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Published in:
Sociology of Health and Illness

DOI:
10.1111/1467-9566.13675

Publication date:
2023

Document Version
Publisher's PDF, also known as Version of record

Citation for published version (APA):
Kamp, A., & Dybbroe, B. (2023). Training the Ageing Bodies: New knowledge paradigms and professional practices in elderly care. *Sociology of Health and Illness*, *Early view*. https://doi.org/10.1111/1467-9566.13675

Received: 9 November 2021 | Accepted: 2 May 2023

DOI: 10.1111/1467-9566.13675

SOCIOLOGY OF HEALTH & ILLNESS

ORIGINAL ARTICLE

Training the ageing bodies: New knowledge paradigms and professional practices in elderly care

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Funding information
Norwegain Research Council, Grant/Award Number: 273696

Abstract

In the Scandinavian countries, reablement has become a principle permeating all parts of elderly care, hence potentially transforming care and care work. This article explores the advent of new knowledge paradigms and practices of physiotherapists and occupational therapists transforming reabling care in particular ways, leading to what we term *a logic of training* emerging in the field. These professional groups have obtained a dominant position as reablement specialists in Norway and Denmark, where our extensive fieldwork was performed as part of a 3-year research project. Taking inspiration from Annemarie Mol's concept of logic, we study how professional practices are organised and infused with specific values, meanings and ideals in situated contexts. We hence explore the logic of training, its abstracted image of the body and rational goal-oriented model for progress measurement and its ramifications when addressing ageing bodies in a complex field marked by the unpredictabilities of the social and lived bodies, administrative rules and temporalities and the quest for empowering and involving clients. The paper concludes by pointing at new contradictions arising

when practicing reabling care and particularly points out the tensions arising in care relations, where ambitions on empowering and disciplining the client and the elderly body may collide.

KEYWORDS
care work, logic, physiotherapy, reablement

INTRODUCTION

In the Scandinavian countries and to some extent also in other welfare states (e.g. the UK and New Zealand), reablement has become a dominant paradigm in elderly care (e.g. King et al., 2012; Wilde & Glendinning, 2012). Hence, a wave of reforms that aim at making homecare reabling and at promoting the independence, self-reliance and self-care of elderly clients have been introduced during the last decade.

The reforms are viewed as a win-win solution to the multiple challenges facing the welfare state and its provision of health and care services (Hansen, 2016). They are represented as a solution to the economic challenges policymakers face with the so-called burden of ageing (Walker, 2000), while independent living and homecare based on mobilisation of activity are also thought to improve the clients' quality of life. The reablement reforms are hence heavily influenced by discourses of active ageing, which envision old age not as a time for repose and withdrawal from public life but as a period of continuing health, activity and productivity (Katz, 2000).

The reforms are therefore closely linked to the ongoing efforts to reduce institutionalisation, which under headings such as 'staying at home as long as possible' have been a dominant strategy in elderly care in Norway and Denmark, where this study took place. As stressed by Aspinal et al. (2016), reablement is not just an additional aspect of care; it has become a principle permeating all parts of elderly care, and both Danish and Norwegian local authorities are required to offer reablement according to elderly care legislation.

Reablement is however a broad term that might be interpreted differently when practised in specific sociocultural contexts. In this article, we explore how reabling elderly care evolves particularly in Denmark and Norway, where physiotherapists and occupational therapists have achieved a position as specialists in elderly reablement.

Therapists are positioned in new roles as leaders of health-care teams and enter new areas of health care, such as serious illness and palliation. The therapeutic knowledge regimes and their practices thus play an important role, not just in physical reablement in the frontline but also in needs assessments of elderly people and in organising and supervising care in inter-professional teams. Hence, reablement in Norway and Denmark increasingly focuses on the bio-mechanical body and its trainability in short-term programmes in order to regain abilities and resources. We argue that the knowledge and practices of therapists directed towards training the body, using methods and measures focusing on physical performance and optimisation through training the bio-mechanical body in standardised ways constitute a certain logic that permeates organisation, practises, values and care relations in elderly care in DK and Norway.

While reablement may be seen in continuation of the 'help to self-help' paradigm introduced in Nordic elderly care in the late 80s (Dahl, 2005), reablement is today more than an ideal of supporting the active, empowered and self-responsible elderly individual. Organised around

specific practices on goal-oriented optimisation of the bodily functions—training—it is also a new way of caring for elderly bodies. What appears is a logic with a particular focus that we propose as a 'logic of training'. In this article, we analyse the core practises of physio- and occupational therapists in elderly care, exploring the implications of these new modes of organising care, producing knowledge and understanding bodies for care and care relations.

OUR APPROACH

In this study, we take inspiration from Annemarie Mol (2008)'s use of the concept of logic in her analysis of two opposing logics: The logic of choice versus the logic of care. The concept of logic, developed in different strands of sociology, for example, lately in French Pragmatic Sociology (Boltanski & Thévenot, 2006), draws our attention to empirically identifiable systems of meaning in a situated context.

