Performative Identity Regulation in Rehabilitative Home Care Work

An Analysis of How Experts' Embodied Mediation of the Managerial Ideology 'Activates' New Frontline Identities

Jensen, Maya Christiane Flensborg; Muhr, Sara Louise

Link to publication in CBS Research Portal

Performative Identity Regulation in Rehabilitative Home Care Work: An Analysis of How Experts' Embodied Mediation of the Managerial Ideology 'Activates' New Frontline Identities

Maya Christiane Flensborg Jensen and Sara Louise Muhr

Journal article (Accepted manuscript*)

Performative identity regulation in rehabilitative home care work: An analysis of how experts' embodied mediation of the managerial ideology "activates" new frontline identities

Abstract

This article explores how therapists when introduced as new so-called frontline 'experts' in home care work, become both discursive and embodied mediators for the managerial ideology of rehabilitation, and how their presence regulates the care aides' subjectivities at work. We show how the managerial discourse of rehabilitation mobilizes the care aides to transform their identity from traditional nurturing to rehabilitation, as a result of promoting the latter as more professional. While the traditional managers/nurses promote the identity transfer through more classic discursive regulation at a distance from 'the office', the therapists do so through what we label performative regulation. Performative regulation is exercised by the therapists performing the desired role at the frontline and thus embodies the ideal and transfers it by embodied practices, not directives. With this notion of performative regulation, the article emphasizes the material, physical, embodied and performative dimensions of professional identity regulation.

Introduction

Many public healthcare workers risk being marginalized as non-professional or semi-professional workers (Butler et al. 2012; Hearn 1982). Several studies show that in particular in female-dominated care occupations in which workers perform what traditionally has been considered housewife tasks such as washing, feeding, changing and in other ways servicing young, sick or older people, workers find it difficult to claim professional status and gain professional privileges such as high salary (Ashforth and Kreiner 1999; Butler et al. 2012; Cheney and Ashcraft 2007; Hughes 1958). In contrast to other more established occupations such as lawyers, a legitimate professional identity is not as easily available for such workers, because they are always measured and evaluated against (what is

perceived to be) more professional occupations (Ashcraft 2013; Butler et al. 2012; Hearn 1982). As a result, workers in female-dominated care occupations, care aides in particular, who perform personal and domestic care tasks in older people's own homes, have historically fought this marginalization and struggled to justify themselves to others as professionals (Dahl 2000; Jensen 2017; Ryberg and Kamp 2010).

To combat such stigma, a general tendency among marginalized (semi-) professionals is to attempt to professionalize the image of their work (Ashforth et al. 2007; Rankin 2001). However, this is not only an individual or occupational endeavour driven by trade unions. Rather, we have seen a growing number of organizational policies that try to minimize the stigma and professionalize the work of care workers, e.g. through so-called up-qualification initiatives. Such policies tend to closely link investment in workers' human resources with quality improvement and cost reductions. Thus seen from a management point of view they are win-win policies because the intension to up-qualify the workers (and associated quality improvement) is expected to increase not only workers' satisfaction but also their work effort (Alvesson and Willmott 2002; Muhr et al. 2012. Previous studies, however, indicate that such so-called win-win policies are not always as valuable for care workers as they may be presented by management. Thus, in particular, studies of 'up-qualification' initiatives and processes at the margin indicate that when marginalized (semi-) professionals become enrolled in processes of professionalization, e.g. start to gain more formal and broadly acknowledged qualifications and adopt new promoted professional identities, other exclusion and resistance processes may arise which keep them in their marginalized positions (Cheney and Ashcraft 2007; Davies 1996; Hearn, 1982; Jensen 2018; Rasmussen 2004; Tracy and Scott 2006).

Most studies of the (by management perceived) win-win policies have, however, looked at how the policies are symbolically constituted and regulated by managerial discourses. To get a deeper understanding of the dynamics that surround such policies at the margin, this paper follows a small but growing body of studies (Cabantous et al. 2016; Cheney and Ashcraft 2007; Sullivan 2012). These studies argue, inspired by for example Butler (1993, 1997) and Callon (2008), that the conditions through which the (professional) "you" becomes part of worker's identity or is performatively constituted at work is not only a matter of (managers') spoken words or bound to the sphere of language. The performativity of language is also "activated" and conditioned by the "material" spaces – i.e. in interactions, physical appearance, bodies, artefacts, task division and occupational hierarchy at work (Cabantous et al. 2016). Thus, to improve our understanding of how subjects are performatively constituted in professionalization processes at the margin, we cannot only attend to

the discursive interventions associated with win-win policies but also how such processes are underpinned by reorganizations of the more material spaces at work.

We propose that the introduction of rehabilitation in Danish home care organizations makes an interesting case for delving into the discursive but also the more material and embodied aspects of the ambiguous processes that characterize professionalization at the margin. In Denmark, as well as many other Western countries, rehabilitation has been introduced to lower the cost and increase the quality of care in home care organizations. To obtain this dual aim, a core idea is, at least rhetorically, to 'up-qualify' home care aides to move their attention from nurturing older people (e.g. by helping them with bathing) towards seeing older people's potentials to become more self-reliant (e.g. by training older people to maintain or regain their capability to bath themselves) (Kjellberg et al. 2011). This is an 'up-qualification' process, which not only entails e.g. training seminars but also is underpinned by a more material reorganization of the workspace. A particularly interesting reorganization for the purpose of this paper is the introduction of the so-called "rehabilitation expert", a new function that has been inserted between the managers (typically nurses) and frontline workers (typically care aides). The purpose of this new function is to ensure that (care aides') attention is moved to and organized around rehabilitation programs (Kjellberg et al. 2011). A specific occupational group (new in the domain of home care provision) is hired in to perform this expert role, namely occupational therapists. Drawing on an in-depth ethnographic study of five rehabilitative home care organizations, this article explores how the new so-called experts become both discursive and embodied mediators for the managerial ideology of rehabilitation, and how their presence regulates the care aides' subjectivities at work.

The analysis focuses on how rehabilitation is communicated as an opportunity for the care aides to construct a new and more professional rehabilitation identity, and the central role the therapists play in enforcing the adoption of the new professional identity in practice at the frontline, where they work together with the care aides. We show how therapists, through their embodiment of the new preferred professional identity, seem to have more influence on the care aides' performance than the traditional nurse-managers do. We label this effort performative regulation, as the care aides are regulated not only by the repetition of an ideal discourse but by performing the ideal together with the ambassadors (the therapists) of the discourse. In addition we discuss the new power dynamics that arise with this mode of regulation, in particular how the therapists – because they do the work with the care aides – are seen as anti-managerial, although they are still promoting the managerial discourse, which helps to legitimate identification with the managerial discourse and moderates resistance.

