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‘I’m not ill, I’m just old’: negotiations of risk – an ethnographic study of the subjectification of older people in assisted body care practices in institutionalized homes

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Abstract

Assisting older people with body care is a vital aspect of long-term care, but is often considered mundane work and unarticulated in official discourses. Exploring body care practices can offer insights into unintended effects of prevailing discourses on the lives of older people. Drawing on poststructuralist understandings of subjectification in terms of dynamic processes depending on relational negotiations, this study explores how older people dependent on body care assistance negotiate the subject positions offered within the discourses. It draws on ethnographic fieldwork (December 2020–March 2021) including participant observations of 33 body care situations in home care and two residential care homes in Denmark. It analyses three cases, revealing how assisted body care in the context of home is profoundly influenced by dominant discourses of risk, positive ageing and homeliness, subjectifying older people as being *at-risk* or *not-at-risk*. *At-risk* are those not active or engaged in preventing biomedical risks related to old age, non-agentive and with limited possibilities in everyday life, while an acceptance of discourses of positive ageing and homeliness subjectify older people as *not-at-risk*, agentive and autonomous. A strong focus on positive ageing and homeliness in body care practices paradoxically holds the potential to de-legitimize ageing processes as well as subjective experiences of declining bodies and older people’s desire for a home that is not primarily a site of medical activity. The article highlights the need to critically discuss care practices that, despite being rooted in ideals of autonomy and the home as inviolable, often undermine these ideals in paradoxical ways.

Keywords: assisted body care; ethnography; older people; subjectification

Introduction

Day-to-day routine body care activities such as washing, dressing and toileting are part of everyday living, often performed alone and in the privacy of our homes, and not reflected upon when the body is functioning (Twigg 2000, 2003). However, dependency on the care of others often comes with old age due to illness or disability, which for some older people means that care workers enter their private home (Dyck et al. 2005; Twigg 2006). Receiving help with the care of one's body involves nakedness, touch and the management of human waste, transgressing normal social relations (Twigg 2006). Moreover, the boundaries between private and public are destabilized and renegotiated when the body is cared for in a home context, restructuring the dynamics of power relations and subjectivities (Dyck et al. 2005; Twigg 2006).

Assisting older people with body care in home care or residential care settings is a cornerstone of the Danish long-term care system (Danish Health Authority 2021; World Health Organization 2019), which is the context of this article. The long-term care system aims to improve the lives of older people, to make them maximally independent of help, and to manage and prevent risks associated with older age to avoid disease, decline and dependency on care (Danish Health Authority 2021; Danish Rehabilitation Forum 2022; Rostgaard 2015). By international standards, Denmark has established a generous model of care; however, like many European countries with increasing longevity, the Danish long-term care system suffers from a declining workforce, and recruitment and retention challenges (Nordregio 2021; Rostgaard 2023). Since the 1980s, de-institutionalization has been the main foundation for long-term care policies and practice by promoting a strategy of 'staying at home as long as possible' (Danish Committee for Older People 1980; Rostgaard 2023), as also seen in European policies (Anttonen and Karsio 2016; European Commission 2021). Consequently, assistance with body care is often provided to older people in their homes or in residential care. Residential facilities aim for a home-like atmosphere to provide a sense of autonomy, privacy and social inclusion despite care needs (European Commission 2021; Healthcare Denmark 2019). Like the United Kingdom, Australia and New Zealand, Denmark has introduced reablement as a dominant paradigm to make older people more autonomous and self-caring to maintain their independence, thus breaking with previous models of passive long-term care as well as supporting the de-institutionalization policy (Aspinal et al. 2016; Danish Rehabilitation Forum 2022; Rostgaard et al. 2022). Long-term care in Denmark is profoundly influenced by discourses of risk and positive ageing, positioning older people as being at risk due to old age but also with the capacity to manage and prevent risks by focusing on maintaining their health and enhancing their capabilities, thus producing active and healthy older people staying at home as long as possible or in a home-like context (Frederiksen et al. 2015; Rostgaard 2015).

The overarching aim of this article is to gain insight into the complex negotiations of risk, old age, subjectivities and home care practices, when the body is cared for and home becomes a site for long-term care (Dyck et al. 2005). This article suggests that exploring mundane day-to-day body care practices, which are often hidden work and unarticulated in official discourses (Twigg 2006), can offer important insights into how older people navigate and negotiate dominant discourses with implications for

their everyday lives and subjectivity, such as their thoughts, feelings and experiences, but also what can be done and what is expected of the care worker–care recipient relationship (Davies and Harré 1990; Willig 2008).

