

## **Biography as empowerment or appropriation:**

### **Research and practice issues**

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#### **Abstract**

Biographical methods are increasingly recognised as making a positive contribution to research and practice in health and social care, in particular claims for empowerment are frequently made. The authors evaluate this contribution and these claims, using a matrix with axes 'bottom up' to 'top down' and 'research' to 'practice', to position and reflect on examples of their own use of biographical methods in research.

#### **Key Words:**

Biography, empowerment, nursing, top-down, bottom-up, learning disabilities, ageing.

#### **Introduction**

no need to hear your voice when I can talk about you better than you can speak about yourself. No need to hear your voice. Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become mine, my own. Re-writing you, I rewrite myself anew. I am still author, authority. I am still the colonizer, the speaking subject, and you are now the centre of my talk

(hooks 1990, 151-2)

I think marvelous, how you've balanced questions and letting me ramble on.

*Well I didn't feel you were rambling on at all*

Didn't you

*No*

Oh good, I felt I was at times

*No, I felt*

Done me a power of good I can tell you.

*Really?*

Yes

*Oh that's very nice to hear*

I've never done this, it's a long time

*Oh well, that's encouraging*

Well, I hope you can make something of it

*Well, I certainly will. Shall I switch it off?*

(Interview with J F, aged 79, 1993)

The use of autobiography and biography has become a relatively common tool in health and social care settings in the UK in the form of life stories, histories, autobiographies and reminiscence. Compared with only twenty years ago such approaches are now relatively commonplace, especially with people with learning disabilities (Gray and Riddens, 1998; Hopkins, 2002; Walmsley and Johnson, 2003), frail older people, particularly those with dementia (Gibson, 1991, 1994; Kitwood 1997; Schweitzer, 1998), looked after children (Ryan and Walker, 1993), and to a lesser extent, people with mental ill-health (Read and Reynolds, 1997). Such approaches have many claims made on their behalf, particularly that they foster the development or preservation of identity (Kitwood, 1997) and that they contribute to that elusive good, ‘empowerment’ (Gomm, 1993) for people who have in many respects little control over their destiny. Yet, as the words quoted above show there is no clear consensus as to whether or not the experience is necessarily of benefit. Researchers may self-critically review interventions in a search for ethical and acceptable practice. At the same time, interviewees may have their own agendas, not always obvious to the interviewer or themselves. As working *with* service users and patients becomes an ever more essential aspect of the work of health care professionals, so issues around ownership of people’s stories, and the ethics of using such approaches become ever more salient. In this paper we critically consider these debates in the light of recent research in what has been called generically ‘biographical methods’, and consider the implications for nursing practice.

### **A brief review of the literature**

Biographical materials have become an important tool for encouraging more patient sensitive practice. Knowing about someone’s past life, it is argued, can point the way for better patient care (Burnside, 1990; McKenzie, 1991; Haight, 1991; Pietrukowicz, 1991; Mapp, 1995; Gray and Riddens 1998, Payne, 1998; Bornat & Chamberlayne, 1999, Clarke et al, 2003). Yet biographical approaches are not necessarily empowering. A complex interaction is set up between subject, author and reader or user of the account, which can make for more or less empowering practice. It is this that is explored in this paper, drawing on some of the debates within the research arena, and using some detailed case studies of practice oriented research.

Biographical materials exist implicitly and explicitly in a variety of forms from documents such as case notes, patient histories, and care plans to more journalistic public accounts in the media following instances of abuse or fatal accident but also in patients’ and service users’ own accounts often presented in the form of life story books, or audio-visual recordings. The ways in which such accounts are elicited have come collectively to be known as ‘biographical methods’ (Bornat, 1994; Chamberlayne et al, 2000; Walmsley, 1995; Bornat, 2001; Webster & Haight, 2002; Bornat, 2002; Coleman, 2002; Roberts, 2002; Chamberlayne et al, 2004).

In tandem with this shift towards a more subjectively understood idea of care has been the claim that such approaches empower participants, enabling them to take control of their own stories, to reverse roles with researchers or practitioners, to claim ownership, to retain the right to interpret rather than allow the academic or professional gaze to take over and even to bring about change in the direction of their lives (Bornat, 1989; Frisch, 1990; Hirsch 1998; Thompson, 2000; Booth and Booth 1998). Whether or not any of these outcomes is measurable or achievable remains a focus for constant debate, for, at the same time as such approaches have come into vogue, so the criticisms have developed. Proponents of feminism (Harding, 1987; hooks, 1990), the social model of disability (Barnes, 1996), participatory action research (Freire, 1970; Kemmis 1990; Zuber Skerritt 2000), as well as disabled activists (Aspis, 2000; Harrison et al, 2002) have all added their voices to the demand that

researchers discard the colonizing ways, drop the jargon, and resist the temptation to take over, use, and abuse people's stories.