Marginal professions and the urge to professionalize

The notions of 'professionals at the margin' and 'marginal professions' have recently attracted attention as particularly relevant to understanding identification and professionalization processes in certain stigmatized organizational settings (Butler et al. 2012). Marginal professions are defined as occupational groups who perform – or are associated with – work that due to social, political, cultural, economic, geographical and epistemological influences tends to have a degrading reputation in society. Professionals are said to be marginalized or risk marginalization and stigmatization if their work is associated with physically, morally or socially tainted tasks that others, given the option, "would prefer not to do" (Chiappetta-Swanson 2005, 93) or in other ways receive low social recognition by doing (Ashforth et al. 2007). The studies thereby suggest that 'professional' (and non-professional) subjects are embedded in a political subtext where the 'professional' is defined by not only 'official' occupational affiliation and 'certification' (e.g. as lawyer, nurse, care aide) but also the associated stigma of their tasks and culturally embodied signifiers of identity/difference, such as gender, race and class (Ashcraft 2013; Butler et al. 2012; Davies and Thomas 2002; Sullivan 2012). In this way, marginalized professional groups typically find themselves sidelined, fighting for legitimizing their work and their group identity as professional while other professional groups have achieved high levels of social recognition (Ashcraft 2013; Ashcraft et al. 2012; Butler et al. 2012; Hearn 1982). Classic examples of marginalized professionals are correctional officers (Lemmergaard and Muhr 2012; Tracy 2004), nurses (Jervis 2001), welfare aides (Ashforth et al. 2007), butchers (Meara 1974) and massage therapists (Sullivan 2012).

According to Ashcraft et al. (2012), there are two major explanations for why some professions become or remain marginalized. The first (and predominant) view shows that some professions have historically been constituted through a process whereby certain groups have been excluded from attaining professional status (Ahuja 2002; Dick and Nadin 2006; Hearn 1982). The second approach, however, shows that when these marginalized groups do get involved in processes intended to 'up-qualify' their professional status, alternative forms of exclusion arise, such as culturally produced stigma, which keep the work stigmatized as less professional (e.g. Davies 1996; Tracy and Scott 2006). . For example, a steam of feminist work (e.g. butler et al. 2012; Ashcraft 2013; Ashcraft et al. 2012; Hearn 1982; Sullivan 2012 has shown how certain occupations, particularly within (low-paid) care work, remain excluded at the margin. As such, it is argued that workers in female dominated

care jobs, such as home care work, which this article focuses on, often find it difficult to justify their professional identities, despite e.g. initiatives to increase their level training, because their task remain associated with household duties and 'women's work' that were once unpaid work performed in a domestic 'private' environment (the home) by women, not in a historically accepted professional setting

Despite the risk to remain a marginalized status, many employees in such marginal professions are attempting various acts of professionalization of their occupations. Professionals, especially the higher-status occupational groups, at the margin use individual or group strategies to distance themselves rhetorically and materially from the marginalized aspects of their work to legitimize their professional status (Ashforth et al. 2007; Jensen 2017; Twigg et al. 2011). For example, in her study of a nursing home, Jervis (2001) found that nurses actively refused to do certain tasks, such as taking older people to the toilet (instead they found a lower-status care aide to do it), and that they used this avoidance strategy as a "statement about their status in the nursing home and the nursing profession" (Jervis 2001, 89).

Discursive managerial identity regulation and identity struggles

This urge to professionalize, however, is far from an individual endeavour. On the contrary, organizations also have an interest in minimizing the stigma and re-professionalizing the work in order to provide employees with an identity boost, which is expected to increase work satisfaction and thus work effort (Muhr et al. 2012; Muhr and Kirkegaard 2013). For this purpose, organizational and political policies are increasingly being crafted in ways that offer employees in marginal professions promises of the professionalization and qualification of their work (Dahl 2009; Rasmussen 2004; Thomas and Davies 2005). For instance, Rasmussen (2004) and Dahl (2009) have shown how the so-called modernization of Scandinavian home care organizations is associated with new organizational policies that are framed and branded as an opportunity for professionalization – offering more 'interesting' and 'professional' tasks and roles to the workers, just like the rehabilitation policy we look at in this article. Organizational policies, and affiliated discourses, are therefore closely tied to the formation of professional identities at work (e.g. Alvesson and Willmott 2002; Ashcraft 2005; Ashcraft et al. 2012). The central roles that identities and identity formation play in these organizational policies make them identity projects (du Gay, 2008). The policies and identities are intertwined because the policies typically aim at transforming and redefining workforce ideas and

feelings about basic identity concerns, such as 'who am I?' and 'what are we?' (Alvesson and Willmott 2002, 625). Concerns also relate to matters of professionalism and professional group identities, such as 'who am I as a (care) worker?', 'who are we as a professional group?' and 'how do we relate to other professional groups?'. Marginal professionals can thus often rely on a broader professionalization discourse from their organizations and occupations as sources to understand themselves as professionals. Alvesson and Willmott (2002, 627) define this type of discursive practice, which forms and transforms workers' subjectivities by prompting a managerial discourse, as "identity regulation", because they argue the transformation of identities becomes the locus and target of managerial control (e.g. Alvesson and Willmott 2002)

Studies (e.g. Davies and Thomas 2002; Hoyer 2016) emphasize, however, that although discursive managerial identity regulation is effective, it does not condition workers' identity formation in any deterministic or homogeneous way. Although there is a general desire to be perceived as professional, management typically has an interest in producing and boosting a *specific* professional identity when a new broader professionalization policy is introduced, which not always concurs with that of employees (e.g. Davies and Thomas 2002, Laine and Vaara 2007, Muhr and Kirkegaard 2013). These studies convincingly show that workers may exploit the multiple, potentially conflicting, 'available' discourses in organizations to resist managerial attempts to regulate and prompt professional identity transformation in the workplace (Fleming 2005; Fleming and Spicer 2003; Laine and Vaara 2007). Thus, it is argued that professionals are not "passive receptacles or carriers" (Alvesson and Willmott 2002, 628) of managerial discourse but rather critically interpret, challenge and resist it (through counter-discourses). The term 'identity struggle' is therefore invoked by scholars to better understand how attempts to navigate and regulate matters of professionalism are complex and involve both managerially produced discourse and employees' various struggles of incorporating or resisting the discourse (Alvesson 2010).

Towards performativity: Adding a material dimension

To unfold the embodied aspects of the way that individuals navigate and regulate identity, the concept of performativity is useful. Performativity theory help us to further elaborate on the complex layers of how the (professional) "you" becomes part of workers' identity or is performatively constituted.

Butler (1990: 25) famously argued that "identity is performatively constituted by the very 'expressions' that are said to be its results". This point illustrates the basic assumption of performativity: we are who we are because of both what we do, but also of how we 'do' or 'perform' ourselves. Performativity should therefore not be "understood … as a singular or deliberate 'act', but, rather, as the reiterative and citational practice by which discourse produces the effects that it names" (Butler, 1993: 2). That is, a subject is constituted in and through this very performativity: "subjected and subjectified within discourse" (Butler, 1993: 12).

This approach to how a subject is constituted ask us to turn our attention to what has been defined as the "spaces that 'activate' the performativity of language" (Wickert and Schaefer, 2015: 121). This entails a conceptualization of performativity that is equally discursive and material, thereby arguing that "performativity [understood as] the constitution of subjects (…) happens through the political engineering of sociomaterial agencements" (Cabantous et al., 2016: 197).

As developed by Butler (2004) the body is thereby deeply implicated as a site for the way identity is performatively constituted:

> As a consequence of being in the mode of becoming, and in always living with the constitutive possibility of becoming otherwise, the body is that which can occupy the norm in myriad ways, exceed the norm, rework the norm, and expose realities to which we thought we were confined as open to transformation. These corporeal realities are actively inhabited, and this "activity" is not fully constrained by the norm (Butler, 2004: 217).

