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Orally Positioning Older People in Assessment Meetings

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Abstract

It has been demonstrated that persons with dementia may be positioned as less competent than participants of the same age without dementia, and that persons with dementia possibly also are positioned as less competent than other older persons without dementia. In the present study, we aim to explore this further by analysing Swedish assessment meetings, in which needs and preferences are investigated for older persons without dementia. The material consists five audio-recorded assessment meetings, where there were at least two conversational partners present (a spouse and/or a child) and where the older person applying for social services was not diagnosed with dementia. The ages of the older persons ranged from 81 to 88, while the age of the relatives ranged from 46 to 93. The results of the present study demonstrate that older persons without dementia mainly are positioned as competent. However, it may be related to the degree of frailty, since the frailest person in the present study appears to be positioned as less competent than the other participants. The present paper adds to existing knowledge on how professionals in assessment meetings contribute to the positioning of older persons as competent and capable of making decisions. The results of the present article may be useful to promote development of education and training of communication skills for care managers in assessments in order to further ensure that older persons with and without cognitive impairments can be actively involved in the creation and interpretation of their applications for social services.
Introduction

The scope of the present study is social positioning, i.e. how people position themselves in relation to one another in terms of, for example, roles in assessment meetings regarding support for older persons. In the present study, the findings regarding assessment meetings involving older persons without dementia are related to results from previous research on assessment meetings involving people with dementia (Österholm & Samuelsson, 2013). It has been demonstrated that persons with dementia may be positioned as less competent than participants of the same age without dementia, and that persons with dementia possibly also are positioned as less competent than other older persons without dementia. In the present study, we aim to explore this further by analysing Swedish assessment meetings, in which needs and preferences are investigated for older persons without dementia. The assessment process that older persons without dementia undergo has been described in earlier research (Olaison & Cedersund, 2006), and it was demonstrated that the older persons’ accounts of their health issues contributed to the construction of their identities as home care receivers. The comparison conducted in the present study between assessment meetings involving persons with and without dementia regarding the oral positioning, e.g. by the use of elderspeak such as great pitch variations, slow speech rate, collective pronouns etc., may shed light on important factors that promote active participation in decision-making by older persons both with and without dementia.

Entitlement for support in Sweden is generally assessed by a social worker, who holds the job title of care manager, working for the municipality in which the applicant lives (Dunér & Nordström, 2006; Cedersund & Olaison, 2010). A central part of the assessment process consists of assessment meetings in which care managers meet with older persons in their homes (Coulshed & Orme, 2006) or in institutional settings (Williams, 2007) to discuss and reach decisions about their home care needs (Lymbery et al., 2007). In Sweden the legal
foundations for the work that Swedish care managers do are found in the Social Services Act (SFS2001:453), which is a framework legislation that does not contain detailed regulations regarding needs assessment. Older persons in general, and persons with dementia also have the formal right to make decisions about care services themselves (Taghizadeh Larsson & Österholm, 2014). In the assessment process of institutional settings, communication is an important tool (Linell, 1990). In the assessment meeting, the professional and the client have different positions, and how they engage in the communication is dependent on these positions. The professional poses questions to the client, who is supposed to give a response, which is then evaluated by the professional, who in turn decides whether the answer is sufficient to accomplish the assessment or if the answer must be further developed (Hydén, 2000).

Institutional talk is characterized by three basic elements (Drew & Heritage, 1992; Heritage, 2004): the interaction involves goals that are tied to institution-relevant identities, the interaction involves special constraints on what is an allowable contribution to the business at hand, and the interaction will involve special inferences particular to specific contexts. Institutional talk is not restricted to particular physical or symbolic settings; institutional talk may occur anywhere, and consequently, ordinary interaction may occur in almost any institutional context (Drew & Heritage, 1992). However, most studies of interaction involving older persons focus mainly on various healthcare-related settings (Plejert, Jansson & Yazdanpanah, 2013; Jansson & Plejert, 2014). Institutional interaction may often be asymmetrical (Linell, 1990; Linell & Gustavsson, 1987), and this is significant for institutional interaction involving older persons (Coupland, 2000; 2001; Maynard, 2003; Grainger, 2004).