The arguments fall into two major categories, the first being that individual stories represent a return to the old discredited medical case book approach (Finkelstein, 1996) associated with the 'medical model' of disability. Many disabled activists, such as Barnes (2003), continue to subscribe to the view put forward by Paul Hunt as long ago as 1966 that much writing by people with impairments 'is either sentimental biography, or else preoccupied with the medical and practical details of a particular affliction' (Hunt, 1966 p.ix), individualizing an experience of disability which essentially can only be understood by reference to the wider disabling context of society. The second, more recent, critique of the fashion for biographical approaches in health and social care is that they become a new form of colonizing of the powerless subject (hooks, 1990, Plummer, 2001) furthering the careers and interests of the colonizers, but doing little for the owners of the stories. The UK policy imperative for Patient and Public Involvement currently (Department of Health, 2000) is likely to increase the pressure upon service users to contribute their stories. For example, in a recent survey of Universities and Further Education Colleges in a UK region, the most prevalent form of involvement was in employing patients in direct teaching of health care students (Trent WDC 2003). In contrast, however, Rickard, points to the 'potentialities, possibilities and challenges of using biographical methods in health studies' (p 165) in an overview which, while acknowledging 'inherent tensions' (p. 169), identifies the positive contribution which these can make to interdisciplinary working, therapeutic interventions and to health training (2004).

Biographical work in health care may well be a positive force; however, the concerns raised in the research community and beyond are sufficient to warrant some reflection amongst practitioners who seek to espouse such approaches.

In this paper we introduce a simple matrix which positions biographical research and practice on a top down-bottom up matrix. In so doing we arrive at a more questioning appraisal of claims for empowerment through biographical work. The approach taken is questioning, but not necessarily judgmental. It is not the intention to recommend or suggest that any one positioning on the matrix is more or less desirable than any other. The matrix is offered as a form of self-evaluation and reflection on practice, as a tool for nurses, and others, to use when adopting and adapting the biographical method in their work with patients and service users, and a tool which should, if well used, protect against the excesses of exploitation and appropriation highlighted by critics of the biographical turn.