Context and materiality is fundamental to Butler's (later) theory of performativity. She argues that language and materiality "are fully embedded in each other, chiasmic in their interdependency, but never fully collapsed into one another' (Butler, 1993: 69). Performativity is in this way both material and discursive and cannot be bound to the sphere of language only. Thus, as also argued by Cabantous et al. (2016), the way identity is activated is not only bound to the sharing of language and managerial words, but the power of the activation is also bound to specific contexts, repetitions and the material surroundings. Words, then, "require a 'felicitous' context if they are to be performative" (Cabantous et. al. 2016, 202).

By combining identity regulation and performativity theory, this paper explores how professional subjectivities are regulated and constituted through discursive and embodied acts. As our analysis will show, the new presence of therapists and their position at the frontline in rehabilitative home care

work ensured that discursive and embodied (more material) acts interacted in ways that did indeed "activate" the performativity of the rehabilitation discourse, an activation that led to identity struggles and behavioural changes among the care aides. And, as we will show, this activation was conditioned by the therapists' presence at the frontline where they became discursive and embodied mediators for the managerial ideology of rehabilitation. We develop the notion of performative identity regulation to explain how this interaction emerged.

Method

Case context: Danish home care organizations

Historically, home care organizations in Denmark have been a field characterized by ongoing transformation and struggles between different understandings of professionalism (Dahl, 2000). Retracing the historical roots of these transformations from the first Danish legislation on home care from the 1950s, labelled 'housemum replacement', to the 1995s, Dahl (2000) concludes that different so-called abstract figures or subjectivities about the home care aides have flourished and co-existed in the home care field. Depending on the historical time in question, Dahl (2000) shows, on the basis of a policy analysis, that articulations of the home care aides' identity over time has drawn on three abstract figures: "the housemum," "the professional" and/or "the specialist" worker. These abstract figures, depending on the historical areas, have infused the care aides' identity in different ways, sometimes in overlapping ways, e.g. as a worker who has signifiers of both "the professional" and "the housemum" (e.g. in the period 1943-1954); sometimes in excluding ways, e.g. only as "the housemom" (e.g. in the period 1954-68); and sometimes in differentiating ways as someone who is either "a housemum" or a "professional" (e.g. in the period 1968-1972), etc. Overall, Dahl's study (2000) shows that care aid workers have been through a historical process where they rhetorically and politically have been targets of ongoing both re- and de-professionalization processes, and that the home care aides' identity historically has been influenced by competing discourses, which to an increasing degree have "perverted" the housemom figure as something that is incompatible with the professional figure (see also Dahl, 2009).

Dahl (2000, 2009) also shows how these processes of re- and de-professionalization have been closely linked to broader changes in Danish policies on care work. To begin with, new narratives and ideas about older people's wellbeing and how workers *should* care for older people have been introduced

from the 1980-90s onwards. Thus several years before the introduction of rehabilitation in home care work concepts such as 'activation', 'help to self-help principles' and 'empowerment' (self-governance) have replaced or supplemented ideas about older people's decline and dependency, as well as the importance of nurturing them (see also Katz 2000, Hansen and Kamp, 2018). Simultaneously, ideas about how home care organizations and their workers should be managed – often to become more efficient – have become more dominant (Ryberg and Kamp 2010). Accordingly, since 1995, public Danish home care organizations have experienced a number of modernization reforms (under the umbrella of new public management), focusing on the standardization of a shared language, time-control programmes, benchmarking ideals, contract governance, outsourcing, free-choice arrangements (between public and private home care), audit programmes and principle–agent distinctions (Nielsen and Andersen 2006; Ryberg and Kamp 2010). In addition, the levels of education and certification of the workers have increased. For example, today, most workers are organized in unions, and only 8% of publicly employed welfare care aides are non-skilled in Denmark. And yet, despite these policy reforms and the increasing distance to the housemom figure as a signifier of the home care aides' identity we have seen in the 2000s how care aides have carried banners with slogans such as "disregarded workers" (Dahl, 2009). In addition the evidence suggest that 94.8% of the organized Danish care aides are women and that care aides, compared to other publicly employed workers in Denmark, receive the fourth-lowest salary (FOA, 2014). And thus, the reason why Danish care aides historically and on an ongoing basis seem to find themselves in a contested field where a legitimate professional identity is not per se available to them seems to go beyond the discourses they have been influenced by, at least until the introduction of rehabilitation.

Research design

The research was designed to investigate how the introduction of rehabilitation influenced home care work and workers: a type of work that as a starting point we knew suffered from marginalization and a bad work environment[1]. Our investigations showed that the introduction of rehabilitation in Danish home care organizations was closely affiliated with the remodelling of the occupational hierarchy.

---

[1] The study was conducted as part of the research project ReKoHver over an eight-month period in 2012, where the first author of the paper collected data in collaboration with four other scholars – Karen Albertsen, Inger-Marie Wiegman, Hans Jørgen Limborg and Flemming Pedersen.

This was because a new occupational group, physical and occupational therapists (hereafter 'therapists'), were hired to work with – and train – care aides in the new rehabilitation methods (Kjellberg et al. 2011). Therapists as an occupational group have long worked in elder care. In Denmark, however, they have typically done so in training centres. The greatest change was therefore that they were inserted directly into the occupational hierarchy. They did not replace any of the existing occupations in the hierarchies in home care, as the nurses sustained their traditional positions as managers, just as the care aides sustained their positions as subordinates who work at the frontline (i.e. in the older people's homes). The therapists were placed 'in the middle' as so-called 'experts' and 'drivers' of rehabilitation and were positioned somewhere between the managerial and frontline functions, as Figure 1 illustrates. In this position they are generally given authority and responsibility for designing and evaluating older people's rehabilitation programs, often with the care aides by their side. Due to this labelling and positioning, we refer to therapists as 'working experts' in this article.

Insert Figure 1 around here

To capture how the introduction of rehabilitation as a new managerial ideology and the therapists as new occupational group influenced home care work and the care aides' marginalized position, ethnographic data was collected in five Danish home care organizations that had recently implemented rehabilitation. It included a multi-method framework, consisting of archival material, focus groups and observations.

Data collection

Focus groups

Focus groups were chosen as a key data source to explore how the care workers with different occupational affiliations and positions (i.e. nurses, care aides and therapists, see Figure 1) reflected on, resisted and negotiated the new changes, professionalization opportunities and regulation of their work that rehabilitation implied (see also Dahl 2009; Liamputtong 2011). Due to the collective nature of focus groups, they are particularly apt to study organizational changes because respondents (often with a shared memory) 'assist' the researcher by asking each other interesting questions and by adding information and contradicting and disagreeing with each other's (re-)construction of stories

(Wilkinson 1998). Further, they are particularly suitable to use in marginalized workplaces for two reasons. First, focus groups are seen as particularly apt to give voice to marginalized groups, who might feel less intimidated among peers than in individual interactions with an unknown external researcher (Liamputtong 2011; Wilkinson 1998). Second, focus groups are recommended as an effective way to investigate how workers at the margin assign meaning to – and struggle over the meaning of – their work (Dahl 2009).