Discrimination based on negative age-related stereotypes, referred to as ageism (Bytheway, 2005; Butler, 1969), is a well-established phenomenon. In conversations,
participants tend to adjust their language and speech style depending on whom they address. A fundamental assumption within the research on ageism is that younger conversational partners, when conversing with older persons, sometimes go too far in adjusting their speech style. These adjustments are based on negative stereotyped conceptions of older persons rather than on the individuals’ needs for adjustments; such phenomena are referred to as elderspeak, patronizing talk or secondary baby talk (Harwood, 2007). Elderspeak was first described by Caporael and colleagues in the early 1980s (Caporael, 1981; Caporael, Lukaszewski & Culbertson, 1983; Caporael & Culbertson, 1986). Typical characteristics of elderspeak are simplified grammar and vocabulary. Other typical characteristics or elements of elderspeak are the use of endearing terms, increased volume, reduced speaking rate, use of repetition, and use of a high and a variable pitch (Harwood, 2007). Elderspeak may be perceived as diminishing and it may have negative effects on the perception of older persons’ competence (Savundranayagam et al., 2007; Kemper et al., 1998). Staff that use elderspeak may also be perceived as less competent and less helpful (Ryan & Bourhis, 1991). However, the use of elderspeak, such as slow rate, simplified syntax and increased volume, has also been shown to be beneficial for understanding and communication among older persons (Cohen & Faulkner, 1986; Kemper & Harden, 1999).

Previous studies within the area of elderspeak have primarily focused on effects of speech adjustments (i.e. how older persons are addressed by younger adults and how older persons perceive they are addressed by the younger interlocutor) at a group level with experimental and quantitative designs. Most of these studies, with a few exceptions (Williams et al., 2009) have been based on non-naturalistic data (e.g. using actors and made-up scripts, situations and vignettes) (Hummert & Mazloff, 2001; Hummert et al., 1998; Kemper et al., 1998; Ryan & Bourhis, 1991; Savundranayagam et al., 2007). In conversation, elderspeak may be used in interaction by younger adults to position older persons as less competent.
Thus, it is relevant to use a naturalistic material to investigate if and how older persons are positioned by others and how they position themselves in assessment meetings when they apply for social services.

Positioning is an “assignment of fluid ‘parts’ or ‘roles’ to speakers in the discursive construction of personal stories that make a person’s action intelligible and relatively determinate as social acts” (Van Langenhove & Harré, 1999, p. 17). In conversation, people position themselves in relation to one another in ways that have traditionally been referred to as roles, and in doing so people constitute themselves and one another as social beings (Bamberg, 1997). In the present paper the framework of social positioning is more fruitful than discussing the interactions only in terms of roles, because the roles in a professional setting are determined by the situation at hand, where one or two participants are applying for help, and one participant has the role of deciding about those matters. Self- and other ascriptions of position usually occur naturally in the social context and are mainly a conversational phenomenon; they emerge progressively throughout conversation (Davies & Harré, 1990). A dominant position in conversation may force other participants into unwanted or unpleasant positions (Harré & Van Langenhove, 1999).

In a previous study, five assessment meetings involving two older persons (one diagnosed with dementia and one without), one care manager and in some of the meetings other healthcare professionals or relatives were analysed in order to investigate whether the person with dementia was positioned differently than the other older person (Österholm & Samuelsson, 2013). Eleven phenomena that positioned the person with dementia as less competent in interaction than the other participants were identified: 1) talking over the head of the person with dementia, 2) not responding to initiatives from the person with dementia, 3) voicing his/her feelings, 4) voicing his/her capacity, 5) prosodic adjustments, 6) voicing his/her opinions, 7) using the diagnosis to imply lack of competence, 8) self-positioning from
the person with dementia, 9) using collective pronouns, 10) mitigating expressions and 11) posing questions implying lack of competence, (in order of frequency from most frequent to least frequent). The results from Österholm and Samuelsson indicate that persons with dementia may suffer from discrimination to a greater extent than older persons without dementia, although no data from similar assessment meetings with older persons without dementia was analysed (Österholm & Samuelsson, 2013). Thus, this will be focused on in the present paper.

**Aim**

The aim of the present study is to explore if and how older persons without dementia may be orally positioned, both by others and by themselves, while participating in assessment meetings for gaining access to social services. Furthermore, the results will be compared to previous findings on assessment meetings involving older persons with dementia.

**Method**

*Data collection*

The empirical material consists of 20 assessment meetings and was gathered between 2003 and 2004 in three municipalities in Sweden. Of these 20 assessment meetings, five were then selected using predetermined criteria, which included assessment meetings where there were at least two conversational partners present (a spouse and/or a child) and where the older person applying for social services was not diagnosed with dementia. The ages of the participants in the five selected assessment meetings included in this study varied, with the older persons ranging in age from 81 to 88, while the age of the relatives ranged from 46 to 93. Three different care managers participated in the assessment meetings (Table 1).