Discourses of old age and risk

Following Asquith and Pack et al. (Asquith 2009; Pack et al. 2019), the term ‘positive ageing’ captures a diverse set of prominent discourses including those of active, productive and successful ageing. These discourses were introduced into gerontology to link ageing to engagement with life (Rowe and Kahn 1997; Torres 1999) and to displace the former decline and loss paradigm (Holstein and Minkler 2003). Positive ageing aims to empower older people to be active and independent and to avoid the expected negative consequences of ageing (Alftberg and Lundin 2012), outlining idealized ways to age which involve being healthy, productive, socially engaged and self-reliant (Laliberte Rudman 2015; Pack et al. 2019). The positive ageing discourses are intertwined with neo-liberal rationality in a way that increasingly individualizes responsibility for the management of, for example, bodily risks of ageing (Laliberte Rudman 2006, 2015; Rose 1999), emphasizing a ‘will to health’, which requires maintaining self-care to manage the risk and delay the decline associated with older age (Higgs et al. 2009; Katz and Marshall 2003). Positive ageing discourses are closely connected to a discourse of risk, which labels certain individuals or groups as at high risk of developing a disease or illness (Lupton 1993). In a biomedical understanding, risk is closely linked to the concept of *frailty*, defined as poor overall health, vulnerability to various environmental stressors and high risk of increased morbidity and mortality (Fisher 2005). Biomedicalization constructs older age as a medical problem or pathology where medical interventions are normalized and older age is under the control and domain of medicine (Estes and Binney 1989; Kaufman et al. 2004).

A decline discourse links older age to negative embodiment with a loss of control of bodily functions, including incontinence and difficulty in maintaining personal hygiene, and a threatening disruption to identity and self (Öberg and Tornstam 1999; Sandberg 2013; Schwaiger 2006), as well as social disengagement (Cumming and Henry 1961). According to Gilleard and Higgs, older age is no longer a stable or coherent stage of life but is fragmented by the competing narratives of the third and fourth ages. The third age is characterized by, for example, agency, opportunity and self-realization, while the fourth age consists of frailty, loss, abjection and othering, forming a social imaginary of decline, decay, impurity, loss of agency and bodily control and the failure to achieve any restoration of that loss (Gilleard and Higgs 1998, 2010, 2011; Higgs and Gilleard 2014). Empirical research has demonstrated how older people take up and negotiate discourses of old age in their lives, but has primarily focused on positive ageing discourses in relation to how bodies are optimized through, for example, beauty work, clothing, dieting and exercise (Pack et al. 2019; Pilcher and Martin 2020), anti-ageing medicine (Cardona 2008), later-life sexuality (Katz and Marshall 2003; Sandberg 2013) or how the discourses affect narratives of retirement (Laliberte Rudman 2006). However, this literature does not focus specifically on older people dependent on assistance with long-term body care and how they adopt and negotiate the discourses of risk and old age.

Conceptualizing body care

Body care can be conceptualized from many perspectives. In health care and nursing, body care is generally regarded in terms of a discourse of hygiene and cleanliness to promote wellness and health and prevent disease (Henderson 1997), often focusing on preventing risk of infection or providing evidence-based care (Richards et al. 2018; Rosendal et al. 2022). Empirical research has focused on the negativities and ethical dilemmas of assistance with body care, including possible violations of dignity and autonomy and how the loss of bodily control and capacity can evoke feelings of vulnerability, fragility and threatened personal integrity (Håkanson and Öhlén 2013; Holmberg et al. 2019; Råholm 2012; Stevens et al. 2021). Recent research on home care focuses on how rehabilitative practices lead to more distanced and physically passive body work, focusing on training and bodily control (Hansen and Grosen 2022; Meldgaard Hansen 2016). Other research focuses on interactions between care workers and older people in body care assistance and how powerful discourses of care, home and age are embedded in these interactions (England and Dyck 2011; Kalman and Andersson 2014; Twigg 2006), in addition to discussing how body care is seen as exercising disciplinary power over older people controlled by a biopolitical care regime (Lee-Treweek 1994; Twigg 2000). However, this perspective could be contested, as the subject is primarily seen as a site of social order (Twigg 2006), unable to negotiate the discourses and thus without agency. Moreover, the above conceptualizations of body care do not provide insight into how discourses of risk and old age are embedded in body care practices in the home. This is an important area to explore, while not necessarily neglecting extant conceptualizations of body care. This article contributes insights into body care practices in the home and in a home-like residential setting and reveals how discourses of risk and old age affect such practices and the subjectification of the older people involved, with implications for their everyday lives.

Theoretical framework

Post-structural approaches informed the conceptualizations of how body care practices subjectify older people (Foucault 1977). Foucault argues that the subject is an effect of power, since power forms the subject and provides the very conditions for its existence (Foucault 1980a, 2003b). The subject is formed through a disciplining of the body through institutional regimes of discourse and power (Foucault 1995). Power in a Foucauldian perspective is not only disciplinary but also productive and operates at a covert level. Being diffused and mediated through social systems, power is constitutive of social relations and practices and embodied in everyday practices (Foucault 1980a; Twigg 2006). Power is implicated in discourse, legitimizing certain ways of seeing and being in the world, and offering subject positions with implications for subjectification and experience. Discourses are not only conceptualized as language use but bound up with institutionalized practices (Willig 2008). Butler argues that the subject is constituted through the power of a discursive exclusionary matrix of a binary heterosexual norm, producing an abjected outside, where the abject designates the unliveable and uninhabitable zones of social life, which do not qualify the body for life within the domain of cultural intelligibility (Butler 1993). Theoretical developments on subjectification by Davies and Harré (1990) highlight simultaneity in the processes of subjectification, using the concept of subject positions to grasp the dynamic and

interactional aspects of becoming a subject. Discursive practices establish different subject positions, and how one is positioned or positions oneself is dynamic and negotiable (Davies and Harré 1990). Based on this theoretical framework, assisted body care is analysed as a discursive practice embedded in a discursively articulated institutional setting. Focusing on body care will enhance understanding of how institutionalized everyday body care practices subjectify older care-dependent people.