## **Introducing the matrix**

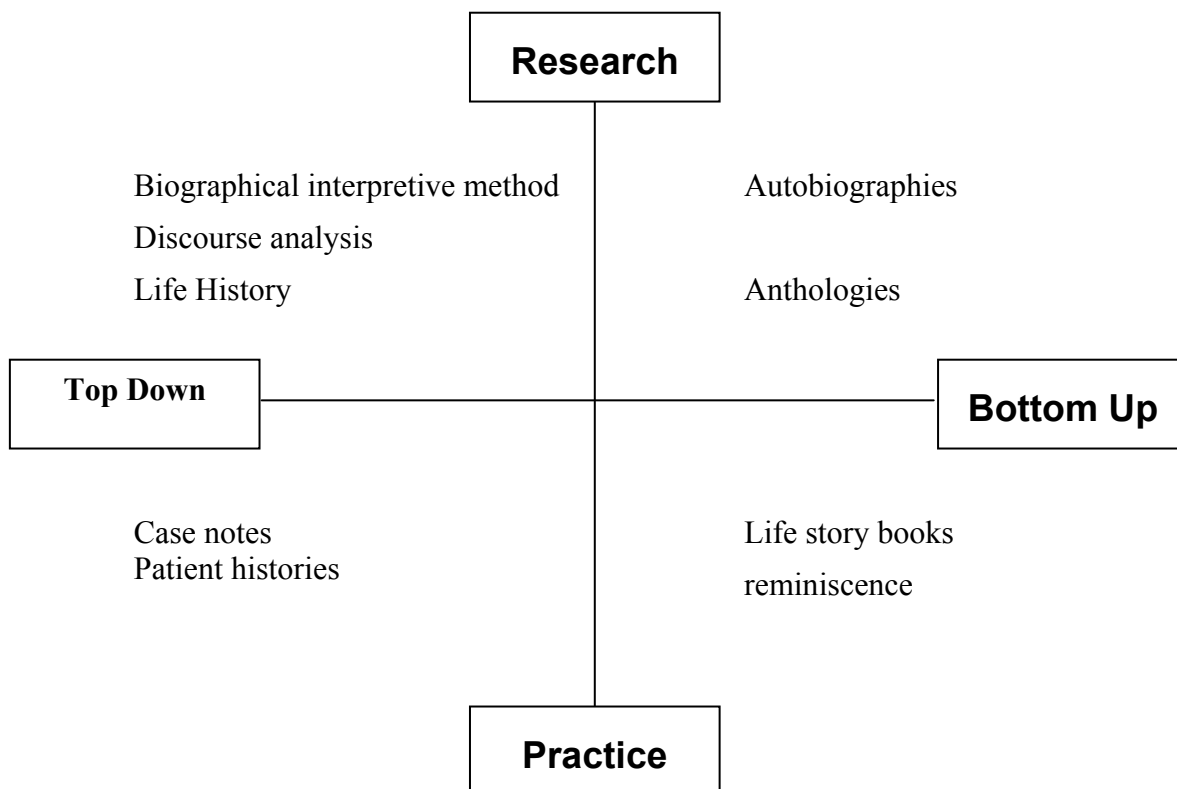
The matrix which appears below in Figure 1 is based on two axes, the first being research and practice, the second, top down and bottom up. Inevitably it is simplistic, a diagrammatic representation of a wide range of practices and definitions of research and research influenced practice. However, in its simplicity it is presented as a tool whereby practitioners, and indeed practitioner-researchers, might be assisted to position their methods and outputs. First however, some definitions of terms are required. By 'research' is meant any activity in which a person or group of people undertakes to solve a problem, or finds ways to answer a question they, or others have posed using stated methods to arrive at an argued conclusion. 'Practice' in this context is activity, in this case relating to health and social care, which involves social relationships which are recognisable as having common and observable characteristics, roles and interactions often, but not always, guided by rules and procedures.

Positions along the Research-Practice matrix describe activity which is more or less practice or research oriented with a mid-point represented by action research in which researchers may be practitioners seeking to bring about change in a practice setting.

‘Top-down - Bottom Up’ in the matrix indicates research which is generated and carried out by those who are detached from subject or research topic. This is in many ways the traditional approach in which an expert researcher or practitioner observes, records and comments upon a person’s life. Although somewhat discredited by critiques emanating from both researchers and activists in feminism, disability and colonial studies (Gluck and Patai 1991; Barnes, 1966; Swain and French, 1999, Plummer, 2001 for example), it is not intended here to convey such criticism, rather to enable the practitioner to recognize the position s/he is adopting. A top-down researcher or practitioner may show great commitment and partisanship in relation to the subject or topic, whether or not they share any of the characteristics of the person or people who are the subjects of the research (see Hammersley, 2000, for a discussion of partisanship and bias in research). ‘Bottom up’ indicates that the perspective is that of the subject, a reversal of the standard positivistic research paradigm, in which subjectivity and closeness to the experience are celebrated rather than condemned as being biased (Barnes 1996, Plummer, 2001, Reissman, forthcoming). Just as top down does not necessarily indicate lack of empathy, so it must be recognized that a ‘bottom up’ researcher who shares many of the defining characteristics of the research subject(s) may easily be non empathic, and judgmental in outlook. Examples of research methodologies and methods are positioned in the top-down and research top left hand quadrant of the matrix. These include quite different approaches, biographical interpretive, ethnographic and life history.

‘Bottom-up’ research is that which is generated from ground level by those who are, in most cases, the recipients of practice as service users or members of the public. Their roles may be many and varied, as Peace (2002) suggests. They may be initiators of research and they may analyse and plan the process, however their position within the structures of health and social care provision is non-professional and without bureaucratic or administrative power. Life story

**Figure 1: A biographical research matrix in health and social care Research**



Life story books and reminiscence work are located in the bottom right hand quadrant of the matrix as these are argued to be examples of biographical work carried out by patients and service users though the extent to which patients and service users generate or control these activities and the uses made of them is an issue which use of the matrix immediately generates.