[Insert table 1 about here]

All the participants were informed of the project and gave their informed consent before the data-gathering process began. The assessments were recorded on audio tape and
transcribed verbatim. All the participants were then anonymized and assigned fictitious names. The XX author of this article was present at all the assessment meetings. The Ethics Committee at XXX University approved the study (Doc no. 03-036).

Data analysis

The material was transcribed verbatim as a whole (Linell, 1994), and the selected examples were transcribed according to conversation analytic traditions, which means that transcriptions are made in exact accordance with what the participants actually said, and translations into English are made as directly as possible (Hutchby & Wooffitt, 1997; see appendix for transcription conventions). Transcriptions were scrutinized by analysis of interaction, and interactional phenomena used to position the older persons were identified, following the method used in the previous paper by Österholm and Samuelsson (2013). Perceptual analysis was used, i.e. listening to the audio recordings repeatedly and reading transcriptions several times. Transcripts and recordings were studied sequentially, searching for the patterns identified in the meetings involving persons with dementia, including: 1) talking over the head of the person with dementia, 2) not responding to initiatives from the person with dementia, 3) voicing his/her feelings, 4) voicing his/her capacity, 5) prosodic adjustments, 6) voicing his/her opinions, 7) using the diagnosis to imply lack of competence, 8) self-positioning from the person with dementia, 9) using collective pronouns, 10) mitigating expressions, and 11) posing questions implying lack of competence (Österholm & Samuelsson, 2013). In the present paper, all the older persons were active during the meeting, and thus there was a need for a division of some of the phenomena into “own” and “other”, e.g. voicing one’s own capacities (I can manage to hang the sheets) or voicing the capacities of the other (Bertil can do that). When there were two older spouses participating in the meetings, it was not always obvious who should be regarded as the formal client, and for one of the couples both were considered applicants in the end. Analyses and categorizations were
made separately by the three authors after thorough calibration, in order to validate the results. The inter-rater reliability was calculated according to the formula accordance/(accordances + non-accordances), and it amounted to 90.4 per cent for all three authors. The final categorization was then made by consensus among the three authors. The assessment of prosodic features of elderspeak (high pitch, modifications of pitch range and loud speech) was made through perceptual analysis. The frequency of each phenomenon was tallied.

Results

In the present data, eleven phenomena were identified that function to position the older persons as competent or not, (Table 2). There were also a number of instances where the older persons positioned themselves as competent or incompetent as well as instances where they were positioned as competent or incompetent by the other participants in the meetings (Table 2).

[Insert table 2 about here]

The phenomenon that was identified most frequently in the analysis was voicing the older persons’ capacity (59), both by the older persons themselves, and by the care managers (26), indicating the fact that the capacity of the older person was the main topic of the meetings. There are also a number of occasions where the older persons voice their opinions (17), as well as some instances of voicing feelings (6). On some occasions the older persons voice their joint capacity (9), indicating that this should be taken into consideration in the decision of the needs for help in the home. Another phenomenon that occurred in the present data was that the care manager and the relative (spouse or other) talked over the head of the older person who was the formal client (13). Different features of elderspeak, such as prosodic adjustments (high pitch, modifications of pitch range and loud speech) and mitigating expressions were also present in the material (12).
There are also examples of the older persons, both the applicant and his/her same-aged spouse, positioning themselves as competent in the data (22). To a lesser extent they also position themselves as incompetent (9). In the following section, examples of the phenomena named above will be exemplified and described in more detail.

**Voicing capacity**

The most common positioning phenomenon is voicing the capacity or lack of capacity of the older person. Voicing is often carried out through giving accounts or reports about the applicant’s capacity. In the present study, capacity refers to instances where participants talk about their physical capacities, pain or illness. The voicing is done both by the older persons themselves, by participating relatives, by the care managers, or by several participants together. The first example is taken from an assessment meeting with Märta (M), who is the formal client, and her husband Bertil (B), and it illustrates how M describes her ability to hang laundry.