Methodology

Study design and methods

This article draws on data from fieldwork, including observations and informal interviews with older people and care workers, collected from two home care units and two residential care homes in the Danish long-term care system. The fieldwork consisted of 22 days of observations between December 2020 and March 2021 of situations where care workers provided body care assistance. There were 33 care recipients (7 men and 26 women) and 18 care workers (17 women), mostly with health and social care qualifications, although 4 had no relevant formal education. No data on the older people's family history, medical history or diagnosis, or on the age or years of experience of the staff, were recorded. Most of the older people had physical and cognitive impairments, while about half of the residents of the care homes had dementia. All care recipients were 80 years old and above. This article forms part of a PhD exploring the institutionalized body care practices of older people in different health-care settings. The present article uses data only from long-term care.

The observations primarily took place during morning or evening shifts when the first author accompanied the care worker. The care workers often engaged with private and intimate body zones when assisting with, for example, showering or changing an incontinence pad. Initially, observations took place in the bathroom, but later also in the living room as the body care practices transgressed the boundaries of the private space of the bathroom and were an important dimension of daily interactions in the living room. Informal interviews with care workers or older people took place immediately after the observations or when there was time during the day. Fieldnotes were written during and after the observations (Emerson et al. 2020; Hammersley and Atkinson 2019). After each day of observations, fieldnotes were written up into a more detailed description of 12 to 16 pages.

The study was conducted during Covid-19. Visitor restrictions became flexible in December 2020, which made the research possible. Overall, Denmark had lower numbers of Covid-19 infections and mortality than most other countries. In December 2020, older people and care workers had their first vaccinations, as these groups were prioritized by the Danish health authorities (Rostgaard and Langins 2020). Fieldwork was allowed if the first author adhered to the Covid-19 guidelines for the specific settings.

Methodological reflections

Ethnography is the study of people's actions in everyday contexts, providing an insight into tacit, covert and taken-for-granted dimensions of culture (Hammersley and Atkinson 2019). Inspired by interactionist ethnography, this study focuses on

interactions and the institutionalized context, not on private experiences or feelings (Järvinen and Mik-Meyer 2005). The first author shifted between actively participating, for example washing clothes, and passively observing (Spradley 1980). Due to Covid-19, the care workers and the first author wore face masks and gloves, which might have influenced the interactions with the older people. Moreover, the first author tried to maintain a distance from the older people, thus often having the position of a passive observer. The care workers were concerned about preventing the older people's mental health from deteriorating due to the Covid-19 restrictions, and therefore mostly used the same routines for body care as before the pandemic. The first author is a registered nurse, primarily from the educational field, with limited experience from long-term care settings. Being a nurse made it more difficult to challenge and discover taken-for-granted knowledge and actions in the field, and she therefore had regular reflections with the third author, who is not a nurse. The care workers sometimes perceived the first author as an external care assessor, which constrained the observations. It was therefore important to build trustful relationships in the fieldwork. Since interpretations must be trustworthy and reliable, they were regularly discussed with a group of care workers and between the authors (Kristiansen and Krogstrup 2009). This article draws on 3 cases from the 33 older people observed in long-term care settings. One case represents an *unproblematic* body care practice whereas the other two illustrate body care practices containing various dilemmas and tensions and are thus *problematic* body care practices. Not all observed body care situations were problematic. However, focusing on cases where the care workers positioned the older people as problematic holds analytical potential as such cases illuminate what is considered the hegemonic and normal way to be old in an institutionalized setting (Holen and Lehn-Christiansen 2010).

Recruitment

The directors of the nursing homes and home care units provided formal approval for the fieldwork. Nurse managers facilitated access to the care workers. The older people were recruited by nurse managers and care workers. The staff were gatekeepers who enabled or constrained the fieldwork. Information posters and letters about the project were provided to the care workers, the older people and relatives.