Further explaining her conception of logic, Mol (2008) underlines it as '*A whole world: a specific mode of organizing action and interaction, of understanding bodies, people and daily lives; of dealing with knowledge and technology; og distinguishing between good and bad*' (Mol, 2008, p. 8). Here, 'logic' bears resemblance with conceptions of discourses and rationales, but it should be underlined that focus is not only on language but also on materialities and practises as ordered and organised in specific historical and culturally situated ways.

Logics may be plural, and when studying situated practices, they do of course not appear in a pure form but have to be distilled following the analytical process (Dahl, 2017; Mol et al., 2010). Where Mol's ambition is to describe the logic of care, ours is however more modest. As we study a logic introduced and shaped by key professionals, we have chosen to focus our analysis on core practices of therapists in elderly care. We hence follow the attempts of professionals to accomplish good care, adhering to a specific professional body of knowledge, certain standards and modes of knowledge production and conception of the elderly body. We explore the specific ways care and care relations are reconfigured and focus on the contradictory and possibly conflictual aspects of these practices, when unfolded in elderly care.

Care practices, albeit well-intended, imply the exercise of power and involve disciplinary or self-disciplinary techniques, resistance and friction (Kalman & Andersson, 2014; Twigg, 2000). Moreover, care is performed in institutional contexts marked by austerity, leading to an increased time pressure that compromises aims of empowering the clients (Mort et al., 2013; Steihaug et al., 2016).

Studying the logic of training explicitly brings the body into the centre of care research. While much of the classic, feministic care research has decentred the body and focused primarily on emotionality, relations, ethics etc. (see e.g. Eliasson, 1992; Tronto, 1993; Waerness, 1984), the body in care has recently been brought back into care studies. As Twigg (2000) convincingly argues in her study of bathing, care work is embodied, and studying bodywork as a cornerstone of care may give access to the more complex negotiations of, for example, relations, identity, status, temporality and sexuality in care. Researching the body in care, she argues, thus represents a new way of challenging the abstract biomedical representations of elderly people as bodies characterised by disease and decay.

However, reablement with its new optimistic, training-oriented gaze on the active and trainable body raises new challenges for researching the body in care. Few studies focus specifically on changes in professional bodily practices implied by reablement. Hansen (2016) uses the concept of bodily choreographies to grasp how care workers maintain a distance to bodywork and elderly

bodies in order to nurture the clients' self-responsibility and independence. Addressing the role of physical training more directly, Hansen and Kamp (2018) and Bødker (2019) discuss how reabling elderly care implies that elderly bodies are seen as potentialities of functionality and as the objects of specific therapeutic training goals.

This article aims to contribute to this latter discussion on reablement and bodies in care. We do so by investigating central therapeutic practices: assessment of bodily potential, goalsetting, training and measurement of progression. These practices are identified as specific ways of organising relations between therapists and clients, using technologies, understanding bodies and knowledge, infused by specific values and ideals of 'good care' and thus suitable for exploring the implications of the logic of training for care work and care relations.

We explore the efforts of therapists to unfold this logic, originating in health-care practises at hospitals and specialised clinics and transferred to a in the complex field of home-based elderly care. This is a field marked by the unpredictabilities of the social and lived bodies (see e.g. Twigg, 2000), but also the administrative logics and temporalities and the quest for empowering and involving clients must be negotiated. Highlighting the strong focus on standardised measurements of progression and the dissonance between conceptions of the abstracted body full of potentials and the ageing lived bodies, we point out contradictions and ambiguities involved in practising reablement guided by the logic of training and discuss the possible consequences for care relations.

METHODOLOGY

The analysis presented is based on fieldwork in elderly care in Norway and Denmark during 2018–2019 conducted by a team of eight senior and three junior researchers. The fieldwork formed part of a larger research project aiming to investigate how contextual dimensions and dynamics, such as structures, policies, professional organisation, experiences and cultures matter in the transformations of care induced by new reforms and concepts. The project focused on four main sites, representing both local and more 'global' reforms of care organisations and care practices in both countries. It was organised in a multi-sited way (Marcus, 1995) and hence comprised the study of practices moving across different sites, care homes, elderly day care centres, homecare organisations, outreach care clinics, training and reablement centres and care authorities and management. Fieldwork was conducted at all levels of care institutions and included both clients and different professional and managerial groups. This produced a multi-sited insight into the variations and similarities of specific care practices, forms of work, specific professionalism and interactions between clients and professionals. The fieldwork was thus extensive in terms of practices observed, interviews conducted and documents included and was team-based, allowing for a thematically focused collection of a huge amount of data.

This form of ethnography must be supported by continued sharing and reflection on data between researchers with different expertise, as it relies on data from very many subjective positions (Armstrong & Lowndes, 2018). As other care researchers have previously found, team-based ethnographies assume a high degree of trust, engagement, flexibility and reflection in research teams (Bikker et al., 2017). The research team reflected and shared knowledge from the project on a day-to-day basis during fieldwork, which generated a form of cumulative research, where new ideas of what to observe and whom to interview arose from the research team during the process.