The application of the matrix is not entirely straightforward. For example, the positions of top-down and bottom-up are contextually relative so that describing work produced by a community-based group as 'bottom-up' may be questioned by those who are marginalised within a community, such as disabled or frail older people or asylum seekers. Clearly memberships and ownership can qualify the use of such labels. One way to position an example of biographical work might be to ask three questions:

Who initiated it and why?

Who wrote it up and how?

Who owns the outputs?

These debates have a lengthy history in feminist, oral history and learning disability research (see for example Roberts, 1981; Gluck & Patai, 1991, Wolf, 1996; Perks & Thomson, 1998; Atkinson and Walmsley, 1999; Hammersley, 2000; Mauthner et al, 2002). Each of the dichotomies placed at the ends of the axes presents opportunities for simplification and complexity. This is what makes the matrix both useful and attractive as a critical aid to research and practice. To elaborate this point we now go on to illustrate this, drawing in part on examples from research undertaken by each of the authors of this paper.

### **Biography in top down research**

In this part of the matrix we can place research approaches which use biography as source material for hypothesising, analysis and interpretation. The researcher sets out on his or her task with questions or hypotheses to test by reference to biography or life history. Alternatively, the researcher uses life histories to construct hypotheses or typologies. Thompson's large survey of Edwardian family life is a well known example of such an approach in oral history (2000, 100-1). Looking at a much later period of family life, Bornat et al investigated the impact of family change on older family members. Though they consulted with older people initially and deliberately chose familiar words and language to describe their research, and though members of the team could empathise with interviewees, drawing on their own life histories to do so, these life history interviews with a sample of 60 people were collected, analysed by the research team and then deposited in an academic archive. The process was essentially top-down (Bornat et al, 1999).

There is a whole range of approaches falling within this quadrant. One which has particular salience for health and social care is Robert Edgerton's celebrated 1960s study of people discharged from a California institution for the mentally retarded. The project has informed practice, albeit in a watered down way. Through interviews with his subjects, Edgerton was able to develop a theory that survival after deinstitutionalisation was largely determined by the person's success, or good fortune, in finding a benefactor to guide them through the vagaries of life on the outside (Edgerton, 1967). One can see here how this finding has influenced practice such as citizen advocacy, widely seen as desirable if less widely practised in fact (Atkinson 1999; Henderson and Pochin, 2001). Although dressed up, one could argue that the advocate is equivalent to Edgerton's benefactor in being on the side of the vulnerable person, and willing to act as a guide and spokesperson. However committed, this is clearly 'top down'. Edgerton initiated the process; he wrote the books; and he 'owns' the data (see Gerber, 1990 for a detailed critique, and alternative set of interpretations). Similarly, advocates are top down in their position on the matrix. They may do their utmost to

empathise with, and give voice to, their advocacy partner – but they are essentially set apart from that person’s experience.

## **Biography in bottom up research**

Whilst biography in top down research casts the researcher as initiator, author and owner, the expert interpreter of other people’s lives, in bottom up approaches the person ideally speaks for him or herself. In learning disability research this approach has gained much credibility in the past two decades. Pioneered by Joey Deacon’s celebrated autobiography *Tongue Tied* (1974), and ideologically buttressed by principles of self advocacy in which people are enjoined to speak up for themselves, there is a considerable vogue for bottom up approaches. The principal example used here is *Mabel Cooper’s Life Story* (Cooper 1997).

Cooper, in her fifties, spent much of her life in long stay institutions for people with learning difficulties. Professor Dorothy Atkinson, Cooper’s partner in the enterprise of researching and writing her own life story, describes how the project was initiated:

The idea itself predated my arrival on the scene by about twenty years, although a start had been made in the interim with the making of a tape for someone else’s college project.

Cooper explains where the idea came from and how it took root:

“Hazel had asked me to do it because she wanted to do it for a college or something she was taking on, and I said ‘OK, but will you put it on a tape recorder for me, and I will try to make a little book out of it, because there’s a lot more to it than that on it’. And because I’d already done the tape with Hazel I thought, well, if I find somebody else, I’ll ask somebody to help me a bit more”.

(Atkinson, Jackson and Walmsley. 1997, 7).

Cooper was the initiator, but because she does not read or write she needed help. Atkinson’s arrival on the scene looking for life story material to feed into her teaching and research enabled the project to take flight. Going back to the questions posed above the story can be interrogated thus:

*Who wrote it, and how?*

The answer to this question is complex. The physical act of writing was Atkinson’s, using Cooper’s taped words. Atkinson also edited the transcribed tape, taking care to involve Cooper in the process, and gain her approval.