Ethical and legal considerations

Informed consent was obtained from all participants, who received written and oral study information. The collection and the use of data for this project comply with Danish legislation and the European General Data Protection Regulation. The study was also evaluated by the local regional ethical committee. The study draws on a process consent approach (Balkin et al. 2023; Beattie et al. 2019; Dewing 2007) and was guided by the following key principles: *informed flexibility*, *sympathetic presence*, *negotiation*, *mutuality* and *transparency* (Dewing 2007). The consents and ethical considerations were not static and predetermined but were continually addressed. The researcher was attentive to signals of distress and anxiety and would then withdraw from the observations. Often, she needed to explain again that she was a researcher, as many older

people thought that she was a staff member. However, this was a balancing act as too much information could cause confusion. Dilemmas occurred when care workers as gatekeepers restricted access to the older people, as they considered that outsiders such as the researcher would distress them. These older people were therefore excluded from the research, while others were too distressed to consent to participate; in such cases, the first author refrained from attempts to obtain consent and did not observe intimate body care situations. Twice the researcher decided to observe a resident from a distance in the communal living room of the residential facility without having obtained informed consent, for example while she was there with other residents. The care workers and authors felt that these observations would not harm the resident, and the authors considered it important to obtain data on residents who were unable to talk or consent (Pols 2005).

Analysis

The analysis of subjectification processes of older people in and through assisted body care practices was inspired by an abductive approach (Alvesson and Sköldberg 2018) in which the analysis is developed by alternating between theory and data and interpreting them in the light of one another. The reading of the material focused on how discourses of risk, old age and home are negotiated when the body is being handled, managed, touched and cared for in assisted body care practices and on how the older people were positioned and positioned themselves within these discourses as part of everyday practices in their home. Emerging themes were reinterpreted, developed and nuanced through readings of the material and theoretical explorations. The article presents three cases to elucidate commonalities and diversity in the negotiations of discourse, subject positions and home. The three cases exemplify tendencies in the data of how different subject positions emerge, are negotiated and entail different possibilities and constraints for subjectification. Further, they illustrate how subjectification is a dynamic process that enables the person to become a subject or risk becoming an object. The cases are presented in the supplementary material, Tables 1–3.

Findings

The analysis revealed two dominant subject positions, being *'at-risk'* and *'not-at-risk'*. These positions are dynamic and established in discourses on risk, old age, and home and homeliness. The discourses enable different care practices and possibilities in the everyday lives of the older people, as shown in the four subthemes in the analysis.

Bodies and the home as medicalized work sites

Anna and Ruth are in their 90s. Neither can walk independently. They never leave their small flats and receive assisted body care and food two to four times a day. They both have electric medical beds. They have the same care worker, Eva. They also share a passion for cats. Despite their many similarities, they are being positioned very differently in body care practices: Anna as being *'at-risk'* and Ruth as *'not-at-risk'*.

When the first author visits Anna with Eva the first time, it is December. Anna's bedroom is dark, and Eva is worried about whether Anna's chandelier has been fixed,

because otherwise she will be unable to observe whether Anna has rashes in the genital area or any pressure sores from her compression stockings. Anna disagrees that the chandelier needs fixing, being very happy with her swing-arm desk lamps by her bed. Nor does she worry about her body. Anna is worried that the chandelier will shine at night if the care workers on night shift forget to switch it off, which has happened a few times:

Eva: Have you fixed the light?

Anna: It's not necessary.

Eva: We need to observe if there's any redness before you get rashes.

Anna: I'm not ill, I'm just old; I haven't got any pressure sores.

Anna also wants Eva to draw the curtains since the light outside is too strong.

Eva: I must have some light.

Anna: I don't want the chandelier, I can't switch it on and off by myself, as I can with the swing-arm desk lamps. You want to change everything.

Eva: That's the work we do.

Later Eva finds out how to switch on the chandelier. (Fieldnote, December 2020)

Previously Ruth has also been in the at-risk category, but now she uses a digital training rehabilitation program, which Eva says has positively affected her life. Whereas Anna is positioned as at-risk, Ruth is now being positioned within a discourse of positive ageing, involving concepts such as activity, agency and a will to work on the risks.

When I first met Ruth, she was terminal, sleeping all day[;] now she's just old, I've worked a lot with her and now she has so much quality in her life, she isn't terminal anymore. (Care worker, Eva, fieldnote December 2020)

Being seen as not-at-risk positions Ruth as an agentic subject with a legitimate way of being old. In Ruth's home, as in Anna's, there is little light on dark winter mornings and insufficient electric lights to light up the room. In Ruth's living room there is a small plastic lamp that resembles a deer. Ruth laughs when Eva asks if she should turn on the deer, which gives a soft light in the dark.

The light and lamps can serve as an analytical entry point to understanding how Anna and Ruth are differently positioned in the care practice. Their homes and bodies are subjected to institutionalized practices in different ways. Anna's at-risk positioning makes her body a medical body with a need for expert biomedical knowledge on old age to manage the risks and prevent further decline. In Anna's case, lamps and light are discursively constituted as institutionalized materialities that Eva needs in order to position herself as a professional health-care worker preventing Anna from disease and further decline. It can be argued that a discourse of risk and biomedicalization of old age (Estes and Binney 1989; Sandberg 2013) dominates in Anna's case. However, as the earlier quotation shows, she does not willingly accept an at-risk position or how this position changes the need for light in her home and the way her body needs to be observed. By opposing the use of the chandelier and Eva's desire to 'change everything' in her home, Anna tries to oppose the subject position of being at-risk, ill and frail. Anna's ability to control the light positions her as a subject in control. Eva, however,

figures out how to switch on the chandelier and thus overrules Anna's attempt to position herself as in charge of her home. In Ruth's home, Eva never questions the light and seems to have no need to observe Ruth's body closely, although one could argue that Ruth is as much at risk as Anna in a biomedical understanding.