The analysis presented in this article covers fieldwork conducted by the authors in all four sites: In total 15 days of field observations with therapists covering their main practices: assessing client needs, setting goals, training and evaluating progress, supervising other care workers,

supplemented by ten 60–90-min interviews with therapists. The authors also conducted several inter-professional focus group interviews. Observations and interviews focused on the meanings, values and ideals pursued by the therapists and the challenges of bringing these into practice in specific situational and organisational contexts.

As described above, the background to the cases we have chosen for analysis was more comprehensive: The research team conducted all together 34 days of shadowing observations of reablement practices of therapists and/or nursing assistants under the guidance from therapists in clients' homes or in clinics where reablement practices were in focus. This provided broader and deeper evidence of how these professionals played a key role in the way institutions of home-based care are reconstructing care.

All observations were documented through notes taken when appropriate and elaborated from memory shortly afterwards (DeWalt & DeWalt, 2010). The interviews followed semi-structured interview guides and were conducted in Danish, recorded and later transcribed verbatim. Quotes have been translated into English by the authors. All persons interviewed and observed gave their consent to participation.

The analytical processing of the data took form as an interactive reflection between individual cases in relation to individual contexts and possible patterns in relation to several contexts and several sites and particularly in relation to our social theory as a context, drawing out logics and finding patterns (Nielsen, 2017). The endeavour was to describe practices, reflect paradoxes and establish rapport with our theoretical understandings and single out dynamics in the transformations of care we observed. The quotes and descriptions of observed interactions presented in the analysis have been selected as illustrative examples of broader tendencies in the data.

Ethical approval was obtained from the Norwegian Centre for Research Data (NSD), ref. no. 128713, and informed consent forms were collected from all interviewees and from the clients visited. Anonymity was secured by changing names and slightly redrafting the empirical material if episodes or quotes were recognisable

ESTABLISHING THE LOGIC OF TRAINING

Physiotherapists originally played a marginal role in elderly care. In recent years, they have however developed methods and measures focusing on physical performance and optimisation through training the bio-mechanical body, which has paved the way for their entrance into this field (Nicholls, 2020; Perracini et al., 2020). Also, occupational therapists see themselves as protagonists in this new reform wave (Zingmark et al., 2020) and show a growing interest in training elderly clients and measuring the improvements in their everyday living. Although the two groups may have a different focus, they increasingly use the same methods, leading to more blurred boundaries between them, and they now enter positions as reablement specialists in many different areas. By offering professional approaches that resonate with current policy visions of reablement, and also of making elderly care more predictable and manageable (see also Katz, 2000), their ideals, knowledge-based and practises have become prominent and hence constitute the core of the logic of training.

The primary focus of therapists is the body as mechanisms and functionality. The therapeutic knowledge and practices aim at optimising the physical functions and/or prevent present or imagined future motoric and physical problems, here connected to ageing. Praestegaard et al. (2015), in their study of occupational societies and textbooks, argue that therapists adhere to a bio-psycho-social paradigm, but their striving to become true professionals has gradually led

them to take over biomedical understandings, focusing on the body as parts and elements and working from ideals of unequivocal cause-effect relations.

Like many other occupational groups that are not considered to be 'true professions', therapists engage in a field with competing groups of semi-professionals and privately educated entrepreneurs such as body-therapists, chiropractors etc. Therapists therefore see professionalism as an ongoing project, which may take different directions (Evetts, 2011; Fornasier, 2017). During the last two decades, physiotherapists have tried intensely to establish professional closure (Nicholls et al., 2020). This has led them to connect closer to both the medical field and its conception of knowledge and to physiology as a newer rapidly developing field that contributes with more specialised knowledge and methods (see e.g. Bergland & Strand, 2019; Perracini et al., 2020).

More recent research into therapeutic practices and knowledge demonstrate that a logic of measuring has become dominant in physiotherapy, also with the aim of engaging patients in 'taking over' former physiotherapeutic professional interventions, such as monitoring and training (Hansen, 2021). A traditional physiotherapeutic conceptualisation of the bodies they work 'with' has been and still is mainly 'the body as machine', following the Cartesian dualism from the 17th century, dividing mind and body (Dahl-Michelsen et al., 2021; Nicholls, 2018).

Recent physiotherapy research has aimed at designing manuals, tests and training schemes specifically directed towards different, often age-related functional problems, in order to enable the measurement of the possible training efforts. This has strengthened therapists' key role in elderly care and has accentuated the development towards more bio-mechanical understandings of the body in elderly care. This has promoted another important characteristic of physiotherapists' practices, namely their organisation as goal-oriented time-limited processes. These processes supported by manuals, tests and standardised training guides are permeated by rational goal-oriented logics: Setting up sub-goals and milestones for a process, where clients are supposedly improving their functional abilities (see e.g. Perracini et al., 2020).

