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Voice and Context in a New Gerontology

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In this chapter, I am concerned with how social researchers, particularly gerontologists, hear what their subjects or respondents tell them about their lives. The focus is not technical communication but the question of how to conceptualize the manner by which experience is given voice. I draw on observational and open-ended interview data from several studies of older people and aging to argue that context, not just individual thought and sentiment, gives voice to experience and that a new gerontology can be built on the understanding. The outcome is a critical empiricism that makes visible the practice and situatedness of aging.

VOICE AND CONTEXT

As in social research in general, gerontology is preoccupied with respondents' answers, not their questions. The gerontologist assesses morale or life satisfaction by asking respondents to indicate, on scales of opinion, the degree to which they are satisfied with life as a whole. Alternatively, respondents may be required to mark questionnaire items dealing with particular qualities of life as they apply to themselves (Gubrium & Lynott 1983). Growing interest in home care targets the caregiver's perception of the impairment cared for, the stress or felt burden associated with caregiving, and attitude toward institutionalization, among related variables such as the degree of social support available and the interpersonal relationship between the caregiver and the care receiver (Gubrium & Lynott, 1987).

Answers feed the search for pattern or regularity in the aging experience.

Careful attention to the research process suggests that respondents may formulate answers in the course of dealing with pertinent questions of their own. While doing research on caregivers of Alzheimer's disease victims (Gubrium, 1986a), I was particularly struck by how often adult sons, daughters, elderly spouses, and significant others stated that they did not know what was going on in their lives nor how they felt about it. I had heard similar remarks and questions in other field settings, but because they now were so forceful and I was simultaneously concerned with how experience is given voice, the comments took on a special relevance.

Some of the questions and remarks referenced the afflicted family member. Caregivers wondered whether it was possible that, despite the forgetfulness and confusion, there was a semblance of sensibility underneath it all (Gubrium, 1988). In support groups, caregivers routinely asked for help in sorting through the meaning of responsibility and voicing the emotions appropriate to their situations. As an elderly caregiving spouse once tenderly noted:

You know, it's kinda hard to face up to it, seeing his mind just going like it is. He's just not the same Harold that he used to be. He was always sharp as a tack. And you'd never find a kinder and more loving husband. [Weeps.] Oh, I'm sorry, but I just don't know what to do or think. My state of mind now . . . I'm empty. I don't know what I feel. I don't even know if I feel anything. I'm just numb. And what does he feel, the poor guy? Do you think he knows? Does he feel anything at all? Maybe you can tell me. Am I different or something? I'm really frightened . . . of not knowing how to feel. Should I be feeling something that I'm not? Or not feeling the way I seem to be? God knows, I must be a sight! Excuse me, please. (Gubrium, 1989a, p. 261)

Other field sites provided occasions for raising questions about general morale and aspects of life satisfaction. Open-ended interviews in community settings, focused on the meaning of house and home among the aged, told of a connection in respondents' questions
between life satisfaction and encounters with varied images of neighborhood and residency. For example, responding to an interview item dealing with satisfaction with his neighborhood, an 80-year-old man remarked:

I'm not sure about that one. I've been thinking a lot about that. What I've been hearing lately on TV and the radio about all the crime and other stuff makes me feel that maybe it ain't so good and I should be scared. But everyone around here says it's all exaggerated and that I don't have anything to worry about. So, what should I think? You tell me. You're the expert.

Needless to say, we did discuss the matter, which was inconclusive. He never did decide during the interview whether he was satisfied or dissatisfied with the neighborhood, but it was clear that he had been thinking about it. The important thing about the response was that his answer evidently was in the making. I later considered that the social organization of this answer-in-the-making might tell me a great deal about how experience is given voice.

Hazan's (1990) recently published field study of community formation in Israel can be read as suggesting that what satisfaction with one's environs mean does not simply arise from personal experience but is mediated by the categories used to assess satisfaction. A new language of community helped to form a sense of integration where there was no sentiment of belonging. The experience of "neighborhood" satisfaction (or dissatisfaction) virtually emerged with a new category—community—for evaluating residential contacts. The question of belonging depended on how one categorized the locale.