Two types of focus groups were conducted in each of the five home care organizations (10 in total). The first type of focus group, the 'frontline focus group', included workers who engaged in daily rehabilitation work at the frontline (i.e. care aides and therapists), whereas the second type, 'the management focus group' included workers who predominantly managed this work from the office (i.e. nurses). It was a long debate among the involved scholars in the project whether therapists should be included in the management or the frontline focus groups, due to their in-between position as 'experts'. We were worried that the care aids would feel intimidated and hold their tounge among therapists, who formally had a higher status than the care aids at the frontline. However, ultimately, we decided to include therapists in the frontline focus groups, due to the interest in how actors with different occupational affiliations at the frontline would assign meaning to and negotiate their shared work in the focus group.

Eight participants were invited to each of the 10 focus groups; however, due to cancellations, the number varied between four and eight participants. A total of 64 respondents participated in the focus groups (28 managers and 36 employees). Each focus group lasted two hours. To allow the home care workers to express themselves, our semi-structured interview guide addressed three broad sub-topics related to the introduction of rehabilitation: a) the experienced aim of rehabilitation; b) the expertise, tasks and cross-occupational collaboration rehabilitation gave rise to; and c) the challenges and benefits for the organization, workers and recipients of rehabilitation. All focus groups were recorded and transcribed.

Observations

Focus groups' ability to reveal the ways that managers and frontline workers assign meaning to and negotiate the changes and regulation of their work and the implications for them as professionals is both a strength and a weakness of this method. Focus groups give limited access to the material, complex and situated circumstances that characterize the 'actual' interactions and work at the

frontline (Twigg et al. 2011). As a result, the focus groups were supplemented with observations at the frontline, collected over approximately four full working days in each of the five home care organizations. More specifically, home care workers were observed at two different locations considered most central to the introduction of rehabilitation: a) the *homes of individual recipients*, where rehabilitation programs were planned, executed and evaluated, and b) at *occupational supervision meetings* at the office, where progress with the programs was discussed. The observation of the events in the homes and the office involved shadowing (Bruni et al. 2004) a therapist's or a care aide's workday (typically driving from house to house and back to the office). See Figure 2 for an overview of the observed events.

Insert Figure 2 around here.

Approximately 140 hours of shadowing were performed. The observations lasted between 30 minutes and two hours. During the observations, extensive field notes were compiled regarding the concrete sensory details of actions (Emerson 1995).

Data analysis

The analysis was conducted through a process inspired by grounded theory (Glaser and Strauss 1967), including a constant movement back and forth between theory readings and the multiple sources of empirical data – field notes, documents and transcriptions. To avoid developing static predefined themes and codes, the material was systematically coded in NVivo 10 through an open coding process.

The first initial coding amounted to around 40–50 codes, such as 'managers', 'maids', 'women', 'therapists', 'experts', 'professionalism', 'expertise', 'resource', 'decline', 'nurture', 'passive', 'self-reliance', 'training', 'distance', 'withdraw', 'tension', 'new' and 'traditional'. These empirical codes clearly showed that some could be grouped under aggregated empirical categories, such as 'the recipients and their (aging) bodies' ('resource' and 'passive'); 'the professional identities and their (embodied) characteristics' ('nurses', 'experts', 'managers', 'maids', 'women', 'expertise' and 'professionalism'); 'time bounds' ('new' and 'traditional'); and 'the professionals' practices and tasks' ('training', 'nurture' and 'self-reliance'). The identification of these categories, combined with

our experiences from the observations, helped us to identify that some tensions existed within each category (e.g. between 'maids' and 'professional' in the category 'the professional identities and their (embodied) characteristics'. This categorization happened in tandem with the exploration of various theories. As the data was re-viewed, re-theorized and re-coded on an ongoing basis, literature on regulation, and identity struggles and critical performativity emerged as particularly helpful.

Through this literature, it was possible to specify four broad topics that could help us to analytically address our initial interest in rehabilitation and the associated professionalization opportunities and changes. The first analytical topic, which we label 'the discursive identity regulation of the care aides', emerged at a basic level from the analytical categories: 'the professional identities and their (embodied) characteristics' and 'time bounds', as well as from literature on discursive identity regulation (e.g. Alvesson and Willmott 2002). The literature helped us to pay particular attention to how rehabilitation could be conceptualized as a managerial discourse that regulated the care aides' identities by differentiating between a 'professional' and 'non-professional' persona within the new area of rehabilitation. The second analytical topic, which we label 'care aides' role struggles and resistance', emerged from the same categories and more-narrow readings of the literature on identity struggles and resistance – particularly at the margin (e.g. Sullivan 2012; Thomas and Davies 2005). Thus, this literature helped us to pay particular attention to, and conceptualize, how the targets of the regulation (the care aides) responded to the regulation attempt.

The third analytical topic emerges from our field notes in particular, which showed the embodied aspects and spaces in which the managerial discourses were activated and contested in the homes. They implied something interesting about how the care aides' subjectivities and struggles became (re-)regulated on an ongoing basis in the homes by the presence of therapists that was difficult to conceptualize through the aforementioned literature. Drawing on critical performativity literature (e.g. Cabantous et al. 2016; Just et al., 2017) that could help us to conceptualize the more material aspects of our observations (and informed by the workers' own descriptions of the differences between the nurse-managers' and the therapists' roles in the focus groups), we became aware that two types of regulation were happening in rehabilitation home care work: the aforementioned discursive regulation and a more embodied type of regulation, which we labelled 'performative identity regulation', which eventually became the label of our third topic.

Analysis: Performative identity regulation in rehabilitative home care work

The findings are analysed in three sections to show how the new so-called experts – the therapists – became both discursive but also more embodied mediators for the managerial ideology of rehabilitation. In the first section, we show (1) how the managerial discourse of rehabilitation is aimed at regulating and transforming care aides' professional identities by drawing on a discourse of professionalization. We then show (2) how the managerial discourse triggers struggles among some care aides and recipients. Finally, the third section shows (3) how therapists, positioned as working experts in the organizations, emerge as crucial mediators through which the identity transfer is 'activated' and performatively constituted and discusses how the therapists, as a new source of regulation, become crucial in legitimating the managerial discourse and moderating the space for resistance.

From 'nurturing' to 'professional': The discursive identity regulation of the care aides

In the home care organizations the manager nurses and the new working rehabilitation experts – the therapists – use a particular vocabulary when they introduce the care aides to rehabilitation. This vocabulary is closely related to the broader managerial discourse of rehabilitation and the activation of a new 'professional' worker identity. This managerial discourse of rehabilitation is communicated through various channels and at different events in the organizations (training seminars, internal instruction documents for employees, materials given to recipients, etc.). Across these channels, rehabilitation is highlighted as a new and better way to provide higher-quality and more-efficient home care. 'New' and 'better' are in this way positioned as being in contrast to the former less-efficient focus on care and nurturing. Below, a therapist articulates how this differentiation between a 'former' and a 'new' way of providing home care is emphasized (by her) at training seminars where the home care workers are introduced to the managerial discourse of rehabilitation and the new approach to care it implies:

> *Anne (therapist): ...the emphasis [at the training seminar] has been put on how to focus on [older people's] resources, rather than nurturing [them]. [Our care aides] need to understand how the traditional care actually made the citizens dependent on*

home care and how they now [with rehabilitation] can make older people independent

from home care. Now the providers have to withdraw and focus on self-reliance.