*Who owns it?*

This is Mabel Cooper’s life story. Atkinson’s part in its construction is fully acknowledged by Cooper and is public knowledge. The process has been explored in some depth (see Atkinson et al 1997; Atkinson and Walmsley, 1999; Atkinson and Cooper, 2000). According to Atkinson, Cooper wanted Atkinson to put her name to it, an offer which was refused (1997, 9).

Here is an example, then, of bottom up research, albeit aided by the skills of an experienced and well respected researcher.

It is rare to find that research projects fall so neatly into these boxes, indeed, one could argue that the use of Cooper’s life story as an illustration in this paper has shifted its position in the matrix, from ‘bottom up’ to ‘top down’. Once material arrives in the public domain, then in print, the original author has little control over ways in which it is used. However, it is a way of categorising and making sense of a very diverse range of research in the area of biography. (see Plummer, 2001)

## Top Down Practice

Most case notes and records fall into this ‘top down practice’ category, though the Freedom of Information Act (Department of Health, 2000) which permits service users to gain access to their own records may in time impact on their pure top down nature. The parallels with research are not hard to find. The raw data comes from the patient or service users’ biography, supplemented often by observations and evidence from other sources – psychological tests, inputs from professionals’, friends, relatives, court reports, etc. It is assembled and deployed usually for a particular purpose by someone with an official status. Rarely is the client invited to self represent, though his or her words may be taken down and used again for quite a different purpose. The example used here is taken from records kept by a Mental Deficiency Committee about a woman detained under the 1913 Mental Deficiency Act, ‘Dora’. It may seem perverse to select an example from almost a century ago. But there are good reasons for this. The first is simply practical. Because such records cite names and often addresses which can identify individuals and relate to sensitive areas, publicly archived records are generally unavailable until 80 years after the date of compilation. The second is that a historical example such as this highlights the official mind at work. Language and thinking have developed, making it relatively easy to detect the impact of a ‘top down’ account. Thirdly, although the practices and attitudes exemplified here seem at first sight alien, eugenic practice lives on, more subtly perhaps, in the new eugenics (Stanworth, 1989, Ward, 2003) - abortion of deformed fetuses post amniocentesis, birth control ‘offered’ to women with learning disabilities.

The biographical account of Dora’s life was compiled by the Bedfordshire Deputy Medical Officer of Health in 1916, drawing upon a variety of sources, but not, significantly, the girl herself. What follows are extracts:

At the Court it was alleged that the girl was a menace to the troops as she had been sleeping with various soldiers in the neighbourhood and complaints had been made by the military to the police about her conduct....

Her appearance is healthy but somewhat dull and heavy ... I am of the opinion that she has not got sufficient mental control to resist men who wish to assault her, but on the contrary her mental condition is such that she accepts these attentions from men, failing to appreciate the immorality of her conduct.

*(her mother reported)* Dora had always been dull at school .... Three years ago the mother was sent for by the girl’s mistress in domestic service as she had been behaving immorally with farm hands. Until her daughter was assaulted whilst in this situation she had exhibited no immoral tendencies, but from that time to the present she appears to have been immoral whenever the opportunity occurred.

Mr. Tibby (stepfather) states that neither he nor his wife will receive the girl into their house as during the time she was living there she accused Mr. Tibby of attempting immoral conduct with her.

In all probability she is not pregnant at the present time.

I regard the girl as a moral imbecile.

(names and source anonymised).

*Who initiated it and why?* – Deputy Medical Officer of Health with the purpose of certifying Dora as a mental defective because of alleged wayward sexual behaviour and complaint from influential professional source.



*Who wrote it and how?* Medical Officer of Health, assembled from reports from other professionals and family, and test he had administered.

*Who owns it?* At the time, Mental Deficiency Committee (not accessible to Dora or her family), now County Record Office.

It is easy to castigate such records as the antithesis of empowerment. One might as easily read the account as one of a girl who had been sexually abused, and was acting out distress. This highlights starkly the importance of being aware of prejudices and assumptions, underlining the necessity of maintaining a self reflexive and critical approach to professional practice. However, to return for one moment to Mabel Cooper, there is a case to be made for such notes, and access to them by the people about whom they are written. Cooper did not, until she saw the 'top down' records kept on her as a person detained under the 1913 Mental Deficiency Act, know much about her past, except what she remembered. The records, hurtful as they were in the harsh judgments made upon her by others, gave her some facts about her life which would otherwise have remained closed to her. From them, she was able to piece together her story and be empowered through knowing that her mother had abandoned her through no wish of her own (see Cooper and Atkinson, 2000).