I often have heard respondents preface their remarks to me about their lives by saying, "It depends." The it-depends quality of answers indicates that respondents precede their answers with questions of their own about experiential contingencies and that answers to these questions affect what is eventually conveyed as responses to inquiries. The it-depends quality of answers implies that the respondent can voice diverse senses of the personal experiences being studied, varying by narrative context (Gubrium & Lynott, 1983). The caregiver who bothers to explain that she feels burdened only in relation to very specific bodily tasks but otherwise thinks about caregiving completely in terms of familial responsibility offers a seemingly contradictory response (Gubrium, 1991). When the caregiver explains further that these specific "burdensome" bodily tasks change in character as she thinks about it and compares her situation with others, her experience "depends" too much to be captured by a standardized methodology.

Perhaps the most intriguing concern of all is the response that one has not thought about the matter addressed in a particular research item. This does not mean that the respondent refuses to answer but only that he or she may prefer to think about the matter before an answer is formulated.

An interesting, possibly unfortunate twist on such a response occurred during my Alzheimer's disease fieldwork (Gubrium, 1986a). In exchange for free day care in a geriatric clinic for Alzheimer's disease victims, family members were asked to participate in the clinic's research program on the burdens of home care. Standard burden-of-care assessments were administered along with subjective evaluations of the patient's impairment, the caregiver's general well-being, and related topics of interest. Family members often discussed their assessment experiences in the clinic's support group for caregivers. Some, especially the newcomers, commented that they had not considered some of the issues presented in the assessments. Group discussions indicated that their answers grew out of their encounters with the assessments as much as answers represented what they had felt all along. Indeed, and this was the possibly unfortunate side of the process, several indicated that assessment items made them think something possibly was wrong with what they were doing and that one could feel very badly about the burdens of caregiving. Assessment items framed the home care experience in terms of stress, strain, burden, and resentment, not commitment, love, familial responsibility, mixed feelings, or companionship, among other complications and ways of thinking about care and caring. One might say that, in some sense, the caregivers learned how to be particular respondents in the very process of answering assessment items.

It occurred to me that such ordinary questions and concerns were as important for the study of aging as the systematic answers that elderly regularly provide those who study them. I have become particularly acute about listening for such questions or related concerns, not dismissing explicit references or clues to them as so much research debris. When a respondent states that his or her feelings or thoughts about something "depends," I pay as much attention to the "what" it depends on and the "how" of the connection as to the eventual answer. When someone asks me what I mean by a particular question, I believe it important to zero in on how that meaning is mutually worked out. When a respondent states or marks that she both agrees and disagrees with a particular questionnaire item, such as might be presented in a caregiver burden inventory, it is important
to probe how a single question can have such a seemingly contradictory response. Rather than treat the response as methodologically meaningless, I wonder what kinds of questions could make such ostensible contradictions reasonable.

A growing interest in how experience is given voice now tells me that expressions such as "It depends" and "I've never thought about that before" are signs of savvy people, rather different in general character from the "judgmental dope" regularly imaged as the respondent (Garfinkel, 1967). According to Garfinkel, the respondent as judgmental dope is tacitly imagined to be the virtual vessel of his or her experience. Answers to research questions lie dormant in the respondent's experience, to be secured by an objective and, one hopes, standardized methodology. Least of all is the judgmental dope permitted to constitute the substantive references of the methodology, even while the dope may be allowed to express sentiments such as how strongly he or she feels about some predefined matter.

Seriously taking account of how the elderly give voice to experience requires that context be given its due. The savvy respondent does not simply break out into a response. Even under the best conditions, her comments can suggest that she thinks about, or thinks over for the first time, the diverse contingencies of everyday life that can specify the meaning of an answer. At the same time, if context figures significantly in how the elderly give voice to experience, it is important that theory entertain the question of what voice is heard when we study aging.

**LOCAL CULTURE**

Adapted from Geertz's (1983) ideas of local knowledge, the concept of "local culture" (Gubrium 1989b) provides a way of conceptualizing how circumscribed domains of understanding situate the meaning of aging. Just as organizational researchers are taking account of traditions, stories, and local symbols to shed light on organizational decision making (Jones, Moore, & Snyder, 1988), the cultures of friendship circles, residential settings, and support groups provide contexts for assigning meaning to matters such as life satisfaction, felt burden, and sense of future.

As part of the Alzheimer's disease research, support groups for caregivers were observed in two cities over a period of 3 years. Some groups were composed of caregiving spouses, mainly the elderly wives of dementia victims cared for at home. A few groups were limited to the adult children of demented parents, usually caregiving daughters. Most groups were attended by a mixture of family caregivers and significant others, including the rare sibling or friend who provided care.