The quote illustrates that the managerial discourse of rehabilitation portrays former traditional ways of providing home care as a nurturing approach to older people. This nurturing approach is affiliated with service activities, which makes older people dependent on help and care. This approach is further contrasted with – and differentiated from – the new rehabilitation approach. The rehabilitation approach is articulated as making older people independent from home care by focusing on their resources and on withdrawal from older people and training them in self-reliance. The quote clearly illustrates that this differentiation of nurturing and rehabilitation – as respectively a traditional and a new approach – directly aims at regulating and changing how the care providers accomplish their tasks and approach their work. The therapist Anne exemplifies how the providers – the care aides – are directly asked at, for example, training seminars to change their approach from the so-called nurturing to what is often referred to as a "trainer" or "coach" identity (see also Hansen and Kamp, 2018). In addition, they are taught that the latter is valued and rewarded as "new", while nurturing is seen as "traditional" and even as a harmful approach to older people's well-being by higher-status professionals, because it makes older people dependent on home care.

This attempt to regulate the home care aides to change their behaviour from a nurturing to a rehabilitation approach is underpinned by a professionalization discourse. The two quotes below show how the care workers are motivated to readjust to the new rehabilitation approach by positing it as a professionalization opportunity, and identity transfer, that will influence not only what the workers will gain from doing rehabilitation work but also who they are as workers:

Paul (nurse): [Rehabilitation has been implemented based on the belief that it] increases the life quality of older people – but also to optimize that which we are educated to do: that is, to re-establish older people's lost ability and to maintain this ability, rather than just doing the chores for them.

Helen (nurse): Rehabilitation is basically about getting their [care aides'] professionalism up front again and to get them to understand that we help them [older people] by training them, not by a passive approach of nurturing.

In the above quotes, Paul and Helen position rehabilitation as a professionalization opportunity by associating the readjustment to rehabilitation with the workers' transformation into professionals, where the workers (again) use their training, skills and qualifications and produce quality outcomes.

This argument is underpinned by the differentiation between what is and what is not perceived as professional in the discourse of rehabilitation. In the quotes, Paul and Helen argue that rehabilitation will optimize and bring back the workers' professionalism: an argument that implies that the workers so far – with nurturing – have not optimized or used their professionalism or, in short, have been non-professional. Thus, we see that Paul and Helen define that to enact a professional identity as a care worker is closely linked to doing rehabilitation and training activities with the care recipients. To strengthen the discourse, they construct an negative identity by defining a non-professional worker as someone who performs nurturing activities – "just doing the chores for them" – and who has a "passive approach" to older people. The discourse of rehabilitation in this way mobilizes the workers to readjust to the rehabilitation approach by portraying the trainer identity as a professionalization opportunity but also by articulating a marginalized negative identity – a non-professional nurturing identity that the workers can (and should) dis-identify from.

Home care aides' reactions: Identity struggles and resistance

The care aides' are well aware of the managerial discourse and the new identity hierarchy that this discourse enforces (i.e. between the now preferred professional trainer and the new negative identity: the nurturer). Yet, it is not always straightforward for them to activate the new expected identity transfer in practice. As a result, the care aides generally experience two types of struggle with positioning themselves within the new discourse of rehabilitation: external and internal. Interestingly, as we show below, these struggles are voiced in ways that seem to both affirm and resist the discourse of rehabilitation.

External struggle to avoid marginalization as non-professionals

One type of struggle that the care aides experience when they try to align to the new 'professional' identity with the discourse of rehabilitation concerns external barriers, such as resistant recipients. Several care aides explain that not all recipients want to become self-reliant (e.g. vacuum themselves), because they prefer to be nurtured or helped (e.g. with the vacuuming). As Clare explains in the quote below, resistant recipients means that the care aides struggle to maintain their identification with the rehabilitation role in their everyday work and to not give in to the now-marginalized nurturing role that some recipients still seem to request and prefer.

Clare (care aide): To give an example [of resistant recipients], I had this particularly difficult recipient, Hannah, where I in the beginning thought that I would never be able to leave her house. It was really difficult [to rehabilitate her]. Of course, she could do it herself. She was totally capable of taking breakfast from the fridge and carrying it to the table, but she wanted me to do it. She almost shouted from the bathroom "could you…", "I would like that and that…" and "it has to be in that and on that plate…". It was really difficult to rehabilitate her because it was really nice for her that I was there. So I had to have a heart to heart with her and explain that she did have an emergency button if she needed more help.

As this quote shows, Clare is of the opinion that some recipients, like Hannah, are obstructing her attempts to align with the professional rehabilitation role because they want Clare to do the things for them, although Clare find that Hannah "could do it herself". Thus, the recipients are often described as pushing the care aides into performing what, in the rehabilitation discourse, is marginalized as the traditional non-professional nurture identity. Clare explains that she has tried to avoid this attempt to be pushed back into the old nurturer identity – or what sometimes was labelled a "waiter identity" by several respondents – and overcome it by negotiating with the recipients: telling the recipients that they could get help somewhere else.

We see that this type of struggle to maintain a preferred professional identity is clearly located in an attempt to align with the discourse of rehabilitation because it replicates the identity hierarchy that the discourse produces. The discourse about the non-professional nurturer is even reinforced by Clare's way of associating it with being at the whim of, in this case, "difficult" Hannah's demands and shouting (and as such performing housewife/waiter activities). Yet, simultaneously, this attempt to position herself as one of the professionals, by trying to avoid the marginalized non-professional role, also emphasizes a difference from the discourse. Clare voices that this recipient does not associate life quality with independence from nurturing, as articulated in the discourse of rehabilitation; rather, Clare highlights the opposite: that this recipient seems to prefer to get help and as such associate the nurturing identity with life quality. Yet, this clash between the recipient's and the identity expectations activated in the managerial discourse causes struggles because it requires care aides such as Clare to, on an ongoing basis, negotiate with the recipient in order to uphold the professional ideal constructed in the rehabilitation discourse.

Internal struggles over pressure to 'become' professionals

Another type of struggle that the care aides experience when trying to align with the discourse of rehabilitation concerns internal barriers, such as their own personal difficulties with identifying with the new professional rehabilitation/trainer identity. As Christina explains, the care aides generally find it difficult to (dis-)identify with the nurturing role:

> *Christina (care aide): Many of us have the problem that we are nurturers by nature,*
> *so if we are present in the home, it is difficult not to wash that back [laughs].*

As illustrated here, some of the care aides, such as Christina, articulate themselves as having a "problem" because they continuously struggle to avoid identifying with the old – and from the management's side, unwanted – nurturing identity and the tasks that come with it (e.g. washing someone's back instead of insisting that the person needs to learn to do it themselves). Thus, some of the care aides acknowledge that they have difficulties performing rehabilitation because they have a tendency to identify with the nurturing identity (rather than dis-identify with it), and thereby this implies that they sometimes resist the discourse (and end up washing the back, for example). However, the quote also illustrates how this resistance simultaneously confirms the superiority of the discourse of rehabilitation, rather than opposes it. Instead of objecting to the discourse (and the new identity hierarchy), we see that Christina problematizes and blames herself for her continuous inability to dis-identify with the nurturing identity. By referring to it as a "problem" and relating it to a culturally embodied signifier of her (female body) – her nurturing nature – she reinforces the discourse of rehabilitation. More specifically, she uses the identity hierarchy that rehabilitation activates to devalorize her own approach as wrong (a problem). This generative reification of the discourse produces identity struggles and requires her to control and keep in check (distance herself from) her inclination to identify with the nurturing identity that she valued.