**Example 1**

Case x (CM: Care manager, M: Märta)

01 CM: sen va de hjälp att hänga tvätt också
then it was help with hanging the laundry as well
02 M: ja (.) tvättar gör ja självt för de är ju maskin bara
yes(.) I wash myself because that is just the machine
03 lägga i (.) men som sagt hänga lakan de kan ja inte
to put in(.)but as I said hanging sheets that I can’t
04 göra
do
05 CM: nej (.) hur ofta behöver de göras
no(.) how often does that need to be done
06 M: ja var tredje vecka
yes every third week
07 CM: mm eh som (.) de är alltså var tredje vecka som du
mm eh like(.) it is thus every third week that you
08 behöver hjälp med att hänga tvätt
need help with hanging the laundry
09 M: ja
yes
10 CM: mm skulle ha Tipp-Ex här ser jag[nu har ja kladdat på]
mm should have Tipp-Ex here I see[now I have smeared on]
11 M: [ode är snart gjort ja]
[and it is quickly done]
12 det ja menar den som kan lyfta armarna har ju inga
it I mean one who can lift their arms has no
13 svårigheter o få upp de inte
difficulties in getting it up no
14 CM: ja tänkte på kläder o så (.) att hänga upp de
I was thinking about clothes and so on(.) to hang that
15 M: nej de klarar vi de kan Bertil göra om ja håller i
no that we can manage Bertil can do that if I hold
In example 1, the care manager reintroduces the issue of hanging laundry, something that has been mentioned as slightly problematic previously during the meeting. Märta emphasizes her capacity by saying that she can wash the laundry herself (line 02), but adds that she cannot hang the sheets, indicating lack of capacity (line 02). This is confirmed by the CM, and she continues by asking about the frequency of the activity (line 05). This is responded to by M (line 06), and in line 07 the CM sums up by repeating M’s utterance in a confirmative way. M expands on the topic by adding that hanging sheets would not be an issue for someone who has no arm problems (line 12), indicating the lack of her own capacity. The CM then asks about hanging of the laundry in general (line 14), generating an account of the couple’s mutual capacity of managing this together (line 15). Throughout this sequence, M is positioning herself, and is positioned by the care manager, as a competent interlocutor who is supposed to conduct the presentation of her needs.

*Voicing feelings*

On some occasions the feelings of the older person is voiced by one of the other participants in the meeting. Voicing feelings, in this study, refers to talk about how participants feel in different situations related to the application of services, but not to feelings of pain or feelings of illness, as those instances are categorized under voicing capacity. The second example of voicing is taken from an assessment meeting with Sven, who is the main applicant, and his wife Emma. The example demonstrates how the care manager voices Emma’s feelings.

*Example 2*

Case x (CM=care manager, E=Emma)

01 CM: *ja tänkte på hur du klarar trapporna o så*
I was thinking on how you manage the stairs and so on

02 går de bra
does that work well

03 E: *ja de gör ja vet du men ja blir hemskt andfådd*
yes I do you know but I get terribly short of breath
In example 2, the CM initiates the topic by asking about E’s ability to climb the stairs (lines 01-02). E answers positively, but she adds that she also has a problem with shortness of breath (line 03). This is recognized by the CM (line 04), and E continues by adding that she sometimes also has a balance problem (lines 05-06). The CM then voices the feelings of E by making an account of what it feels like (line 07), and this is confirmed by E (line 08). However, the voicing by the CM may also be of a more generic character, meaning that in general it feels scary to walk as if you are drunk.

*Talk over the older person’s head*

In the study by Österholm and Samuelsson (2013), it was common that the other participants in the assessment meetings talked over the head of the person with dementia. This happened also in the present data, but to a lesser extent. The example below is taken from an assessment meeting with Gunnar, the main applicant, and his wife Mona, and it illustrates how the care manager and Mona talk about the needs and the feelings of Gunnar even though he is lying on the bed next to them.

*Example 3*

**Case x (CM= care manager, G=Gunnar, M=Mona, his wife)**

01 CM: hur e de me kläder o så o att sätta på sig o ta av
how is it with clothes and so to put on and take off
02 sig kläderna hur går det
your clothes how does that go
03 G: ja de hjälper hon mej också med (.) men de e inte
yes she helps me with that too (.) but it isn’t
04 lika påfrestande
as demanding
05 M: Gunnar vill inte va riktigt klädd längre utan de blir
Gunnar doesn’t want to be properly dressed anymore
06 mest nattskjorta i allmänhet o morronrock på
but is mostly nightshirt in general and robe on
07 CM: okej
okay
08 M: mest för att de e så besvärligt me kissetabletterna
Example 3 starts with a question from the CM to G (line 01), to which G responds in lines 03-04. M expands G’s contribution by explaining that typically G does not wear ordinary clothes (lines 05-06), which gets a minimal response from the CM (line 07). M continues with a description of why G does not want to have trousers (lines 05-15) and this rather long contribution also contains voicing G’s feelings “de e väldigt tröttsamt” (line 10) (“this is very tiresome”). However, this may also be an expression of how M feels. However, by the end of the turn, M concludes that “this is very tiresome for him” (line 15) suggesting that she is voicing G’s feelings. The CM closes the topic and moves on to another question (line 16), but this time she poses the question directly to Mona, and not to Gunnar.