Support groups may be classified by function and leadership. Some groups have a didactic mission, and others are more socioemotional. The didactic group aims to teach and guide participants to think and feel in particular ways about their troubles and situations. The socioemotional group offers a formal opportunity to express and share feelings. Some groups are facilitated by experienced members at large; others are led by professional service providers. The support groups observed in the Alzheimer's disease study combined the functions and leadership styles. On occasion, some groups were didactic; at other times, they were socioemotional. Leadership style could vary by discussion topic. Any group could become antiprofessional and member-guided when professional ignorance of home care complications was at issue; the same group could become decidedly attentive to expert opinion when so-called medical breakthroughs were being discussed.

Each group had a local culture that, despite function and leadership style, served to frame the experiences that participants brought to each other's attention. A support group's interpersonal history was a configuration of categories for comparing and assessing individual caregiving experiences. In one group, the notion of the "really" ideal caregiver was an especially persistent background concern of participants, presenting them with a local standard for evaluating caregiving responsibilities. One caregiver in particular, Jessica, who no longer attended but was influential in community Alzheimer's disease service activities, was a virtual exemplar of "total devotion" to the home care of a demented family member. Jessica presented participants with a basis of comparison for the evaluation of their own caregiving activity, felt strain, and sentiments about possible institutionalization. For example, participants used Jessica's legendary experience to assess whether their individual contributions were "all that great" compared to "what Jessica does for her husband." The husband was a so-called living vegetable, who presented Jessica with an ostensible "36-hour day" burden of care.

Jessica's status as the ideal caregiver was not always positive. When a condition known as "denial" was entertained, believed to be a tacit refusal to acknowledge the reality of an event or experience, Jessica became an exemplar of overdevotion, which brought to bear a different context for interpreting filial responsibility. She was still an ideal caregiver of sorts but one not to be emulated. In the context of denial, Jessica was used to evaluate whether, in comparison, one was being
realistic about continued home care. The question now was whether one had gone “too far,” that is, to a point where a totally devoted caregiver becomes the disease’s so-called second victim, caught in a spiral of overconcern and the denial of personal and familial strain.

Against the background of the support group’s local culture, the issue-linked quality of Jessica’s exemplary status offered support for diametrically opposed decisions regarding institutional placement. When Jessica presented the positive ideal, participants hesitated to speak of the possibility of placing their demented loved ones in a nursing home. It was not uncommon for those considered too (coldly) rational in assessing their home situation to be thought of as rushing to judgment in deciding “it’s time,” a common expression referring to the time it is appropriate to consider an alternative to home care. When Jessica portrayed the negative ideal, participants discussed at length the indirect and insidious impact of dementia on the caregiver and other members of the household. On such occasions, one was likely to hear participants entertain denial as underpinning overdevotion.

From this support group we learn that ostensibly measurable entities, such as the perceived degree of impairment, felt stress, and the inclination to institutionalize the patient, do what Silverman (1989) calls “escaping.” Depending on the issue under consideration, either devotion or denial, Jessica’s legendary status cognitively shifts (escapes) from a positive to a negative standard of comparison. Parallelizing this, participants who use Jessica as a basis for evaluating their own caregiving tend to experience rather dramatic alterations in understanding their circumstances, thoughts, and feelings.

Not all support groups had such singularly prominent exemplars. Prominent exemplars tended to homogenize the meaning of the burden of care over time, as diametrically opposite as their details might be. Support groups lacking such exemplars provided a wider spectrum of evaluative categories for the interpretation of individual experiences and engaged participants in more intensive efforts to designate standards of comparison.

The local cultures of the groups were not simply given. In communicating caregiving experiences to the group, each participant contributed to the group’s changing or growing local culture. The process of interpersonal comparison was not just a chain of interindividual contrasts against a stable evaluative background, but comparisons simultaneously entered the exemplary background for further comparison. Each comparison and resulting judgment became, in its recollection, a local basis for subsequent contrast and judgment. To that extent, the local culture of each support group always was both old and new, continually ramifying the context available for designating the personal meaning of caregiving.