Anna's being positioned as an at-risk subject changes the meaning of her body and her home: they both become medicalized work sites. Her living room is reconstructed physically with a mobile lift, but its meaning also changes; it becomes a site where an at-risk body is managed. This demonstrates how Eva and Anna negotiate how the body and home must be perceived. Anna's body seems to be understood by Eva in the light of biomedical knowledge, although Anna rejects this biomedical understanding of her body. Furthermore, Eva does not recognize Anna's attempt to take control over the lighting in her home or accept Anna's reassurance that she is not ill. Anna is thus not positioned as agentic and her attempt to expand the boundaries of what it means to be old is not acknowledged by Eva. The analysis indicates that Anna's position within the discourse of risk is sedimented and permanent through the body care practice, as is Ruth's position as not-at-risk.

The will to counteract bodily decline and death

The discourse of positive ageing prevails in Ruth's body care. Assistance with body care is regarded as active training, which shapes the way Eva provides care to Ruth. When Eva talks about Ruth, it is with a certain pride in her voice, telling how Ruth is no longer terminal. In a medical perspective, people are categorized as terminal when death is inevitable within a few weeks or months (Capital Region of Denmark 2025). However, Ruth can move her body again and she needs less sleep than before. Eva believes that Ruth has regained quality of life. Ruth's recovery and her ability to engage in the training program provide a position of being not-at-risk. The digital training program used by Ruth is designed to encourage older people to exercise using a technical device like an iPad. Ruth has agreed to exercise at scheduled times, even though it sometimes exhausts her. In doing so, Ruth is subjectified as someone who accepts that she is at risk, but with the potential to mitigate the risk if she takes on the responsibility to do so actively. Eva states that it is not only the training program that has changed Ruth's life and moved her to a not-at-risk position but also the continuous focus on self-care in body care practices like combing her hair or changing her incontinence pad in bed. Eva explains that she always works in a rehabilitation-oriented way; this is the backbone of her care provision.

Eva uses the mobile lift to transfer Ruth to her bed from the wheeled toilet chair. Eva places Ruth on top of a clean incontinence pad.

'Now we're training. Lift up your hip and turn to the left,' Eva says to Ruth. 'Wow! Isn't she just doing great? She couldn't do this six months ago. When she's had a shower, I help her a bit, because then she's tired.' (Care worker, Eva, fieldnote December 2020)

By supporting Ruth in exercising, Eva seems to have pushed death farther away. Eva's care provides results and growth (Liveng 2007; Wærness 1982), and one could argue that there is no timely, biological end (death) if the body and mind are trainable. In that

way, daily tasks like changing an incontinence pad or taking a shower change meaning. They are transformed into training activities. In addition, the materialities and spaces of Ruth's home are reconstructed to facilitate this training. The focus on training and rehabilitation also changes the position of the care worker. Eva is no longer 'just' a care worker dealing with a body in decline; she is also a trainer, enhancing quality and duration of life.

However, this intertwining of care and training practices is challenged by Anna. This shows in many of the micro interactions that constitute body care. In this example Anna and Eva disagree on Anna's choice of trousers:

Eva: They're too small.

Anna: I'll use them until I die.

Eva: But they don't fit you anymore.

Anna: Yes, they do.

Eva: Try and pull up your trousers by yourself.

Anna: I can do it by myself.

Anna cannot pull up her trousers independently since she is hanging in the stand aid, unable to move her hands.

Eva pulls up the trousers and transfers Anna to the wheelchair.

Anna: I want to sit down now; I've had enough.

Anna pushes her wheelchair to the desk by the window and lights a candle.

(Fieldnote, December 2020)

Anna likes her trousers even if they are (perhaps) too small, and she argues for keeping them by referring to her approaching death. It seems that a discourse of decline and death is more relevant to Anna than the construction of bodily activity and progress. Anna's rejection of change can also be seen as a way to position herself as in control, as a sign of agency and vitality, despite her body being in decline.

The home as a site embodying tradition and representing the former self

We have argued that different discourses of risk and old age shape the way care recipient and care worker are positioned in body care practices. However, discourses of risk and old age need to be seen as intertwined with yet another powerful discourse, the discourse of home.

The discourse of home reinforces a position of not-at-risk, as the discourse of home positions the older people as subjects who engage in everyday activities related to the home as a place that holds a history and a future. The discourse of home is found in the cases of Anna and Ruth in different ways:

Eva helps Anna to change an incontinence pad. Anna stands in the stand aid, her lower body naked:

Eva: Are you ready for Christmas?

Anna: No, I can't walk, so how could I be ready?

Eva: The Christmas decorations outside are lovely.

Anna: Yes, but I'm not interested since my cat's missing.

Eva: Do you think there'll be snow soon?

Anna: I don't care, it's not important for me. (Fieldnote, December 2020)

The focus on Christmas and pets is also present when Eva assists Ruth with getting dressed in bed.