**Older persons positioned as competent**

In the present material there are also instances where the older persons are positioned as competent both by themselves and by the other participants in a rather explicit way. However, this category bears resemblance to voicing capacity. In the present material, competence refers to general descriptions of competencies regarding ability of making decisions on everyday chores and in relation to the application of social services rather than to competence related to the physical status of the older persons. The following example is taken from an assessment meeting with Cecilia, who is the applicant, and her son Göran, and it illustrates
how Cecilia’s competence and decisiveness are made relevant by the care manager as well as by Cecilia herself.

*Example 4*

Case x (CM=care manager, C=Cecilia, the applicant, G=Göran, her son)

01 CM: ja jag tänker inte så utan att jag tänker att om du yes I don’t think like that but I think that if you
02 skulle vilja ansöka om ett sånt här larm would want to apply for such an alarm
03 C: jaha jag vet inte va säger du ((addresses the son))
ok I don’t know what do you say
04 G: ja JAG tycker ju att du skulle ha ett well I think that you should have one
05 C: ja jag tycker att jag tycker inte att jag känner mig yes I think that I don’t think that I feel
så dålig än that bad yet
07 CM: NEJ NEJ e ju inte de att jag kommer hår o tycker att NO NO it is not that I come here and think that
08 du e dålig de är ju inte så utan de e ju just för att you are bad it is not like that rather it is just because
09 du inte ska BLI dålig (.) man kan se det som en you shouldn’t BECOME bad(,) you can see it as an
10 investering att har man de här larmet så ökar investment that if you have this alarm the safety
11 tryggheten lite o att de går bättre increases a little and that it goes better
12 C: men om jag inte bestämmer det här idag but if I do not decide this today
13 CM: de behöver du inte göra nej det måste du inte göra de you do not need to do that no that you don’t have to
14 är ju du som bestämmer it is you who decides

In example 4, the CM initiates the sequence by asking if C wants an alarm (lines 01-02), and C responds by turning to her son, indicating insecurity, and lack of competence to some extent (line 03). Her son explicitly declares that he thinks that C needs an alarm, thereby positioning his mother as less competent both regarding the ability to express an opinion and regarding the ability to live by herself (line 04). C demonstrates that she perceived the son’s contribution as positioning her as less competent, and she then reclaims her competence by contradicting her son (lines 05-06). This is supported by the care manager, underlining that she does not think that C is “bad” (lines 07-08), and she also explicitly declares that it is C who has the right to decide (lines 13-14).

The ability to choose and decide for themselves, as in lines 13-14 in the previous example, is explicitly pointed out on several occasions. The next example is taken from the
assessment meeting with Gunnar, who is the main applicant, and his wife Mona, and it illustrates how the care manager explains that Gunnar can choose for himself among different aspects of his care.

*Example 5*

Case x (CM= care manager, G= Gunnar, the main applicant, M= Mona, his wife)

01 CM: sen är det ju så Gunnar att du kan ju ansöka om detta then it is so Gunnar that you can of course apply for this
02 nu och är det så att du inte är nöjd med det så har now and if you are not satisfied with it you have
03 du rätt att tacka nej då the right to say no then
04 M: så dom kan komma på prov då so they can be on trial then
05 CM: ja yes
06 M: ska du ha med dej den här would you like to take this one with you
07 CM: ja jag tänkte det (.) i annat fall om du vill fundera yes I thought so (.) otherwise if you want to think
08 lite till så är det okej för mig också då kan ni a bit more it’s ok for me too then you can
09 skicka den sen (.) det är vilket ni vill send it later (.) whatever you want
10 G: fundera lite till då think a bit more then
11 CM: du vill fundera lite till (.) ja jag kan ju berätta you want to think a bit more(.) yes I can tell you
12 det att när du fyller i den så kan du ju skriva där that when you fill it in you can write there
13 att duskhjälp eller helavtvättning är det du vill that showering help or whole-body washing is what you want to
14 ansöka om sen det kan ni ju skriva sen annars (.) jag apply for later that you can write later otherwise(.)
15 kan lämna en till så kan ni ha en kladd och en att I can give you another one so that you can have one draft
version
16 skicka and one to send
17 M: jaha mm okay mm
18 CM: och hur många gånger per vecka och så där o om ni and how many times per week and such and if you
19 vill fundera på trygghetslarm så kan ni ju fylla i want to think about a safety alarm you can fill that in
20 det också om ni vill ansöka om det det ni vill ansöka too if you want to apply for whatever you want to
21 om hjälp med apply for help with

In example five the CM explains that G can apply at the moment, but that he also has the right to decline later (lines 01-03). M requests confirmation of her understanding in line 04, which she gets in the following turn (line 05). The CM underlines that G has the right to think about the decision, and that his wife can help him to fill in and send in the form later on (lines 07-
G positions himself as a competent decision-maker by saying that he wants to think about the decision (line 10).