Performative identity regulation: Therapists as embodied mediators of the discourse

The tensions and struggles expressed by the care aides are widely known among the nurse managers. However, several nurses acknowledge the fact that it is difficult to (re-)regulate the work identity of the care aides at a distance (from the office) and on the basis of their nurse expertise:

Karen (nurse-manager): Fundamentally, nurses don't take a rehabilitation approach to their work. We have a lot of other competences, but regarding the rehabilitation mindset that, for example, occupational therapists have, we are miles away. So now we are asking the therapists to support care aides in learning this mindset so that they [care aides] can start working from a rehabilitation logic [in practice].

Lena (nurse-manager): The care aides in my division tell me that they need to get it [rehabilitation] both explained and shown and that they preferably want it shown in the homes of the citizens. So I spend a lot of time discussing with my therapists how we can disseminate this [the rehabilitation principles] in a pedagogical way that makes sense for the care aides. And care aides stress to me that their learning style is that: "we need to hear it, we need to see it and we need to do it". It is of course a learning style that is time-constraining, but it works.

As the quote illustrates, some nurses directly brand the therapists as experts on rehabilitation. And in addition, they highlight the therapists' central role in teaching the care aides to readjust to rehabilitation in practice, at the frontline where the therapists, in contrast to the nurses, work side by side with the care aides in the homes. As the nurse manager Lena specifies, she views it as crucial that the therapists could disseminate and make the rehabilitation ideal 'visual' to the care aides. This is something the therapists are capable of because they were authorized to design and evaluate the specific rehabilitation programs in the homes with the care aides. In this position they could perform and bodily communicate, i.e. show, voice and do, the new ideal side by side with the care aides and thus 'activate' the managerial ideology of rehabilitation in ways where the care aides could 'hear,' 'see' and 'do rehabilitation with them. In other words, the value of the therapists' presence at the frontline seems from a manager-nurse perspective to be that the therapist represents a 'living', 'situated' and 'human' guideline, i.e. role model of an otherwise abstract discourse, which the care aides find difficult to translate into practice or do not fully buy into. The extract from an observation note below is chosen to illustrate how the therapists indeed seems to emerge, as human guidelines, that activates and mediates the abstract rehabilitation discourse through their own performance, by exporting a specific expertise to the care aides and by motivating them to use rehabilitation as an approach despite potential resistance.

I meet Maria (the care aide) and Sophia (the therapist) outside the home of the home care recipient Leila. Leila has received home care provision from (among others) the care aide Maria for several years. However, she has recently been enrolled in a so-called rehabilitation programme. A few weeks before the visit the therapist Sophia designed a rehabilitation programme for Leila. On the day of this observation, the care aide Maria and the therapist Sophia are meeting to evaluate Leila's (and Maria's) progression on the programme. Before we enter the home Sophia explains to Maria that the aim is to reduce Maria's service in the home from two to one time per week, or maybe completely end it. As we enter the home and sit down around Leila's table in the living room, Leila starts to cry. Sophia asks how she is feeling. Leila replies "Not that well". After a while, Sophia gently asks how Leila would feel if they reduced the bathing from two to one time a week. "That is fine", Leila says, but adds "However, I cannot dry my toes myself". Sophia asks "Why not?" Leila explains that she had an operation and unfortunately did not recover well. Sophia asks "Can you stand on a towel?" Leila responds "No, the problem is that I am suffering from diabetes" [toes need to be completely dry]. Maria suggests "You could use a hairdryer?" Sophia responds "That is a really good suggestion, Maria"; Leila says "The problem is that I am dizzy". "When?" Sophia asks. "Most of the time", Leila replies. Sophia looks puzzled. "Last time you said it was only when you took a shower". "No", Leila explains, "I am trying acupuncture treatment now". Then Sophia changes the subject. She asks how often Leila takes walks outside. Leila explains that she cannot walk that long because her "legs start to shake". "That is a sign of a lack of training", Sophia explains. "I will encourage you to walk a little longer every day. What about visits from your family – how often do you get them?" "Only once a month", Leila says and starts crying again. "That must be tough", Sophia acknowledges. "Have you thought about getting a 'visiting friend'?" "Yes", Leila replies. "I am on the waiting list". Sophia says that she acknowledges that Leila is going through a "difficult time" and that she can always call the home care unit if she feels bad. In addition, she explains that she has decided to reduce Maria's visits from twice to once a week. Outside the house, Sophia and Maria have a short conversation. Sophia explains that she did not end Maria's visits in the home because she is afraid that "Leila's situation will worsen". However, she explains to Maria that she is new in her position and asks in a worried voice: "Was I too soft

[on Leila]?" Maria replies: "I think you did well, but it is hard to tell what parts of it are just good acting". "Yes", Sophia says. "It is hard to know whether she is playing us or whether she actually needs help".

As the extract illustrates, the recipients were often not excited about rehabilitation, which generated tension and uncertainty in the homes. Yet we see how the therapist as an embodied mediator of the new professional ideal was able to enforce and "activate" the discourse in the home of Leila in at least two interrelated ways: by showing what it implies when 'professional' experts perform rehabilitation in practice and how recipients' often ambiguous responses are expected to be handled professionally.

First, by embodying the new professional ideal in their dialogue with the recipients (which the care aides can observe), therapists such as Sophia show care aides what it implies when 'professional' experts in rehabilitation 'train' the recipients to become self-reliant in practice. For example, the therapist Sophia's aim-statement (reducing services in the homes from two to one time per week) and her dialogue with the recipient Leila implies that professional 'training' in this context is not so much about intensive physical training. Rather, it seems that 'training' as it becomes mediated into the homes of the recipients through the doing and saying of therapists such as Sophia is very closely affiliated with the act of cutting down on care by motivating the recipients to become independent of care provision and discussing the ways in which, for example, hairdryers, walks, families and volunteers could take over the work from the care aides.

Second, the extract shows how care aides learn the managerial discourse through the therapists' embodiment of the rehabilitation ideal and how recipients' often ambiguous responses are expected to be handled professionally. Like in the extract above, therapists commonly approaches recipients such as Leila, who are both compliant (e.g. Leila says it is fine to cut down on her bathing) but also raises concerns about whether they are capable of becoming self-reliant (e.g. Leila expresses concerns over whether, due to her diabetes and dizziness, she is capable of bathing herself). Yet, we see how Sophia is not focusing on the concerns, but rather on questioning them (e.g. how often Leila is dizzy) and on how to overcome them (e.g. that Leila can use a towel and her final decision to cut down the visits in Leila's home). In addition, we see how Sophia, as other therapists, rewards the care aide when they mirror this 'pro-active' way to handle recipients' concerns (e.g. Maria's suggestion about the hair-dryer as a solution).