This expertise implies a specific gaze on the client and the bodily potential for training, bringing specific solutions to the problems and needs of clients. This implies a specific approach to clients and their bodies and a specific way of applying knowledge and technologies.

The ability to assess the physical potential of the individual client is considered the essential professional competence and forms the basis for establishing an appropriate training programme. These training programmes focus primarily on general bodily strength and balance, conceived as essential preconditions for clients' mobility and ability to master everyday life. One of the physiotherapists explains her professional practice on assessment as follows:

> It is primarily about training and assessing the potential for improvement concerning strength and balance. This is often the central issue. We have a lot of clients with fractures. Or they have neurological disorders, have had a stroke or the like, and then it's important to assess what you actually can achieve physically. We have the knowledge to set the dosage right for each client and to adjust it individually – so setting the goals connected to physical activity, that's our focus.
>
> (Interview with physiotherapist, Norway)

With this focus on physical activity and the bodily potential, they develop ways and means of training. Reablement and the goal of making people regain their abilities and possibly become independent of help constitute a positive horizon for the therapists' professional work, which they describe as the core of their professional identity. So, referring to Mol (2008), a logic on training with a specific approach to knowledge, technologies and bodies and with specific values evolves. An important part

of this logic is developing training programmes—technologies—based on specific knowledge on the potentiality and trainability of specific bodies. Here, the value of gaining bodily mobility is at central.

One therapist expresses this as follows:

> To find out how to enable mobility in the best way together with the client. Find good solutions, simply. I am very engaged in this "training bit". To do exercises which the client needs. You cannot carry out different forms of treatment in the home, like you can in an institution, so training becomes more dominant.
>
> (Interview with physiotherapist, Norway)

In this quote, where the therapist illustrates her engagement in developing proper training for the client, she also illustrate her specific contribution and interpretation of 'activity' as physical mobility. The wishes and judgements of clients is seriously considered, but the response is restricted to adjusting goals and programmes for physical training.

Therapists often take part in the first assessment of the clients' needs, after their dispatch either from the hospital or in connection with requests for homecare. However, when organising reabling elderly care in Danish and Norwegian contexts, there is an attempt to integrate therapists in all parts of care work, often as consultants and supervisors for the homecare units. With their focus on the bodily potential, they often engage in re-assessing care needs, pointing out the potentials of making clients self-sufficient. Training often forms part of the enabling care offered, as therapists intervene and use their expertise to assess how adequate physical training might help to solve the problem. In the example below, a physiotherapist illustrates how she usually solves problems by making the client more self-reliant, giving an example of a typical supervising conversation with a care worker on her interaction with a frail client who refuses to go to the toilet on her own:

> So an example could be that somebody (a care worker) says: "But, I cannot.. she (the client) refuses to go to the toilet on her own, when I come to visit" and then I say: "But actually she can go herself. So maybe this is about her feeling insecure. So we may consider: should she use a walker? Or should you walk a little closer to her, or should I train more intensively with the client?"
>
> (Interview with Physiotherapist, Denmark)

As illustrated in this example, the therapist practice the logic of training on specific care practices when acting as a supervisor to other care workers, hence transmitting this logic. The therapist assesses the problem as a question of the bodily potential and trainability, asking if the client 'objectively' can walk by herself, or she may be trained to do so. She then addresses the social part, that is, the client's insecurity that may also cover anxiety in a wider sense, as a question of lack of physical strength or confidence, which may be remedied by providing something to lean on, bodily. Hence, problems and solutions are reinterpreted, and an objectifying gaze on the bodily potential of this frail client is introduced. In this process, aspects of the client's subjective relation to and experience with her own body are bypassed or sought controlled.

GOAL SETTING AS A COMPLEX SOCIAL ACCOMPLISHMENT

Setting training goals for the client is a core element of the therapist's knowledge-based practice and constitutes a specific way of organising care and care relations. Goal setting implies assessing the physical abilities and the potential for reablement and converting this to a relevant

goal-oriented and time-limited training programme. Progression in reaching goals is important in relation to assessing the professional performance and success of therapists. Moreover, they form the basis for evaluating progress in therapeutic communities of practice. At meetings among professionals where the training work is discussed, each client will be discussed as a case, and the goalsetting, progress or problems in practice, and the futilities or benefits of training, as well as possibilities for terminating the service will be estimated and evaluated.

However, while this is viewed as a rational process and as a basis for assessment of progress and productivity, goal setting is shown below as a complex and often contradictory process, involving negotiation of power and client relations. Goal setting serves several aims; apart from being an ideal implied by the reablement paradigm, goals are also considered important for engaging clients in their training programme and for giving them hope.