There are also examples where the applicants position themselves as incompetent, and these instances often regard competency regarding the knowledge of how the social welfare system works. This type of positioning as incompetent may have occurred regardless of age, and it is reasonable to believe that this is more related to the meeting with the authority and the institutional character of the interaction, than to the fact that the person is older. Example 6 is taken from the assessment meeting with Märta, who is the main applicant, and her husband Bertil, and it demonstrates how Märta positions herself as incompetent.

**Example 6**

Case x (CM=care manager, M=Märta, the main applicant, B=Bertil, her husband)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>CM: då frågar jag Märta e de så att du önskar skriva i then I ask Märta is it so that you wish to write in</td>
</tr>
<tr>
<td>02</td>
<td>ansökan att du önskar få ha en knapp du också the application that you wish to have a button too</td>
</tr>
<tr>
<td>03</td>
<td>M: ja de kanske e lika bra de jag vet inte ja kan inte yes it is perhaps just as well I don’t know I can’t</td>
</tr>
<tr>
<td>04</td>
<td>bedöma det judge that</td>
</tr>
<tr>
<td>05</td>
<td>B: jag förmodar I presume</td>
</tr>
<tr>
<td>06</td>
<td>CM: mm men jag fyller i det (. ) ska jag fylla i det mm but I fill in that (. ) shall I fill in that</td>
</tr>
<tr>
<td>07</td>
<td>M: ja gör du det yes do so</td>
</tr>
</tbody>
</table>

Example 6 starts with the explicit question from the CM about M’s wish to get an alarm (lines 01-02), whereby M positions herself as incompetent to make such a decision (lines 03-04). B joins in (line 05), but is interrupted by the CM, who contributes to the positioning of M as incompetent to decide by first deciding that she should apply for an alarm (line 06), but softening this with a request for confirmation in the same turn. M responds with a confirmation of this decision, which to some extent re-positions her as a competent decision-maker (line 07).

**Elderspeak**
In the material, there are also examples where the older persons are addressed with features that have been described as elderspeak, e.g. mitigating expressions or prosodic adjustments. The example below is taken from the assessment meeting with Cecilia, who is the applicant, and her son Göran, and it illustrates how the care manager mitigates the situation both by downscaling her own competence, and by using the collective pronoun “we”.

Example 7

Case x (CM=care manager C=Cecilia, the applicant)

01 CM: ja jag kan förklara lite hur det fungerar jag ska yes I can explain a little how it works I will
02 inte gå in på allting för då *då tror jag inte att vi not go into everything because then *then I don’t think that we
03 reder ut det* jag ska säga det så enkelt som möjligt will sort it out* I will say it as simply as possible
04 här det är ju så att hemtjänst då det kan ju vara here it is so that home service then can be
05 olika saker det kan ju vara städ och tvätt och different things it can be cleaning and washing and
06 personlig omvårdnad och inköp men om man nu säger personal care and shopping but if you now say
07 hjälp med städning då får man hjälp varannan vecka help with cleaning then you get help every second week
08 och då hamnar man i hemtjänst nivå 1 och det finns and then you end up in home service level 1 and there are
09 fem nivår och beroende på hur ofta och hur mycket five levels and depending on how often and how much
10 hjälp man vill ha så hamnar man i en viss nivå och help you want you end up on a certain level and
11 varje nivå så betalar man då för hjälpen man får men every level you pay then for the help you get but
12 det är inte en fast summa för hemtjänst nivå ett alla it is not a fixed sum for home service level one all
13 hemtjänstnivå 1 betalar inte samma och det beror ju home service level one do not pay the same and that depends
14 på att alla har inte samma ekonomi alla har inte on that not everyone has the same financial situation everyone
15 does have
16 samma förmåga att betala så för någon kanske en summa the same ability to pay so for someone maybe a sum
17 C: nej no

This example shows a very long, and fairly complex contribution from the CM mitigated by different forms of expressions known to be part of elderspeak. These include the use of the wording “explain a little”, and the down-scaling of the CM’s own competence, as well as the use of “we” in the wording “then I don’t think that we will sort it out” expressed with laughter.
in the voice. However, the length and the complexity of the utterance may also position C as competent, because she is ascribed the ability to take in the message despite its length.