It is now easier to understand why the nurse Leanne (quoted above) emphasizes the powerful role that therapists play as 'living', 'situated' and 'human' guidelines of an otherwise abstract professional

ideal in the homes. Positioned at the frontline as authorized experts, the therapists moved into what Austin (1962) calls the 'felicitous' context – in this case the homes – where some of their 'utterances' did not require repetition in order to become performative. For example, when therapists decided to cut down the care aides' visits in the homes, the care aides were no longer told to make recipients more self-reliant of care aides; they *had* to make them more self-reliant. Moreover, in their position at the frontline where therapists moved from home to home, and context to context, they repeatedly used the same bodily communication in front of the care aides – the same words, practices, artefacts (e.g. rehabilitation plan) and approaches to handle the recipients. This contextualized type of repeated bodily presence and communication seemed particularly powerful as a means to performatively constitute the new professional ideal and change the behaviour of the care aides, because the therapists as embodied mediators were able to enforce and show how rehabilitation should be performed in practice, and how nurturing behaviour could be avoided and replaced by other acts.

"Activating" new identities among care aids/mirroring bodily communication

As the extract from Leila's home illustrates, care aides such as Maria start to mirror the therapist's bodily communication. For instance, as the extract shows, Maria is not only coming with suggestions that mirror the therapist focus on making Leila more self-reliant of care (e.g. the hairdryer). We also see that Maria, in the discussion with Leila about weather, Leila actually is 'sincere' (when she addresses her vulnerability) or 'playing with emotions', emphasizing that Sophia has not been "too soft". Thereby, this clearly indicates that Maria knows that being too soft and feeling sorry for older people is not valorized or rewarded as 'professional'. Thus besides mirroring the therapists' performance, the care aides also sought to adopt and embody the way therapists interpreted the situations in the homes and their way of practising 'training', i.e. by cutting down on their own nurturing practices. There was a change of performance that the care aides related directly to the eye-opening experiences of working with the therapists, as Elisabeth and Julie explain below:

> *Elisabeth (care aide): Many of us experienced an eye-opener [working with the therapists]. We realized that we did a lot of different things that the older people could do themselves.*

> *Julie (care aide): I've also felt a bit ashamed because, frankly, you have nursed [the recipient] more than you should have; then you can stand there and get totally barrrhhh, it's actually not okay that I didn't stand with my hands behind my back if*

you are then told [by the therapists] afterwards, "She [the recipient] could have done
that herself". Oh yes, stupid me [gently knocks herself in the head]. Then I stand there
and get completely embarrassed. I want to help, but I realize that she [the recipient]
could have done that herself.

As the quotes show, the care aides clearly not just learned that the older people could do more than they expected, but that being too soft and doing nurturing practices was "stupid" and unwanted and something to feel ashamed about. In addition some care aides even, as the below quote shows, embodied the professional ideal deeper, and it ended up being something that the care aides now pass on to their trainees:

Elisabeth (care aide): I use rehabilitation every day. Today I had a trainee with me,
and I used it to teach her "Turn your back to him [the care recipient they visited] and
leave. Let him handle it himself". But I've also received great support from Leanne
[therapist].

Elisabeth explained that she used rehabilitation every day (i.e. also when therapists are not present) and was starting to teach her trainees how to do it and that this behavioural change was a product of the therapist Leanne's "great support" and teaching. We label this effort, where care aides became subjectified and change their behaviour not only through the repetition of a professional ideal, but in particular through performing this ideal together with therapist ambassadors of the ideal, as performative identity regulation.

Regulating by discursive and embodied practices, not directives

The new presence of therapists reshapes the space in which managerial discourses can be activated in home care organizations and as such the conditions under which the care aides' professional "you" can be (re-)regulated. On the one hand, the care aides' subjectivities are still influenced by the nurses' acts. As the nurse Lena exemplifies below, the nurses do indeed try to (re-)regulate care aides to align with the new rehabilitation ideal so that they do not "give in" to nurturing from the basis of the office:

Lena (nurse-manager): We start a citizen on a rehabilitation programme and agree
with the citizen what they have to do on their own. But then the care aides come along
with their "Aw, I feel bad for him/her" [said with a somewhat mocking laugh]. So we
[the managers] focus quite a lot now on communicating the fact that it is not loyal

towards your colleagues [the ones who perform the rehabilitation discourse]. (...) But I think we [the managers] are good at keeping an eye on it and dealing with it immediately if it happens.

The quote shows how Lena, in a response to experienced resistance, tries to re-regulate care aides' struggles and position them against a higher professional ethos by using 'negative' means such as blaming and mocking, as part of her identity regulation over care aides. Lena problematized the care aides who did not adopt to the new ideal as bad colleagues and persons who just want to "fix" things for the older people – as waiters (i.e. not professionals). This rhetoric is clearly evident in the way that the care aides Christina and Julie quoted above problematized their own internal identity struggles with adapting to the new ideal.

On the other hand, the care aides' subjectivities were also influenced by the therapists' acts in the homes. These were acts that generally were seen as more anti-managerial and 'positive', although they were indeed activating the same discourse as the nurses. The following excerpt from a conversation at a focus group shows that the care aides rarely interpreted the therapists' role as "controlling":

Leanne (therapist): OK, I'm looking at you [the care aides], as I am a little curious… When we [the therapists] have been out on the job with you, have you ever felt that we 'looked over your shoulders' – that we controlled you? Because I have a few times wondered if any of you perceived it that way. Because that's definitely not why we are there. We were with you to support your work. But I wonder how you felt?

Elsie (care aide): No, I don't think so [that it's controlling]. In any case, I haven't heard anyone saying that. It was, after all, not us who were in focus – it was the citizens you focused on, to see what they could actually do. So nobody has mentioned that [they felt controlled].

Beth (care aide): It has only been positive [that the therapists have been with them at work].

Joan (care aide): But you [talking to Leanne] do know that I thought so [that it was controlling]. That's why she [referring to Leanne] is asking [looking at the others]. I hate when someone is standing behind me [when I work].

We can here see how the therapists worked to be seen as 'supporters', rather than as 'sources of control'. The two care aides who bought into this argument are thus prime examples of effective performative regulation. As we can see, instead of understanding the therapists as yet more managers

who controlled *their* work, they perceive the control to be directed at the recipients. Only the care aide Joan viewed Leanne as a source of control. However, interestingly, she had already discussed this with Leanne, and thus Leanne most likely used the knowledge of Joan's dissatisfaction to test how general this idea about control was – and work with it in the room, as she also managed to do. Her core message subtly managed this idea, for example by allowing the 'positive' care aides to explain her role to the more sceptical care aides. Thus as the quote below illustrates most therapists were reflexive about putting themselves in a position where they could impact the care aides most effectively:

> *Emma (therapist): I have become more aware of how I can make things work... In the beginning, I took control of the situation very fast... However, we have been told [by the nurses] to try to make the care aides take more and more responsibility [when it comes to rehabilitation]. I believe it works when I ask "Do you mind drafting it [the rehabilitation plan] today?" I think it is really good because it is an exercise for them [the care aides] to try to do it themselves... it is good to get 'hands on' because when they have tried it a couple of times, they say "Ah, this is how you do it".*

This quote shows the therapist Emma discussing how her own performance "works" (i.e. impacts care aides). She explains a technique where she asks the care aides whether they would "mind" taking up a task and exporting her 'own' practices (i.e. the drafting of rehabilitation plan), rather than dictating to them how to do it, thereby making them feel ownership over the practice and exporting her own expertise, rather than appearing as a source of control.