Below we follow the goal-setting process, where a therapist uses a standard tool, COPM (Canadian Occupational Performance Measure) in his interaction with the client. This manual, which is used by both groups of therapists, supports a systematic survey of the client's abilities to manage daily activities and offers a method on how to set goals and make priorities while involving the client. COPM is used to varying degrees and in different versions in Norway and Denmark, and other manuals may be used. The philosophy of systematically monitoring problems and setting goals with the client accompanies the use of all these tools. They also form an integral part of the professional practices of documentation:

> Eve is a fresh and well-kept lady of 92 who lives in a third floor flat overlooking the fjord. We step inside, and Tore presents Eve with his errand: together they must go through a form so that he can identify her challenges, and together they can make a plan for her reablement. He emphasizes: "You can just answer freely, nothing is a wrong answer." She nods benevolently.
> Tore then reads aloud from the form, she answers and he takes notes. It is a lengthy process that does not allow for much real conversation and social contact. It resembles a formal, structured interview.
> First, problems in personal daily activities are identified: Eve says that she can use the shower but is a little unsure of her balance, but she has something to hold on to, so it works out. She has started to sit down when she gets dressed, but that also works. She says that in the past, she managed to use the crutch, but that does not work anymore, as she does not feel secure enough, so she has to use a walker. Tore says: "Then I'll write that it's a challenge to get up and get dressed and that you want to go back to using the crutch". .... The next topic is leisure. Tore asks and she answers: "Well, my sight has got bad. I used to go to the theatre with my family, I don't do that anymore. I don't want to go alone, and after my best friend died, I don't feel like it". Tore asks about other things she likes to do. "Before, I went to folk high school and the senior centre," she says. She has been very happy with the folk high school and continues talking about it... Tore takes notes and then interrupts her, asking if she would like to be part of a strength and balance group. He does not explain this further, but she is a polite elderly lady and says: "That would be good. I would like that".
>
> (Field notes, Norway)

Here we follow how the therapist succeeds in introducing 'strength and balance' as the solution to the complex set of problems experienced by the client. This case illustrates the client's

broader life expectations, experiences and hopes, which are consequently redefined as physical and trainable needs. Broader aims in life that are linked to hopes of other gains, such as contact with others, a fulfiling life etc., by being able to participate in study circles or folk high school are evaded in the professional-client dialogue and translated into exercises to improve physical strength and balance, with the ultimate goal of making the client independent of services from homecare:

> Then Tore introduces the goal setting: He asks: "As for our cooperation, what is your goal?" She replies: "To get back to where I was". Tore tries to make her be more specific, and she explains that she means to get well enough to go to the chiropodist, dentist, hairdresser, to study circle in the autumn and shop in the supermarket. Then, Tore needs her to make her priorities, and asks her to give scores to the different goals. This is really difficult for Eve to understand. Tore recaps on her different goals, emphasizing the importance of being able to use the crutch. She first gives a score of six to using the crutch again, but when Tore questions this score, she changes it to 10. This scale is clearly not intuitively understandable. It ends up in a large number of activities that she gives a score of 10, those she would like to work on. And at Tore's suggestion, it is about using the crutch again. They agree on that as number one. "It's a lot about strength and balance", Tore notes. Time is running out, and we leave the elderly lady, after having made an appointment for future training. Later in the afternoon, the training plan is added to the notes in the record:
>
> Main goal: To be independent in transfer situations using crutches. Sub-goal: shower on your own, make meals, go down the stairs alone. Measures: strength and balance training.
>
> When back in the car he remarks to me, that this version of COPM really is too detailed and too long; a shorter version would sustain a better dialogue, he thinks.
>
> (Field notes, Norway)

As illustrated, this way of organising care relations positions the elderly person as a respondent, an interviewee and hence affect care relations. As the very thought of setting goals and ranking them seems to be at odds with the experiences and approaches to health care of many elderly persons, this may alienate them from this process. Moreover, what is requested is not any kind of a goal but a goal that may be translated into training programmes, potentially leading to independent living at home. In contrast, the goals that the clients articulate refer to wider aims in life or more utopian wishes of regaining former abilities and resources. According to the therapists interviewed, this is often the case.

Hence, it is quite an accomplishment to produce usable goals, as the goal setting should reflect professional knowledge and ideals of person-centredness, but also serve the aims of giving hope to clients of improving or achieving something desired, such as going out to meet others.

Accordingly, this process of setting goals and priorities requires the therapist to tinker (Mol et al., 2010), to diligently negotiate and nudge the client towards specific goals in relation to specific everyday activities that may fit into establishing programmes of physical training in time-limited trajectories. In this process, it becomes clear how the organisation of the goal-setting process, using a standardised manual, frames the relations and the negotiations in new ways, that may affect power relations in care. So, negotiating power relations in ways that resonate with ideals of empowerment of the client becomes an important part of the professional task.

TRAINABILITY IN SHORT-TERM PROJECTS

As the training programmes are constructed as short, time-limited projects, the activities of how to start up and terminate the training play an important role in the professionalism and practical work of therapists. These practices may be ambiguous and conflictual. The goals are not always met, so a termination implies difficult discussions on what then to offer the client. This is a process where the trainability of the client clashes with administrative temporalities and the shortcomings of ageing social bodies.