**Discussion**

The results demonstrate that the older persons without dementia participating in assessment meetings, formal applicants as well as spouses, are positioned as competent regarding the decision-making process. The conversations during the meetings are very different compared to meetings where the older formal applicant also had dementia. On the part of the care manager there is no significant difference in the way the formal applicant is addressed, compared to their spouses. In some of the meetings it was also hard to tell to whom the role of formal applicant should be assigned, because both of the spouses had potential care needs. Even if most of the phenomena from meetings where one participant has dementia occur in the present data, they do that to a much lesser extent than in the previously described meetings, supporting the idea of “dementiaspeak” as something other than elderspeak, from Österholm and Samuelsson (2013). The most common feature from the previous study, talking over the heads of the persons with dementia, occurred seven times more frequently in meetings where one person had dementia than in the present material (65 compared to 9 times). The second most common feature from meetings regarding persons with dementia, ignoring of initiative, did not occur at all in the present data. The meeting in the present material where talk over the head of the older person was most frequent, regarded Gunnar as the formal applicant. Gunnar is rather frail, and maybe this makes him more vulnerable to being positioned as less competent than his same-aged spouse. This finding is also in accordance with the fact that frail persons attract more elderspeak, but older persons with health problems have also been shown to consider elderspeak as comforting and reassuring rather than diminishing and patronizing (Nelson, 2005). There is also one feature identified in the present data that was not present in the study of older persons with dementia,
namely the voicing of joint capacity, in the sense that the couple expressed their co-operation in managing the daily chores as demonstrated in example 1 (line 10).

The interactions have an institutional character to some extent as they involve a certain goal, (Drew & Heritage, 1992; Heritage, 2004), even though the meetings take place in the homes of the applicants. However, the interaction is rather symmetric, mainly in terms of interactional space but also regarding division of interactional labour, in contrast to previous research on triadic interaction (Coupland, 2000; 2001). The interactions follow the previously described pattern where the professionals pose a question, the applicants and/or their relatives respond, often followed by some kind of recognition of the response by an evaluation or a confirmation (e.g. Drew & Heritage, 1992; Hydén, 2000). In the present material the contributions from the formal applicants are in general recognized as equally adequate as the contributions from the other participants, even if the relative is a younger person such as the son in example 4.

The older persons, both the formal applicants and their relatives, in the present material often express their needs by descriptions of their capacities (example 1), or feelings (example 2). These needs are discussed and assessed in order to reach decisions about the home care needs, in accordance with descriptions of the assessment process described in previous research (Coulshed & Orme, 2006). The expressions of joint capacity among couples, aligns with the previous finding that most couples develop some areas of mutual dependency, that is areas where both spouses rely on each other for their well-being (Agnew, Van Lange, Rusbult & Langston, 1998; Wieselquist, Rusbult, Foster & Agnew, 1999). Research on couplehood, carried out at the Center for Dementia Research (CEDER), has shown that couples where one of the spouses has dementia express a sense of still being a couple, inter alia by the use of the pronoun we (Nilsson & Hydén, 2013). An important part of the dementia research, at least as it is carried out within the CEDER research program, is to try to establish how life with
dementia may be perceived and lived. The findings from the present study may add to this knowledge as it helps to characterize how social positioning works for older persons without dementia, thus demonstrating that some features are not typical only for assessment meetings involving persons with dementia.

However, there are also instances in the present data where the older persons are positioned as needy and as less competent than young and healthy persons by the use of different interactional resources, and features from elderspeak such as talking over the older person’s head (example 3), mitigating expressions (example 7), and prosodic adjustments. These findings support the existence of elderspeak (Caporael, 1981; Caporael, Lukaszewski & Culbertson, 1983). Nevertheless, it is different mainly in terms of frequency, from what was described for persons with dementia in similar situations (Österholm & Samuelsson, 2013), thus adding to the complexity of when and to whom elderspeak is used (Kemper, 1998b).