### **Bottom up Practice**

The importance of developing a positive sense of identity, especially where life experiences have been unpropitious or identity is compromised in institutional settings, has been increasingly recognised since the days Mabel Cooper was a hospital resident. The fact that she now has written her own life story is evidence of this changing climate. Children in care, or adopted, people with learning difficulties, older people in residential care, all are potentially enabled to gain or retain a sense of identity through biography (see for example: Bornat, 1993; Ryan & Walker, 1993; Schweitzer, 1998; Stuart, 2002). Life story books, reminiscence, photo albums, precious possessions are means by which knowledge of a life is bolstered in more enlightened care settings. Training which involves exposure to worked through biographies of typical care recipients has helped to strengthen claims for changed practice, awareness and more appropriate and sensitive service delivery (Pietrucowicz, & Johnson, 1991; Bornat, 1993; Goldwasser & Auerbach, 1996; Bornat & Chamberlayne, 1999; Garland & Garland, 1999).

The extent to which such outputs can be located and pinned down as bottom up practice remains a question as we will now go on to illustrate with a worked through example of a biographically-based research project.

### **Biographical practice in a continuing care ward – using the matrix**

The project was an approach to grounding research and practice in a bottom up framework, inclusive of patients and nursing staff<sup>1</sup> (see Adams et al, 1996). The research aim was to find out how biography was used in nursing care and to offer the nursing staff, the patients and their relatives a model for biographical practice which would open up opportunities to enhance personal worth, agency, control and social confidence (Kitwood & Bredin, 1992) for everyone concerned.

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<sup>1</sup>. The project 'Models of biography and reminiscence in the nursing care of frail elderly people'. was funded by the Open University Research Committee and run jointly by Dr Joanna Bornat, School of Health and Social Welfare and John Adams of Sir Gordon Roberts College of Nursing and Midwifery, Kettering. The research assistant was Mary Prickett.

The project took place on the continuing care wards of two NHS hospitals within the same Health Authority during 1993-4. These were wards which were then under threat from health care policies which were seeking to economise and rationalise bed use by older people. Eventually most were to close and the alternatives, beds in private nursing homes 'in the community' or targeted and heavily rationed domiciliary care have become the norm<sup>2</sup> (Glendinning et al, 2002). For the nursing and other staff employed there, this policy change put a question mark over their status and future professional lives. With few exceptions these were unqualified staff conscious of their lowly position in the nursing hierarchy, a position compounded by the fact that they were nursing a group of people who were disregarded and marginal in relation to any notion of cure. Medically, the people occupying the beds were there because they were thought not able to 'improve'. The roles occupied by visitors and friends were restricted by the space and facilities offered in a hospital ward.

The methodology was action research, using a 'technical collaborative' approach. The researchers planned to test a biographical intervention in a practice setting and, with the help of practitioners, to achieve innovation in clinical practice.

The work began with baseline measurements, where consent had been given, of patients' levels of cognition and of depression, followed by observation on the wards. Data from observation provided evidence of the extent to which biographical references contributed to normal daily interactions between nurses and patients. Interviews followed with those patients able to talk about their past lives. Copies of the tapes and transcripts were given to patients or their relatives. The planned next stage was to work with the nursing staff to produce a life-story scrap book for each participant, to show that it was possible to produce a pleasing result with little resource.

Such were the aims, methods and stages of the project. We now use the matrix as a tool for evaluation.

### **The matrix as an evaluative tool**

In the original plan, the project occupied a place part way between research and practice on the vertical axis, perhaps nearer research. In order to minimise researcher effect the nurses had not been told at the outset what was being researched. The topic was described as 'Communication' rather than reminiscence or biographical work. This perhaps skews the position on the horizontal axis more towards the top- down end. However, the aim from the outset was to engage with the patients in an interactive and collaborative way. Overall then, the research plan might be positioned somewhere in the bottom right hand quadrant of the matrix.

As the project proceeded complications arose. The ward staff proved less than enthusiastic about the project, despite support from managers. It had been planned to include staff in the production of the life story books once the observation phase was complete. This proved difficult. Nurses were, with only one exception, 'too busy' to take part. The researchers revised the approach, and proceeded by completing the books with the help of patients, relatives, the local history library and other sources. 11 were completed, and each was given to the patient or a relative.