In our observations of the therapists' regular meeting, where they discuss client cases, it is striking how messy and unpredictable these training processes may turn out to be. These are practices that concern people who are seriously ill or might be in grief, have limited physical strength and may have alcohol problems, social problems, a difficult relationship with their partner etc. The following description stems from a regular inter-professional meeting where both therapists and other care workers involved in training take part:

> "No progress" is a recurrent problem that is taken up at the weekly review meetings in Denmark. Several of the stories are about training clients to manage bathing or toilet visits independently. In one case, the training period is prolonged as there seems to be physical potential, but as the therapist in charge says: "She may master a lot, but she's feeling very insecure". One of the therapists brings up a case of a client where further training must be given up. The client is able to take a bath independently, but he only does this because the care personnel urge him to do it. After this effort, he becomes so exhausted that he is unable to do anything at all, not even dry himself. He refuses to let his wife help him with the bath, but trying to push him to accept her help is not a possibility anyway, as his wife is in charge of everything else in the house and alsohas a job in addition. So, it is concluded that withdrawing help with bathing is impossible, and that this client should be allocated long-term care. Another kind of case that is brought to the discussion concerns a client with serious abuse problems that is also admitted to reablement. Here training is obviously useless, and other possibilities for help and support are discussed, involving other institutions than homecare. There are very many "cases" on the agenda. This is a normal situation, and the assessor, known as reablement advisor, who is leading this meeting, concludes with the following remark: "Well, again we did not even get through half of the cases on the agenda".
>
> (Field notes, Denmark)

Hence, complex and often difficult decisions of negotiating the trainability of ageing social bodies within the administratively constituted temporalities are an important activity. The question of the kind of support to offer to non-trainable clients is particularly difficult. Can they avoid providing services to clients? Is there a bodily potential, and should these clients be offered yet another training programme? Or should they be offered permanent help? The last option is costly, and involves giving up the client's positive ambitions. Thus, such cases give rise to serious reflections, where all other options are considered before jumping to conclusions.

In summary, while the ideals of rational, goal-oriented training programmes permeate the logic of training, this kind of governance through linear, short-term efforts is difficult to accomplish in practice. As we have illustrated, one of the implications is that the broader goals and needs of the client are typically transformed into trainable goals. Based on Mol's (2008) conception,

clients may try to attune their bodies to these care practices, but with difficulty, while professionals are obliged to integrate the bodily practices that clients will participate in, and relate to the expectations of clients. But the predictability and manageability of care aimed for in the administrative ways of organising the training activities in short-term programmes, certainly have shortcomings when addressing frail elderly people.

ATTEMPTING TO CONTROL THE BODIES OF OLD AND FRAIL CLIENTS

As illustrated above, training elderly bodies is difficult and creates encounters with the complexity of ageing, living for a long time with a fatal illness, frail bodies and vulnerable social lives. Introducing reablement and training for this group of clients has become part of ensuring independent living in one's own home, self-reliance and self-care. The therapeutic professions define reablement as a complementary intervention to other forms of elderly care, even to palliative care, in order to prolong active life and to help relieve the pains of chronic or fatal illness (Timm et al., 2018).

This section investigates how the logic of training is practised in an acute social situation in relation to frail bodies of aged and fatally ill people. In all four cases, it was considered an important economic, political and social aim to prevent or postpone renewed admission to hospital of frail elderly clients. In one of the cases, an innovative way of restructuring care practices to make them more reabling was introduced. A reabling team of therapeutic professionals would intensify training of the fatally ill and visit clients in their homes immediately after discharge from hospital. Previously, this would have been a practice for nurses with experience of geriatric and/or palliative care for this category of frail clients.

The task of the reablement team is to welcome an 82-year-old man, discharged after seven months in in-patient care. Following a fall at home, the client was first hospitalised and then stayed in a nursing home, where something went wrong. He was subsequently re-admitted to the hospital and later to a reabling facility, before finally being sent home. The elderly man suffers from an incurable cancer and has already been given a stoma, has broken his hip and leg and has several other diseases.

The therapists, a physiotherapist and an occupational therapist, arriving just 10 min after the elderly man returns from the hospital, have 90 min to receive him and start up a reabling programme. They have prepared a therapeutic plan containing the following: initiation of everyday reablement which the client can monitor himself, a training programme with the physiotherapist in his home as a help for start-up, reorganisation of the home by the occupational therapist, brief visits from a nurse mornings and evenings to change the stoma bag, and morning visits every day for a wash. This morning, they tell me, the occupational therapist will examine the home for changes to be made, and the physiotherapist will make a functional test of the client in order to set goals and immediately start training.

Hence, much attention is paid to avoiding new falls in the home and the imagined potentialities of immediate training of this client. However, a social encounter and dialogue with the client and his wife about their current wishes and goals are not planned for.