In interaction, people position themselves in relation to others (Bamberg, 1997), and positioning emerges throughout conversation (Davies & Harré, 1990). In the present study the older persons are often positioned as competent in different respects, both by themselves and by the other participants, as in example 4. Another feature that stands out in the assessment meetings studied in the present paper was the repeated pattern of focusing the ability to make decisions as demonstrated in examples 5 and 6. In Sweden, where older persons in general and persons with dementia have the formal right to make decisions about care services by themselves, existing forms of proxies do not have the right to intrude on their right to self-determination (Klemme Nielsen, 2012). This is supported by the findings in the present paper by the way the care managers on several occasions specifically stress the persons’ rights to make the decisions themselves (example 4). However, when it comes to decisions about care services made for persons with dementia, legislative contexts are usually not presented, and
the point of departure seems to be that decisions are to be made without the involvement of the person with dementia, even though this might not be regulated legislatively in the country in which the study was conducted. The persons with dementia seem to be marginalized when decisions are to be made. There are different ways to conduct this marginalization, and one way is not to tell the person that a decision has been made until it is time for implementation, thereby not giving the person any opportunity to react before it’s too late (Taghizadeh Larsson & Österholm, 2014).

Conclusions

The results of the present study demonstrate that older persons without dementia mainly are positioned as competent, thus supporting the notion of “dementiaspeak” as suggested by Österholm and Samuelsson (2013). However, it may be related to the degree of frailty, because the frailest person in the present study appears to be positioned as less competent than the other participants.

Even if there are elements of elderspeak in the present material, there are very few signs of discrimination or of the older persons being positioned unwantedly or unpleasantly as proposed by Harré and Van Langenhove (1999).

The present paper adds to existing knowledge on how professionals in assessment meetings contribute to the positioning of older persons as competent and capable of making decisions, and is therefore useful in the education of professionals the encounter elderly people in their work. The results of the present study, with detailed analysis of interaction, in addition to results from the previous study of assessment meetings involving persons with dementia (Österholm & Samuelsson, 2013), highlight the difference between meetings involving cognitively healthy older persons and meetings involving persons with dementia. Thus, the results of the present article may be useful to promote development of education and training
of communication skills for care managers in assessments in order to further ensure that older persons with and without cognitive impairments can be actively involved in the creation and interpretation of their applications for social services.
Acknowledgements

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References


### Tables

#### Table 1. Summary of assessment meetings and participants, OP=older person

<table>
<thead>
<tr>
<th>Case</th>
<th>Participants</th>
<th>Place of meeting</th>
<th>Length of assessment meeting</th>
<th>Previous social services</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Care manager, older person, son</td>
<td>OP home, in the living room</td>
<td>40 min</td>
<td>No previous services</td>
</tr>
<tr>
<td>5</td>
<td>Care manager, older person, son</td>
<td>OP home, in the kitchen</td>
<td>58 min</td>
<td>No previous services</td>
</tr>
<tr>
<td>14</td>
<td>Care manager, older person, wife</td>
<td>OP home, in the bedroom</td>
<td>65 min</td>
<td>No previous services</td>
</tr>
<tr>
<td>17</td>
<td>Care manager, older person, husband</td>
<td>OP home, in the living room</td>
<td>52 min</td>
<td>No previous services</td>
</tr>
<tr>
<td>19</td>
<td>Care manager, older person, wife, daughter</td>
<td>OP home, in the kitchen</td>
<td>30 min</td>
<td>Home care including help with shower and getting dressed</td>
</tr>
</tbody>
</table>

#### Table 2. Identified phenomena in each visit, and in total of the material as a whole.

<table>
<thead>
<tr>
<th>Phenomenon</th>
<th>Visit 1</th>
<th>Visit 2</th>
<th>Visit 3</th>
<th>Visit 4</th>
<th>Visit 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talk over older person’s head</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>-</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Prosodic adjustments</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td></td>
<td></td>
<td>12</td>
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<tr>
<td>Voicing capacities, other</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>10</td>
<td>5</td>
<td>26</td>
</tr>
<tr>
<td>Voicing capacities, own</td>
<td>5</td>
<td>11</td>
<td>6</td>
<td>21</td>
<td>16</td>
<td>59</td>
</tr>
<tr>
<td>Voicing opinions, own</td>
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<td>4</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>17</td>
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<tr>
<td>Voicing opinions, other</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Mitigating expressions</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>Collective pronouns</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Voicing feelings, other</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>Voicing feelings, own</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6</td>
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<tr>
<td>Voicing joint capacity</td>
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<td>-</td>
<td>1</td>
<td>8</td>
<td>-</td>
<td>9</td>
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<tr>
<td>Competence older person pos. as competent, own</td>
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<td>2</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>22</td>
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<tr>
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<td>2</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Competence older person pos. as competent, other</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Competence older person pos. as incompetent, other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
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