Ruth: Can you call later and order Christmas roast duck for Christmas Eve?

Eva promises to call later, and she tells Ruth: I'm so lucky; I'm the one who'll put you to bed on Christmas Eve.

Eva: Do you want to wear the rabbits (soft shoes)? They both laugh. (Fieldnote, December 2020)

Ruth tells Eva that she once had a cat that was killed by the traffic outside her house. She would like another cat, and Eva has tried to get her one, but it is difficult to find one of the right age.

It doesn't work to have a young cat peeing all the time and wanting to go out.

There is no one to empty and clean the litter box. (Care worker, Eva, fieldnote, December 2020)

In both cases, Christmas and pets are the subject of the conversation during body care. This conversation offers a way of positioning both Anna and Ruth as agentic subjects with past lives and present needs and longings in a situation where dependence and loss of agency are obvious. However, Anna opposes the invitation to take up the position of a subject who has things to do; she says she cannot walk and therefore she cannot be ready for Christmas. She thus resists the position that the discourse presents. For Anna, what matters to her is the fact that her cat is missing, and the limited possibility for her and the care worker to solve the problem.

Ruth, however, engages whole-heartedly in the conversation about Christmas and pets, and she accepts the institutional offer to order duck and the fact that her wish for a pet is difficult to realize within the institutional framework. Although Ruth cannot prepare for Christmas as she used to, she is positioned as a woman with agency, she engages in domestic activities in ways that enable care workers to perceive her as a subject they can relate to on a personal level and thus also look forward to seeing and caring for on Christmas Eve. In that sense, the way Ruth positions herself in the discourse of home establishes a connection between Ruth as an older care-dependent subject and the woman she used to be. The mutual conversations around Christmas as a homely event seem to enable and support a subject position as agentic and likeable. However, the wish to have a cat is downplayed in the dialogue with Anna but positively accepted in the dialogue with Ruth.

(Un)controllable bodies and the risk of objectification

Per (case 3) represents an at-risk position within the discourse of risk. He is a man in his 90s, living in a residential care home. Per has extensive care needs, needing assistance when eating and considerable body care as he is unable to control body waste. He is verbally unable to express what he wants. Per often walks up and down the long corridors with his walker.

In a residential setting, Per challenges the normativities of what it means to be old in ways that differ from those seen in the case of Anna. Whereas Anna negotiates her

position with Eva in the space of her private room, the positioning of Per is dependent on other actors as well as physical spaces.

I've seen a lot, but never anything like this. (Care worker, Lizzy, fieldnote March 2021)

Lizzy talks about Per's aggressive behaviour. He hits and scratches the care workers when they try to change his pad. Lizzy and the other care workers are concerned about Per's wellbeing. Lizzy has contacted Per's general practitioner and a geriatric psychiatrist to ask them to reconsider his medication. Further, a specialist nurse has been involved in providing a psychosocial intervention. Lizzy, the other care workers and the nurse agree that it is Per's diagnosis that causes his actions, which positions him in a (biomedical) discourse of risk and disease.

We've had different professionals to help, to make the best of it. Because we don't want care neglect. He got very aggressive and punched and kicked – and we were, er, – we've also had different professionals to help us ... I think personal care should be in the morning, like he'll be washed and get his pad changed, because it's soaking wet. But sometimes we just can't get it done, because it would be an abuse of power. And then we realized we could do it later in the day, when he was less aggressive, so we could approach him and change his pad. I had to get used to this because I don't feel like I've done my job when I go home without having done the body care. (Care worker, Lizzy, fieldnote, March 2021)

Per is positioned by the care workers as a subject in need of specialized care. Biomedical and gerontological knowledge has enabled the care workers to understand and accept Per's aggression and resistance to body care as acts of disease. This positions Per and his actions as understandable and professionally manoeuvrable; Per's body care is rescheduled, even if it disturbs the institutional choreography (Rosendal 2024) and the care workers' idea of the best timetable.

The discourse of homeliness is also involved in the case of Per, adding another layer of complexity to the way he is positioned.

One evening Per walks around the shared social space of the nursing home using his walker. The living room is the centre of the home and is decorated with Christmas lights, gnomes, decorations and a miniature crib with Mary, Joseph and the infant Jesus. This is where the residents eat, watch TV and socialize. Unlike private living rooms, which are often used for body care, the communal living room is supposed to be a 'clean' space with a cosy atmosphere. The living room often smells of food, since the kitchen is part of it, and the area is intended to give the residents a sense of home.

Per has urine and faeces in his incontinence pad and his trousers are soaked. He pushes the walker into the chair of another resident. Watching Per, Alex from the kitchen staff says to me, 'I can't stand it when he does that'. Three care workers put on gloves and guide Per back to his private room to clean him up. (Fieldnote, December 2020)

This incident suggests that the subject position provided by a biomedical discourse of disease and risk is not as stable as it might seem. When Per moves from the relative

privacy of his own room into the common areas, his position becomes fragile. Visible defecation and possible aggressive behaviour make Per unfit for a position within the space which is meant to enable residents to engage in social activities and relationships in a homely setting, positioning themselves as subjects who are relationally connected to others. However, Per and his leaking body threaten the norms of social life in the living room, and he is escorted back into the privacy but also the isolation of his room.