INTERLOCUTORS

To limit the voice of elderly to individuals is to overlook the public or social quality of discourse. When I speak about myself, I am both subject and object. As subject, I describe; as object, I am described. Just as two speakers can agree or disagree with each other, similarly one can concede or disagree with myself about my thoughts and sentiments. By the same token, the individual is not necessarily privy to what he or others otherwise take to be his “own” discourse. The psychiatric or casual rhetoric of denial certainly challenges claims to personal knowledge, just as the weeping caregiver and the 80-year-old man in the earlier extracts asked others to specify their inner voices for them, especially their sentiments. We not only speak for ourselves, to ourselves, and about ourselves, but others speak for us, to us, and about us. No one, it seems, just speaks. We all are, with and among ourselves, interlocutors of our thoughts and feelings (Todorov, 1984).

As interlocutors, we bring a variety of understandings and conceptual schemes to descriptions of ourselves or others. In one support group, Jessica’s exemplification provided a basis for speaking about and interpreting the caregiving experience. Other support groups provided different understandings and subsequent “readings.” The innermost privacies of participants took on different meanings in the context of alternative local cultures, what Kristeva (see Giddens, 1979, chap. 1; Hawkes, 1977, chap. 4) has called the “intertextuality” of discourse. The interlocutor even provides a basis for preserving the mind of the mindless, a substantial subset of whom are represented by senile dementia (Gubrium, 1986b). What is more, the mind of the mindless is preserved according to the context (“text”) in which the interlocutor’s related experience is embedded.

Although I do not argue that behavior is a mere text, consider dementia victim Paul’s social relations as a way of seeing how context, through the interlocutor, gives voice to experience even among those presumed not to have much, if any, mind at all (Gubrium, 1991). Paul is a nursing home patient with Alzheimer’s disease. He occupies a room adjacent to the nurses’ station because the staff likes to “keep an eye on him.” Paul is a so-called wanderer, which means that he loses track of his whereabouts and “wanders off.” He occasionally enters others’ rooms and, in the words of some women
on the floor, "scared us half to death." Less commonly, he finds his way to another unit and temporarily is lost. Paul's wandering and "restlessness" can cause the staff to restrain him. At times, he is found secured in a geriatric chair, a precaution against stumbling. Occasionally, he is fastened to his bed with arm and leg restraints. Paul tends to be very loud when restrained. Neither the other patients nor staff are sure if it is better to tolerate a restrained Paul yelling or a quiet Paul who, at any moment, might wander into someone's room.

There are various opinions about Paul's intrusions into others' lives. Some patients cannot understand why the nursing home admits what they take to be mental patients. To them, Paul is the peak of physical health: wiry, strong, energetic, ambulatory, "ruggedly good-looking." As an LPN once remarked, "To look at him, you'd think absolutely nothing was wrong with him." This suggests only one thing: Paul has "completely lost his marbles." At the same time, Paul occasionally is the source of much hilarity. His good looks are the butt of jokes and gossip among some patients about how certain women on the unit "really" want Paul to sneak into their rooms "for a good see." Paul's "antics" cause an equal amount of gossip and joking among staff members. To the staff, he basically is harmless, not at all violent, and, in his own confused way, a "gentle giant." In Paul, the staff sees a man who, when he is not being too difficult, brings variety to their work lives.

Paul exudes incoherent conviviality. He regularly ambles to the nurses' station and wants to "talk over" things. When staff members take the time, particularly in the relative quiet of the afternoon, they pretend to gossip with him about whatever they attribute to being on his mind. Although they cannot understand him, it is evident to them that he thoroughly enjoys their company. When he laughs, they laugh with him. In doing fieldwork on Paul's unit, I fondly recall the many times Paul would casually place his elbow on top of the nurses' station, chest-high for him, and in his affable manner ask glowingly, "How's life, partner?" From previous experience, I knew that whatever I said in response would probably not be followed by anything comprehensible. Nonetheless, partly through courtesy and partly because his greeting was so charming, I regularly responded in kind: "Fine, partner. How's life been treating you?"

I once poured him a plastic cup of water in the process because he seemed a bit parched. I had been drinking water while taking field notes. He took the cup, half toasted me, and slugged it back, as if it were a stiff drink. He immediately smiled, gently slammed the cup on the top of the station, and stated with apparent pleasure, "That hit the spot." I poured him another. After that, we made a habit of this for a time, combining what seemed to be the semblance of conviviality with the non sequiturs of his dementia. For me, it was a tender and welcome exchange each time it occurred. For the staff, it was a source of good-natured teasing about how Paul and Jay went drinking every afternoon.