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<sup>2</sup> The Royal Commission on Long Term Care reported that 38 per cent of long-term care beds had closed after 1983 during which time the number of beds in private nursing homes had increased by 900 per cent (Sutherland (Royal Commission on Long Term Care), 1999, paragraph 4.7).

Reference to the matrix immediately shows that in attempting to be empowering to the patients and their relatives, the researchers had been disempowering to the staff. To them, this was very much a top down research project, and one in which they had no ownership. The matrix raises the question of, in this case, bottom-up for whom? The original aim was to contribute to improved nursing care, to extend nurses' knowledge of the lives of patients they were in daily contact with and to collaborate with them in doing so. One can account for resistance from staff in part in terms of general dissatisfaction and concern about their own futures, but must also acknowledge that this resistance was also born of a professional pride in their particular caring work of which the project took too little account. This struggle over involvement means that the project moved up and down and to and fro on the two axes as the process unfolded. The nurses' biographies were not officially part of the project but they, perhaps unwittingly, ensured that their practitioner life stories were a factor.

Despite this unforeseen development, the life story books were completed through cooperation with the patients' relatives and friends. The books proved their worth on the ward. Despite the claim by several of the nurses that they were familiar with their patients' lives, new stories were forthcoming. It also became clear that even when people were least able to contribute verbally some degree of control and influence was being exerted in relation to the contents of the life story books. The bottom up quality of a biographical approach to this particular piece of action research is perhaps confirmed. Perhaps also, the very contested nature of the process pulls it down towards the practice end of the vertical axis. It was the intention to influence practice and although the process had not developed as expected, the ownership of the project had clearly shifted over the weeks.

In terms of tangible products, the life story books occupy the bottom right hand quadrant but the effect on practice was much less obvious. Interestingly the research project seemed to act as an encouragement to those who were strategically better placed to negotiate around the survival of their wards. Nurses on adjoining wards where rehabilitation was the focus were keenly taking on reminiscence work and given the resources and encouragement to do so. Similarly, staff who saw the future for themselves as a palliative care ward were equally keen to develop biography as part of their repertoire of care interventions. These outcomes had not been predicted.

Here perhaps confirmation that biographical research may indeed have empowering outcomes, if not always those intended by the researchers. The fact that it could be appropriated in this way is suggestive of empowering qualities both latent and explicit, in this case for the patients in terms of the process and the outcome and also, unexpectedly, for some nursing staff too. Use of the matrix has facilitated an object lesson in how to design and operate research in a practice terrain, most acutely, the need to engage staff at a very early stage.

Finally, what of the dangers of appropriation and exploitation of people's stories by researchers and practitioners? The subjects, frail older people, were not fully able to comprehend the purpose of the activity, though undoubtedly friends and relatives did, and embraced it with some enthusiasm. There is no question that the researchers have appropriated this story to develop careers, and to disseminate information. But it would be hard to argue that people's lives were diminished or harmed by the intervention, and one might indeed make a case that they were, if only marginally, improved. For that reason we would defend ourselves against the allegation of theft of people's stories, or use to bolster the 'medical model'.

## **Conclusion**

It is proposed that the matrix has helped to identify three aspects of biographical work in which empowerment is illuminated and perhaps elaborated as a process. First, in relation to time, the very fixed nature of the matrix illustrates how power and interests can shift as different biographies are brought into play and as the process of research shifts within the structures which define and determine practice. A research project has its own biography and the matrix helps map and check shifting empowerment balances during its lifetime.

Second, in considering the interests of stakeholders, ideas of research ownership and control may have to be redefined as perceptions of what is biographical in a project becomes more and less explicit, while different stakeholders shift in their understanding and appreciation of the biographical in their own and others' lives.

Finally as a moderating influence on claims which biographical research and practice has consistently made as to an empowering role, the use of the matrix is perhaps a helpful caution, a restraint, a reminder that claims to speak for people, to 'give back' or to 'provide a voice' are only at one end of a continuum which also locks into professional interests, structural constraints and limits on resources. In the end, as others have pointed out (Buchanan & Middleton, 1994, p 68) biographical approaches can enlighten and change awareness but the extent to which they can alter the conditions in which people live and work is limited.

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