondents were on relatively low incomes, to my surprise, none experienced problems with credit and debt. This observation is recorded in an analytical memo:

All of the carers regardless of their circumstances and background...maintained that their income was adequate in meeting their needs. On one hand this might have indicated that the sample was unrepresentative of older people as a whole, with much research suggesting that a large proportion of older people do in fact live in poverty. On the other hand it could simply indicate the willingness of respondents to uncomplainingly adapt to their adverse financial situation. Thus all of the carers interviewed had relatively low household incomes and all showed evidence of economic ‘downsizing’ and the social exclusion arising from this.

I was further surprised that none of the carers in the initial round of interviews felt their co-resident caring role to be unwillingly imposed as a result of poverty, as another analytical memo records:

In spite of the class gradient found by Arber and Ginn (1992) in the provision of co-resident care and their corresponding suggestion that the greater occurrence of such care amongst lower social classes was attributed to their lack of material resources with which to 'resist' this role, none of the pilot sample, regardless of their material circumstances, felt that their role had been imposed upon them as a result of material circumstances

These observations led me to question the economically determinist hypothesis initially adhered to, that is, that older people are relatively poor, that this poverty will help to force them into a co-resident caring role and that this role will be perceived in a largely negative light. Instead I developed a greater awareness of the positive benefits of caring and the influence of non-material factors such as culture and disability on the role of respondents and such factors were further explored in subsequent interviews, in the analysis of interview transcripts and in wider reading. This process of fieldwork and subsequent analysis of my findings, which led me to slightly alter the focus of my research, led me into the relatively unfamiliar theoretical territories such as that of postmodernism. Reading around this issue deepened my understanding of it. Thus, while I am still myself by no means an expert on postmodernism, nor have I adhered to a postmodernist perspective, I have tried to incorporate a consideration of some post-modern issues such as culture and patterns of consumption into this thesis.

Dissemination

As Bryman (2001) observes, the dissemination of research findings is an integral part of the research process, including, presumably, PhD research. Thus, although less than half of all PhD students are currently estimated to publish their findings, it is argued that such publication should be an integral part of the process of post graduate study and its aftermath (Mooney, 2002). In accordance with this, the ongoing findings of this research have, at the time of submitting this thesis, been presented at four conferences and in three journal articles (see below). It is argued that this dissemination is beneficial to the academic credibility of the postgraduate researcher. As Mooney (2002: 2) states:

Without publication and/or presentation at conferences, students or recent graduates cannot hope to achieve the professional visibility necessary for the development of their academic careers.

In spite of these advantages of publication, it is sometimes argued that such publication is a distraction to the research student, having a potentially negative impact on the progress of their thesis (Mooney, 2002). However, contrary to these claims, I would argue that such dissemination is also beneficial to the research process itself. There are a number of reasons for this. Firstly, the prospect of publication enhanced my motivation and encouraged me to present my findings in an accessible and understandable way. Secondly, such dissemination helped to publicise the role of older carers and therefore, I would argue, played an important part in the process of empowerment of participants. I would further argue that this dissemination also empowered myself as a researcher and helped to counter the feelings of disempowerment associated with other aspects of postgraduate life. For I viewed this publication as a form of recognition of the value of the work which I had done and as such found it highly rewarding. Thirdly, the writing up of findings enabled emergent themes and key points to be identified and refined. As such, different presentations and publications focused on different themes, those of 'gender differences' (Argyle, 1999); 'the ageing process' (Argyle, 2000a); 'formal support' (Argyle, 2001b); 'disability' (Argyle, 2001c; 2002c); 'poverty' (Argyle, 2001d); and 'money management' (Argyle, 2002b).

Due to the iterative nature of analysis in this research, dissemination was ongoing, running alongside the fieldwork process rather than taking place at the end of it, as conventional linear models of research stages suggest. As a consequence of this the feedback and learning gained from dissemination helped me to further refine the content of my thesis. For example, the anonymous referees for my article in *Disability and Society* (Argyle, 2001c) provided me with many useful suggestions. The publication of the article led me to be informed of a meeting in London in which a new report on older carers was launched (Milne et al, 2001). This, in turn led me to revise and update my literature review. Similar literature updates and revisions were facilitated by my attendance at academic conferences. For, while my attendance at such conference was

often for the purpose of presenting my own research findings, I was obviously able to familiarise with the current work of other researchers at the same time which itself had a beneficial impact on my PhD. For example the annual British Society of Gerontology conference has been an invaluable source of new ideas and material, some of which, such as the work of Baldock et al (2001), have been incorporated into my thesis. It should also be recognised that the writing of the thesis itself was an important element in the process of analysis, leading me to review my fieldwork data and constantly revise my literature review. Like the dissemination of my findings this process of writing-up was an ongoing process, starting in 1999 with a 7,000-word report on my interim findings and gradually being built upon as fieldwork and analysis progressed. I have also endlessly revised the structure of my material. For example, initial thesis drafts comprised of nine chapters but I was advised to condense my material into fewer chapters so that it looked more like a thesis and less like a book. The contents of individual chapters and the title have also been revised. For example, due to its shifting focus, I changed the title of my thesis from the rather cumbersome *“An exploration of the influence of material circumstances on the role of older co-resident carers”* to the more accessible and succinct *“Caring and Resources in Older Age”*. As such, in the supposed dichotomy of writing styles between ‘holism’ in which items are written only once and ‘serialism’ in which numerous drafts are written, this thesis has definitely fallen into the latter category, although it is also holistic in the sense that respective chapters are interrelated.

CONCLUSION

In the introduction it was suggested that the research process is not simply a linear one, moving through progressive stages but is instead more of a spiral (Bryman, 2001). This complexity is well illustrated by the polyhedron below adapted from the polyhedron of oppression (Williams, 1992) referred to in chapter one. Thus the outer perimeter of the polyhedron illustrates the conventional perception of research phases, moving in a clockwise direction from the original idea through to analysis and dissemination. However, as this chapter has highlighted, this is an over simplification, with all research stages being potentially interrelated in a multi-directional way. For example, it has been seen that the analysis and dissemination of data can in turn lead to a revision of the

research aims due to such things as the ‘emergent’ research design and the provision of feedback. Similarly, due to the fact that the research methods utilised in this thesis were guided, largely by pragmatism and compromise, the nature of these methods were themselves adapted with sample selection, data collection and modes of analysis all being revised in the light of fieldwork findings. It will be the purpose of the next three chapters to outline these findings.

Figure 2.1: A Polyhedron of the research process