Paul's wife, Adele, often "spoke" with and for Paul during her frequent visits to the nursing home. As with my own participation in Paul's self-presentation and self-management while drinking, Adele not only spoke her own mind to Paul but audibly conveyed for him what she believed to be his thoughts and sentiments. When she found him restrained, she sometimes approached the nurses' station and, sympathizing with the staff about the occasional need for this in Paul's case, asked whether they knew how he must be feeling, tied to his chair or bed. As she once explained:

I know the poor fellow doesn't like it. You can just hear him. He feels like you've put him in jail. He doesn't understand how this could happen to him. When I'm in there, I know that deep down inside, he's asking how anyone could do this to him. Can't we maybe let him stand up and stretch a bit? I know he was pretty bad this morning. I'll watch him.

I overheard and actually participated in a number of "conversations" that Adele had with Paul. Joining in, I found myself embellishing the discursive logic that she, by speaking for him, articulated as his. In turn, Adele spoke for herself. One time, in one of these conversations, Adele indicated that Paul was bothered about his relations with others on the floor. I found it reasonable to ask him whether his relations with certain patients were causing him to be annoyed. Adele responded for him in a manner that seemed to follow. I then answered in a compatible fashion. These "conversations" were not always consensual. There were disagreements, such as when Adele inferred that I was misinterpreting what Paul was thinking. The disagreements led to corrections that were comprehensible in the flow of their exchanges. The organization of discourse itself gave a minimally lucid tone to all contributions (Heritage, 1984; Sudnow, 1972).

Yet this was not just a discursive ritual. It had a moral imperative. The staff knew that when Paul allegedly felt wronged, Adele complained bitterly. They knew Paul was sorrowful because Adele informed them of it. They realized when Paul was being left alone too much and that he, like any human being, needed company and affection from others because Adele spoke for him. With others' discursive support and conversational indulgence, Adele kept Paul's voice and spirit socially alive and working.
Paul's ascribed thoughts and feelings reflected the local cultural contradictions of the nursing home. Adele expressed distress for him when she "knew" Paul felt frightened in the company of strangers. She wanted him to feel that this was home, not a hospital, or at least as much like home as possible under the circumstances. She repeatedly reminded others, both staff and patients, that Paul had a past and thus she stood as his sentry against the overwhelming institutional claims of the present. She spoke of what he was, what he had accomplished in life, and how much others admired him for it. She recounted his foibles and transgressions, too, and used the information to account for his present conduct. In practice, Paul had a living past. Adele made sure of that. She publicly maintained his biography, using it to dilute the thrust of the organization into daily living.

Although, administratively, Paul was an individual, experientially he could not be separated from those around him. This, of course, is true for all of us. What made Paul's situation particularly significant in this regard was that it vividly showed that voice does not belong to individuals but is assigned to them. What is more, the voice Adele presented was practical, organized within the concrete context of speech and its related actions.

LIFE NARRATIVE

To give voice to experience presumably is to speak of one's life. Gerontologists regularly ask the elderly about their lives as if life simply were there for the asking; although, perhaps more than other researchers, they are alert to problems of communicative competence. As noted earlier, the competent respondent reaches back and into life to obtain answers to questions about it. Experience, in effect, coincides with life. But is life itself simply there for the asking, containing and giving shape to personal experience, even under the best of methodological and communicative conditions?

Consider some preliminary findings from a study of life narrative among nursing home patients suggesting that life may be separated from experience. The separation is significant for understanding what is voiced in studies of aging. Early in the research, I became intrigued by a peculiar kind of qualification, used to signal the separation, that sometimes followed open-ended discussions with patients about the quality of life in the nursing home. The discussions centered on the personal articulation of a prominent cultural tension of nursing home life, whether it is experienced as home or a hospital.

Focal were the meaning of home and the extent to which "this place," meaning the nursing facility, was or was not like home and why.