We argue that the positioning of Per as someone who cannot be present in the shared spaces of the nursing home demonstrates a subject position close to abjection. An abject is defined by Kristeva as 'what disturbs identity, system, and order. What does not respect boundaries, positions, rules: the in-between, the ambiguous, the composite' (Kristeva 1982: 4). From this perspective, it can be argued that Per is at risk of not being seen as a subject. His bodily behaviour threatens to destabilize the way body care and 'home' are performed in the care setting. When Per's body is out of control and unable to engage in the institutionalized regimes of body care, he is transformed into the 'constitutive outside', an impossible state of being. Although there are arguably hygienic reasons for putting on gloves before entering Per's room, this also forms a very symbolic divide between the clean and the unclean, rendering notions of a clean-unclean dichotomy where the unclean displays disorder (Douglas 2003).

Every day at noon, Ruth is placed on a toilet chair in her living room while Eva heats up her lunch in the kitchen. As in the case of Per, Ruth's bodily functions transgress the spatial divides between the clean and unclean spaces of the home. However, in Ruth's case the position of a subject who can be contained is not endangered in the same way:

Ruth gets on the toilet chair at noon, when she needs to defecate, Eva explains. Eva leaves Ruth in the living room on the toilet chair and goes to the kitchen and heats up the prepacked meal of meat balls and cabbage stew. It starts to smell of cabbage. After eight minutes, Eva returns to Ruth. 'Has anything come out yet?' Now it also smells of cabbage and faeces in the living room. Ruth says yes. 'Have you done a lot?' 'A little bit,' Ruth answers. 'A little bit is ok,' Eva says. She transfers Ruth to the bed with the lift and places her on the clean incontinence pad that she has already laid out. Eva arranges the pad and Ruth's trousers and puts on the duvet and a towel, so Ruth can eat in bed without making the duvet dirty. Eva places the TV in front of Ruth. Now it's time for 'farty cabbage'. Ruth starts to eat while she watches TV. (Fieldnote, December 2020)

Whereas Per is at risk of being positioned as an abject who cannot be included in institutional regimes and social life, this is not the case with Ruth. Ruth does not react with aggression; in fact, she also laughs when Eva jokes using words like 'farty cabbage' as a comment on the simultaneity of defecation and meal preparation. There is predictability in the way Ruth's body waste is planned and arranged. Body waste, space and social order in the home are thus reconfigured into a smooth, non-threatening event. This enables coexistence of body waste, cabbage and care. The situation does not destabilize Ruth's position as a not-at-risk subject. In the case of Per, however, it is difficult to maintain the boundaries around his private body, as it is exposed in places where it disrupts norms of interaction.

Discussion

The care of the body is a mundane practice often not reflected upon by those who are able to do it for themselves in privacy. However, this article reveals the complex day-to-day negotiations when older people are dependent on assistance with body care in a long-term care system. Assisted body care, we suggest, consists of powerful and somewhat paradoxical practices, influenced by dominant discourses of risk, positive ageing and homeliness, and offering different subject positions. This is demonstrated through the two overarching positions of not-at-risk and at-risk. These positions are profoundly unstable and interact in unpredictable ways that are undesirable for the older people, the care workers or the governing institutions, with important implications for older people's everyday lives and subjectivity.

Data obtained from participant observations illuminated how biomedical and gerontological knowledge is used to explain and guide the care workers' practice. These knowledge regimes constitute a body care practice in which the body becomes an object of medical observation. It is the prevention of medical ailments and the maintenance of bodily functions that sets the agenda, raising conflicts between the older people's wishes and longings in relation to their body, their home and how to live and ultimately die. The knowledge regimes transform the body, but also the space of the private home, into a medicalized space, even if the older people object. This indicates how biomedical and gerontological knowledge has gained a privileged status, in opposition to autonomy and the basic notion of the home as inviolable.

In line with Foucault, the analysis supports the idea that biomedicine and gerontology constitute an institutionalized version of truth (Foucault 1980b, 2003a), which legitimizes certain actions and behaviour, while de-legitimizing others. For instance, the older people dependent on body care were to some extent de-legitimized if they did not subject themselves and the space of their private home to the actions and requests from the care workers, who embodied the biomedical and gerontological regime of practice. This finding also aligns with Martinsen et al. (2022), who found that older people had to negotiate their own influence over their situation and found it difficult to set boundaries, where dependence seemed to relegate them to a subordinate position. However, in our study, the older people negotiate the discursive regimes in very different ways with implications for how they can think, what they can experience and what they can do in their everyday lives. A rejection of the position of 'active' and a refusal to engage in prevention of biomedical risks related to old age seem to sediment a position of being at-risk and thus non-agentic and problematic, since the question of agency tends to fall on the care workers in the biomedical knowledge regime.