> The occupational therapist walks around in the rooms of the first floor and examines the situation. Then the therapist sits down opposite the elderly man, who is sitting in a wheelchair and looking out of the window at his garden and yacht, which is placed

there. The therapist presents him with the reablement plans, not as something to discuss, but as already planned. "We're talking about preventing falling now, but you don't quite agree with me, your wife tells me that you don't want us to start up preventing falls in your home. So, I have ordered a toileting chair". He answers: "No, I don't want to have handles installed in all the doors of my home, and I don't want a toileting chair in the bathroom". The therapist listens without arguing further, but still calls the technician on her mobile phone to come and install these assistive technologies.

(Field notes, Denmark)

Here the lack of collaboration with the client and his wife seems to be due to the acuteness of the situation. But also the administrative logic, the demands for therapeutic intervention from the care organisation, play an important role. Reablement and training should give results even before they are initiated. In this case, the therapists seem almost personally responsible for the effects of care, and their actions are reminiscent of a rescue team, with a plan that must be forcefully implemented.

Hence, training is a practice involving categorising and disciplinary elements.

The physiotherapist comments: '*You had training before at the reabling facility, but you weren't good at doing what you had learnt - is there anything we can do differently now?*' The man replies: '*The training activities were no good there, and I didn't want to participate*'. The therapist reminds him of his previous fall in the home, but the client goes on:

"*Luckily, I didn't have to do them in the hospital*" and the therapist comments: "*It was your own lack of body control that put you in this situation, and this was the reason you had a fall, and this was what they wanted to train you to prevent, so that you won't have to stay in hospital for seven months again*". The client replies: "*This won't happen again*" as if the whole trajectory had been his "fault".

Hence, the therapist holds the man responsible for his unhappy and difficult situation, categorising him as a client performing badly in this kind of disciplinary practice.

An interesting dimension of the dialogue is that the client refers to training and reablement as a very abstract and incomprehensible practice. Where the therapists want to activate his body and work with it as an abstraction of potential abilities, the man has experiences of his own specific body. He expresses what he subjectively needs from his body, that is, that he may trust it and that he wishes to be at peace with his body. Thus, he does not correct the body that he also is, or disturb a body that has already been disturbed by the many actions of bodily intervention and handling by others, which is what he has experienced during his long trajectory in hospital:

When the physiotherapist is about to start the training as planned, she takes the elderly man into his bedroom and takes a rollator with her. He is then tested for his ability to sit on the bed, lie down and get up. Following this the physiotherapist starts to train him to get up from the bed with support from the rollator. She asks him to grip, let go, and get up and sit down several times and comments on how he uses his hands and knees. The man does the best he can, but mechanically, and he starts to trail off, talking about what happened during his seven months in hospital. The physiotherapist motivates and appeals to him, but suddenly he sits down and refuses to continue, and tells the therapist with great conviction: "This is how it is! I just cannot walk without support any more!" and then argues for not continuing this kind of training. The physiotherapist becomes silent and walks out of the bedroom leaving him there and enters the sitting room where she exclaims to the occupational therapist: "I can't do any more training today, this is just not possible!"

The elderly man represents a cohesive social and bodily experience of himself and his situation. For him, it is not meaningful to measure the bending of his knees and the strength in his grip because his own social experience of himself as embodied, and with his body, is that he cannot walk anymore! Social life demands a specific degree of trust in the body as a prerequisite for living and enjoying life and includes the body as a 'knowing carrier' of sociality, wellbeing, trouble and pain.

To summarise, this analysis underscores the difficulties of bringing the logic of training into the practice of managing frail ageing bodies. Not just the body but the clients' whole social life and experience of their own bodies appear to oppose to this logic. Moreover, the administrative logic seems to accelerate the process and contribute to hampering the inclusion of the clients' knowledge experience and preferences. Thus, training may as in this case become a disciplinary practice.

CONCLUDING DISCUSSION

This article aims to explore how the introduction of a new logic may lead to change in Danish and Norwegian elderly care, in ways that may potentially change care and care relations. By using the concept of logic, we underline how these changes encompass both ways of understanding care needs, organising interaction, of understanding bodies, people and their daily lives and of dealing with knowledge and practises (Mol, 2008). This logic of training is introduced and shaped by a specific professional group, the physio- and occupational therapists. They offer approaches that resonate well with current policy visions of reablement and bear promises of making elderly care more predictable and manageable. Hence, their ideals, knowledge base, techniques and practises that centre on improving the performance of elderly bodies using short-term, goal-oriented, standardized training programmes have become prominent in elderly care.

Our analysis of therapists' knowledge base and their core practices, namely the assessment of bodily potential, goal setting and training, show how this form of care is practiced in ways that may create new contradictions and tensions in care work and care relations. Moreover, it illuminate the shortcomings, the biomechanical conception of the body that form the basis of training and its ability to grasp the lived individual and unpredictable bodies.

We illuminate how this professional group of therapists is deeply engaged in detecting and developing the potentialities of elderly clients' bodies in a way that involves and engages them. This involves new modes of framing care needs and solutions, making individual assessment of the trainability of the body a centrepiece of their professionalism. However, the analysis also reveals how standardised training schemes dominate their work practices, particularly privileging the clients' mobility and ability to perform everyday tasks that otherwise would be performed by homecare services. Hence, the administrative logic of elderly care, where care needs are defined according to political and administrative standards, also affects the logic of training and accordingly implies a narrowing of the scope of training.