Eighty-six-year-old patient Ida's remarks initially highlighted the manner in which a discussion about the quality of life in the facility could be qualified. Our discussion began with an extended conversation about the meaning of home. Home to Ida meant what it did to others. It was linked with family, notably with bonds of trust and love. Ida spoke at length of growing up in poverty on a farm some distance from the nearest town. She clearly noted that "even if we were poor, we didn't know it," touchingly describing how her mother made them all feel wanted and "rich" in the important things of life. Ida traced the warm and loving atmosphere of her early life into the home she eventually made for her own husband and children. Theirs, too, was not a life very well off, but it was loving, and as she emphasized, their modest abode was a home. In speaking of home, Ida seemed to savor the word, as if its bare sound was pleasing to her ears. She wasn't different from many other patients in this regard. Asked to recount the meaning of home, Ida would linger on the word, slowly drawing it out, with a facial expression seeming to suggest that home was swirling around in her head with total abandon. She seemed momentarily intoxicated by the word.

We gradually turned to life in the nursing home. Ida spoke at length about other patients, the staff, the so-called atmosphere, families, the food, and other services. Having just discussed the meaning of home, she compared what was offered in the facility with her understanding of the trusting and loving household. Although the food in the facility was not bad, she explained that it was not like home. The staff, particularly two "very sweet aides," were nice to her and treated her like a mother. Ida complained that the staff sometimes could be flip and uncaring, but she understood that "the girls," meaning the nursing staff, had jobs requiring them to be more than just friendly to patients. Evaluating the facility's atmosphere, Ida remarked that "they" try to make it as much like home as possible, noting that she had been in worse places. She remarked that there were very sick people in the facility, and it was difficult to think of the place as a home; in that regard, it was more like a hospital. Still, Ida lived there, and, to the extent that "they" tried, she reported that it was homelike.

We spent considerable time discussing such matters. Some of my questions sounded like quality-of-care inquiries; others dealt with overall life satisfaction. It was evident that Ida felt the facility to be adequate for what it was. She was not totally disgusted with the nursing staff, as some patients were, nor was she completely satisfied,
nursing home experience, because, according to Ida, her life is over. By the same token, we might hypothesize that the patient whose last chapter was about the nursing home experience might be informing us that his or her life was not over. We might even guess that, for some, the life before placement has ended and a new one inside the nursing home has begun, as preliminary analysis of the life narrative material suggests is a possibility. Conversion and recovery experiences certainly can be narratively conveyed in this fashion.

The narrative material is beginning to show that, as a basis for undertaking personal evaluations of quality of care, it is important to consider patients in terms of their life orientations to the nursing home. For the patient who orients to the nursing home experience as part of his or her life, one might guess that it would seriously matter what the overall quality of care is in the facility. Among those who lives are claimed to be over, the quality of care would have a different meaning and urgency.

A comparative sample of life stories and related narrative materials collected in adult congregate-living facilities shows that few consider their lives to be over. Last chapters are about the present, not the past. In contrast, sorting through the life stories of the nursing home sample suggests that there are several different orientations to the nursing home experience. There are those, like Ida, who see their lives as over and say that they are now “just living” or existing; others see life as yet to come in a world after living. Some see the life in this world as being extended beyond where it might have ended if they had remained on their own. Some make a new life for themselves in the nursing home; the last chapter of their stories is about the present.

These are preliminary results. There are as yet many complications to take into account. For example, respondents differ in understanding what is meant by conveying life in terms of chapters. Weekly fluctuations in health status seem to affect the bounds of the life story, as the longitudinal analysis of repeated waves of interviews suggests. I have tried to limit the study to the so-called classic nursing home patient, comparing his or her life narrative to short-stay rehabilitation patients. The differences between them are not clear-cut in terms of nursing home orientation. For example, it is possible that even after residing in a facility for as long as 5 years, a few elderly patients show that one can still think of the experience as rehabilitative and hope to return to one’s life, not move forward to a new life in the facility or in the beyond or forbear a life that is now over.
Gerontology has come a long way in its short 40-odd years. Prescientific bromides and maximis of successful aging have given way to hypotheses about and systematic observations of the aging experience. Alternative theories have been formulated for why variables pertinent to growing old go together the way they do. Observations have been extended not only beyond Grandma’s house and the town’s crone but to comparisons of city with village, culture with subculture, and industrial with developing nations. Methods have been developed to sort experiences, from standardized measurement devices for attitudes and sentiments to indicators of quality of care. The aim has been to engage objectively the process of aging so as to systematically trace its organization.