Conversely, acceptance of the subject positions offered within the positive ageing discourse seem to position the older people as agentic and autonomous, despite the frailty of their bodies and their dependence on assistance with body care. This finding resonates with Pack et al. (2019), who found that the ability to engage in meaningful physical, mental and social activities is seen as an important aspect of agency, whereas older adults experiencing decline are positioned as passive subjects lacking agency. However, in our study the participants' agency or lack thereof cannot be seen only as a question of declining health or of the inherent free will of the older people. On the contrary, the agency or non-agency of older people is not something that they possess; it is

closely related to their acceptance of the risks and ability to actively attempt to mitigate them in a manner that is acknowledged within the discourses and by the care workers. Body care practices focusing on training and self-care are construed in a more positive light than care which is not rehabilitative. The latter could be termed compensatory care and exists in this study in combination with rehabilitative body care, since the participants all had extensive care needs and were dependent on assistance with body care, without any possibility to regain function or independence. This concurs with other studies showing how compensatory care coexists with reablement, but is placed below reablement in a normative hierarchy and considered 'bad care' that is only relevant if reablement is impossible (Bødker et al. 2019; Dahl et al. 2015). Reframing care as reablement seems to discursively silence bodily decline and continuous dependence, leading to resistance or conflicts in relation to how to conceptualize the body, the home and what it means to be old. Thus, reablement of body care seems to hold the potential to silence the more unpleasant and dirtier forms of body work as well as bodies that are decaying and dependent (Gilleard and Higgs 2010, 2011; Meldgaard Hansen 2016).

This article sheds light on body care practices in two institutional settings: a residential care home and home care. An important finding is that discourses of homeliness are inherent in assisted care of the body, interacting with discourses of positive ageing and risk in ways that add complexity to body care practices and the question of how they subjectify the older people dependent on these practices. The institutionalized focus on homeliness reflects a rationale relevant to efforts to de-institutionalize long-term care (Rostgaard 2023). However, as in the case of Per in this study, who transgresses the boundaries of what is considered normal behaviour in the residential care home, the pervasive ideal of homeliness involves a risk of exclusion connected to body care regimes and attempts to control the leakiness and profound uncontrollability of old bodies. This indicates the fragility of the homeliness construction and suggests a need for critical discussion of institutional practices and mechanisms that aim at including and supporting older people by emphasizing autonomy and independence, while in fact excluding and isolating some residents. Overall, this calls for discussions of the best place to care for certain groups of older people, such as those with dementia and long-term body care needs (Bartlett and Brannelly 2018; Björnsdóttir et al. 2015) and of whether counter-discourses should be emphasized, such as discourses of citizenship, which are concerned with social justice and fair treatment by societal institutions (Bartlett and Brannelly 2018). The discourse of homeliness in residential facilities seems to include some subjects in the realm of the home and exclude others, which can be seen as problematic as the facility is in fact home, as there are no real alternatives. Considering the prevailing political ideas of de-institutionalization and ageing in place (European Commission 2021; World Health Organization 2002), it is important to be continuously aware of how frail, older people dependent on long-term body care understand their bodies and homes and how and where they want to be cared for.

Concluding remarks

The restructuring of long-term care with policy trends of de-institutionalization and reablement means that assistance with body care is primarily delivered in a home-like context. This article's exploration of the everyday interactions of body care has revealed

the complex and often conflicting negotiations of care, bodies and home and homeliness and how these shape processes of subjectification. The article draws on 3 cases from 33 older people observed in different long-term care settings. The small sample size is a limitation of this qualitative study and generalizations based on a positivist view of science cannot be made. However, as described by Hammersley and Atkinson (2019), a few cases can facilitate in-depth investigation better than a large study sample. Thus, the rich and nuanced descriptions from the ethnographic data can illustrate how the discourses operate in daily body care practices. Moreover, due to the context of the Danish long-term care system, the transferability of the study outside this system, must be made with caution.

The study does not address the potentially important gender perspective, even though most participants were women. It could have been beneficial to explore how discourses of gender interact with discourses of homeliness and positive ageing.

This study concludes that both older people and care workers are governed towards care practices that focus on progress and possibilities, leading to dilemmas when the body cannot comply or the older person refuses to comply with certain discourses. Moreover, this study makes visible how a strong focus on positive ageing and homeliness paradoxically seems to have the potential to exclude processes of ageing as well as subjective experiences of bodies and homeliness. This article calls for further research to explore whether the exclusion of the decline and uncontrollability of the body from discourses of older age will be reinforced, thus limiting possibilities for subjectification of older people as legitimate participants in social life.

For policy makers, the present study can be seen as a call for critical reflection on the political framing of care practices, leading to a more balanced notion of ageing than as predominantly active and positive. Taking into account that ageing for some includes frailty and a decline in activity and that ageing is in fact a process of more or less unpredictable change could enable more nuanced accounts of what it means to be(come) old and dependent on assisted body care. This could potentially result in more genuinely dignified care practices and decrease the burden of subjectification for more older people, including those who do not or cannot align themselves with dominant discourses.

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