This is also a dominant feature of the goal setting process. Goal setting is a core activity in establishing a training programme and measuring progress. However, goal setting—at odds with the positivistic, bio-mechanical ideals involved—is a complex, socially shaped process, as also Franklin et al. (2019b) have recently illuminated. We show how goal setting, using standardized schemes and techniques, implies a new way of organising care relations that may position the client as an interviewee answering questions. Professionals might encourage clients to formulate their own goals in accordance with the ideals of client empowerment, but this may also imply exerting a form of governance. They may also reinterpret the goals expressed by the clients, or they may outright define the goals as those that are trainable and aim at making the client self-sufficient and independent of help from homecare. Hence, different forms of governance

may be in play. The clients' goals are often broader and involve social goals as well as goals of bodily performance. As pointed out by Olsen et al. (2020), studying reablement practices in Norway, goal setting is often closely coupled to goals of retrenchment. Hence, this intricate work of goal setting involves negotiating professional knowledge, care and power-relations and administrative logics. Our study hence contributes to the wider, critical literature on goal setting in clinical practise (e.g. Barnes & Cotterell, 2012; Franklin et al., 2019a; Murdoch et al., 2020; Protheroe et al., 2013) by illuminating the implications of technologies like occupational standards and political-administrative organisation that these practices are entangled in.

The new logic of training unfolded by the therapists will—as we illustrate—as an overall tendency move the focus to the abstracted image of the body with potentialities and as a measurable entity of many smaller parts that may be 'worked on' and thereby also attempt to control or modify the clients' experience of their bodies.

Training ageing and fragile bodies may prove difficult and create tensions in care relations. The narrow gaze on the bodily potential forms a certain zone of visibility but escapes the wider conception of bodies as socially shaped and reflecting the social life of the client. Attempts to control the bodies do not always succeed but may result in resistance expressed in conflicting conceptions of the bodily condition and its training potential, or simply the material body's failure to comply. Consequently, we see new professional practices of dealing with cases of 'no progress', the work of tinkering with trainability and eventually deciding when to stop training and provide traditional care and give up on the clients' moral claim to self-sufficiency.

This logic with its gaze on the potentials and trainability of the biomechanical body represents a rational goal-oriented model of reablement, and considering the complexity of care work, we may expect that contradictions and tensions will occur. Studying the practices of the therapists reveals how they negotiate these tensions in their meticulous work to establish a training plan and a trajectory that may make sense in a logic of training. Our analysis however, shows how this process is entangled in new forms of governance in contradictory ways. Hence, the greater predictability and manageability envisioned by applying this approach to elderly care may not be easy to accomplish.

This study add to the newer stream of studies of reablement that indicate the advent of a new normativity on good care, emphasising the development and training of people towards independence and self-reliance (Bødker et al., 2019; Hansen, 2015; Flensborg Jensen, 2017; Jensen & Muhr, 2020). Our study focuses on the new practices of care based on therapeutic professionalism directed at making bodies able through standardized, goal-oriented training programmes. This implies restructuring of care and care relations, new professional techniques and knowledge production. We propose the logic of training to term this development and show how this may result in ambiguous practices, where ambitions on empowering and disciplining the client and the elderly body may collide.

This is of great importance, as the logic of training is expanded across still more care practices. As other studies in this field (Flensborg Jensen, 2017; Hansen, 2016; Jensen & Muhr, 2020) have shown, this gaze on the body and its trainability is also the focal point when supervising other care workers. Hence, the ramification of this development for care, care work and care relations is an important subject for future care research.

AUTHOR CONTRIBUTIONS

Annette Kamp: Conceptualization (equal); Data curation (equal); Formal analysis (equal); Funding acquisition (equal); Investigation (equal); Methodology (equal); Project administration (equal); Resources (equal); Software (equal); Supervision (equal); Validation (equal); Visualization (equal); Writing – original draft (equal); Writing – review and editing (equal).

Betina Dybbroe: Conceptualization (equal); Data curation (equal); Formal analysis (equal); Funding acquisition (equal); Investigation (equal); Methodology (equal); Resources (equal); Software (equal); Supervision (equal); Validation (equal); Visualization (equal); Writing – original draft (equal); Writing – review and editing (equal).

ACKNOWLEDGEMENTS

The article is based on research funded by the Research Council of Norway, project number 273696 and is a part of the research project 'Creating Integrated Person-centered Care in Different Settings' (CONTEXT).

DATA AVAILABILITY STATEMENT

Research data are not shared.

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How to cite this article: Kamp, A., & Dybbroe, B. (2023). Training the ageing bodies: New knowledge paradigms and professional practices in elderly care. *Sociology of Health & Illness*, 1–17. https://doi.org/10.1111/1467-9566.13675