Yet for some, this is a story of scientization as much as the growth of a scientific gerontology. Against scientization, there has been a decided surge of interest in the place of personal meaning, the unstandardized, and the emergent in everyday life. Gergen (1980) has underscored the need to take account of what he calls the elocutionary, that is, the experientially contingent and accidental qualities of life change, not limiting research to predefined experiential categories. More recently, Bruner (1986) has set forth a narrative mode for cognitive development to teach us that human imagination is an essential feature of action. Anthropologists Myerhoff (1978) and Kaufman (1986) have shown how elaborately storied indeed are the lives of the elderly, which are assigned meaning in accordance with diverse cultural codes. Cursory examination of the proceedings of recent annual conferences of the Gerontological Society of America suggests that there is a solid concern with subjectivity: the categories and qualities of growing older, being old, associating with the aged, and caring for frail elderly.

Luborsky (1990) refers to this development in the field of aging as “the romance with personal meaning and lived experience.” The so-called romance is part of a broader thrust, what Silverman (1985) features as the search for authenticity in reaction to the overwhelming rationalization of everyday life. For example, Silverman and Bloor (1990) view patient-centered medicine as a kind of romantic reaction—a body-centered medicine, shifting the so-called medical gaze from lesions and physiological systems to include the patient’s understanding of his or her illness. Overall, the aim has been to get beyond the (overrationalized) languages of scientific discourse to the actual voices of experience.

Drawing on Foucault (1973, 1979), Silverman (1985) and Gubrium and Silverman (1989) present both ethnographic and conversation- analytic evidence to argue that the romance with personal meaning is a kind of language, as potentially rationalized and rational as its objective scientific nemesis. Personal meaning and elocutionary change are understood, communicated, and described in language, the language of feeling, and as such they are as subject to the rules and concrete conditions of communication as any object of experience. In relation to Alzheimer’s disease, Gubrium (1988, 1989a) has shown that the incommunicable—experiences that some say cannot be put into words—are conveyed according to culturally recognizable codes, such as through the ordinary poetry used to communicate what “it’s like” to witness the mental demise of a loved one.

The point is that if we are to take account of how experience is given voice in a new gerontology, the rush to discover and trace personal meaning must not discount the social organization of voicing, that is, the various and diverse contexts within which speakers and listeners formulate, communicate, and respond to interpretations of life. Attending to voice without context is tantamount to looking upon Derrida’s (1981) “[continuus play of difference” or experience without organization (Denzin, 1990), which I cannot accept. The world of literary interpretation might imagine, even encourage, this form of whirling textuality, but the world of everyday life has tradition, formal organization, and political surroundings that, in practice, concretely enter into and shape the voicing of experience. I have tried to show in this chapter that although local cultures are not fixed, they nonetheless provide discernible categories for assigning meaning to self, to convey who one is and is not in some regard. As Paul’s story suggests, interlocutors present, or harbor, meaningful contexts within which to preserve the thoughts and feelings of those diagnostically bereft of reason. And as life narratives seem to indicate, the orienting framework of stories about matters such as nursing home living can cast living as life for some and uncharted for others, not just more or less authentic personal sentiments about institutionalization.

In my analytic of experience, voice and context stand in dynamic tension. One—voice—focuses our attention on subjective relevancies, and the other—context—informs us that voice is ineluctably part of language and communication, things essentially situated and shared. Scientism would have us drown voice in objective context, transforming context into conditions without voice or, as is scientific habit, into standardized and measurable equivalents. The romance with
personal meaning would dissolve context in the voicing of “authentic” experience, trivializing the public markers, resources, and available categories of everyday life. In contrast, just as the subjects, respondents, and informants whose lives gerontologists study must wend their way between the varied voices and contexts of experience in the “real world,” a new gerontology might best tolerate the tension rather than attempting to integrate voice and context into an analytically unified vision of aging, totalizing experience.

This new gerontology, then, is against theoretical integration. Rather than attempting, through some system of propositions, to logically link and contain voice and context as categories for analysis, it emphasizes the practice of everyday life, being attuned to life’s distinct voices and their situatedness, akin to Bourdieu’s (1977) idea of “habitus,” where life is invented in discourse but “within limits.” The goal is a critical empiricism; its aim, on the one hand, is to make visible the variety, contingency, and inventiveness in any and all efforts to present life and, on the other hand, to resist the temptation to put it all together into an analytically consistent and comprehensive framework privileging certain voices and silencing others.

REFERENCES


Voice and Context in a New Gerontology