All in all, the therapists were able to exercise a different kind of identity regulation over the care aides than were the nurses. Rather than needing to 'sell' the managerial discourse through a managerial position (at the office), or blaming the care aides for resisting this ideal, the therapists exercised regulation by performing the roles and tasks together with the care aides to regulate the care aides' perceptions of themselves as professionals and 'good' employees, which was seemingly a crucial supplement to the nurses' discursive regulation and much harder to resist.

Concluding discussion

Despite ongoing waves of professionalization processes and up-qualification attempts, care aides have historically fought marginalization and exclusion processes and struggled to justify themselves

to others as professionals. To better understand the material spaces and discursive processes that constitute professional identities at the margin and their implications for care aides, this article has explored how the new so-called experts – the occupational therapists – have become both discursive but also more embodied mediators for the managerial ideology of rehabilitation. By doing this, we contribute theoretically and empirically to the study and conceptualization of the complex and omnipotent nature of identity regulation (e.g. Alvesson and Willmott 2002; Kunda 1992; Kunda and Van Maanen 1999) and the struggles and resistance that emerge because of managerial attempts to professionalize professions at the margin (Ashcraft, 2007; Ashcraft et al., 2012; Butler et al., 2012; Dahl, 2000, Rasmussen, 2004) in three interrelated respects, which are visualized below in Figure 3.

Insert Figure 3

1) First, the article empirically shows how organizational policies such as rehabilitation are discursively regulated (Box A, Figure 3) in ways that are closely tied to the formation of professional identities at work because they offer employees in marginal professions promises of new professionalization and (re-)qualification, or in short closely tied to classic identity regulation (e.g. Ashcraft 2005; Ashcraft et al. 2012; Thomas and Davies 2005). Yet, it also extends these studies on classic identity regulation by showing that it is not only a new professional identity that is discursively crafted and activated by the discourse of rehabilitation. Rather, in rehabilitation home care, an negative identity (the "nurturer") is crafted along with the new professional identity. Thereby, the discourse of rehabilitation mobilizes workers to readjust to the rehabilitation approach not merely by introducing a new identity hierarchy that clearly defines the professional identities that are valued and rewarded in the managerial discourse but also by defining the identity that the workers are expected to dis-identify from (in order to not be sanctioned as non-professionals). This discursive crafting of an identity hierarchy may reflect an enforced effort to regulate (by ordering) the previously documented (Dahl 2009; Hoyer 2016) plural identities that are available in home care organizations (which workers tend to use as a source of resistance). In addition, the analysis shows that this discursive regulation is not static but ongoing. More specifically, we see that the struggles that the discourse of rehabilitation gives rise to among care aides are widely known by managers and that these re-inform their ongoing discursive regulation. In an attempt to control the scope of the struggles, the nurse-managers reinforce the identity hierarchy by relating the nurturing identity with being a

disloyal colleague and feminine stereotypes, such as classically embodied signifiers of being soft, having a female gender and doing housewife/waiter activities in the home. Signifiers, which other studies (England and Dyck 2011; Hearn 1982; Lee-Treweek 1997; Rasmussen 2004) have also shown, are typically used to emphasize the degrading and marginalized image of anti-professional persona. Thus, overall, we see that discursive managerial regulation relies on the dynamic construction of an identity hierarchy that simultaneously offers the potential to both boost and degrade workers' identities.

2) Second, by specifying two types of struggle that the discourse of rehabilitation activates for the care aides, the article expands the literature on resistance and identity struggles (in marginalized workplaces) (e.g. Alvesson and Willmott 2002; Fleming 2005; Fleming and Spicer 2003; Laine and Vaara 2007). It shows that the struggles care aides express in the professionalization processes concern a dual effort to both avoid (re-)marginalization (Box B, Figure 3) and to become recognized as professionals (Box C, Figure 3). A noteworthy aspect that characterizes this dual effort is, however, that none of the struggles are expressed as "worker corps kicking back against" a managerial discourse (Thomas and Davies 2005, 685), nor do they reflect that workers are "passive receptacles or carriers" of the managerial discourse (Alvesson and Willmott 2002; Laine and Vaara 2007). Rather, they reflect a type of struggle that seems to both affirm and resist the discourse of rehabilitation simultaneously (see e.g. Thomas and Davies 2005 for another analysis of the omnipotence of resistance). We propose that the vague and defensive ways the struggles are expressed are due to the fact that the care aides explain their difficulties with adopting the new ideal by problematizing their own so-called personal barriers or resistant recipients, 'rather than say that they [their difficulties] are caused by the professional ideal as such' (see also Jensen, 2017). This is a defensive strategy that is not only affiliated with the nurses' (re-)regulation of the workers (i.e. that portrays workers who do not live up to the new ideal as disloyal colleagues and 'waiters' or, in short, non-professionals). Rather, we show that the therapists as embodied mediators of the rehabilitative managerial ideology play a crucial role in limiting the space to resist the new ideal.

3) As the therapists are positioned as 'working experts' at the frontline, they become crucial sources to condition and enforce the care aides' identity transfer and moderate their resistance by activating and performatively constituting the professional rehabilitation/trainer persona (Box D, Figure 3). This leads us to the third contribution of the article. As mentioned, the controlling nature of the managerial discourse was continually challenged in practice because some care aides found it difficult to identify with the new professional identity and some care recipients questioned the discourse, e.g. by raising

concerns about their capability to become self-reliant. Yet, the nurse-managers acknowledged that they, from the basis of the office, had limited power to (re-)regulate the care aides' alignment with the new preferred professional persona in the homes. In other words, discursive identity regulation was limited, as the discourse was formulated in an abstract way far from the actual practices in the homes. However, our study illustrates how the therapists – as new human actors (Callon 2008) – who work side by side with the care aides supplement the discursive identity regulation by activating the performativity of the managerial discourse of rehabilitation and the professional persona in the homes. They do that through what we, inspired by recent performativity discussions (Cabantous et al. 2016; Just et al. 2017), refer to as performative regulation. We found this to be a type of regulation that is exercised by working experts who perform the managerial ideal of professional rehabilitation next to the targets of identity regulation, and thus embodies the ideal and transfers it by their own embodied practices and presence as living human guidelines of the ideal rather than (abstract) directives.

Through these three interrelated contributions, we contribute to the identity literature by developing a framework that brings together identity regulation and critical performativity theory in ways that allow us to explore the conditions (material and discursive) through which the professional "you" is performatively constituted. This framework is particularly valuable because it shows the mundane and subtle ways that regulation is currently performed at the margin, i.e. not (only) by directives but also by discursive and embodied practices. The notion of performative regulation seems important to further our understanding of how regulation is not only discursive and cultural but also embedded and embodied in the work and working bodies themselves (see also Twigg et al. 2011). In addition, by developing this notion the paper also adds to discussion on the exclusion processes that keep workers such as care aides at the margin despite professionalization attempts. As we have shown, the therapists did perhaps not upskill the care aides (adding a new layer of knowledge). Rather, care aides' risk of marginalization was reinforced in the sense that they were asked to DE-skill themselves from their previous nurturing knowledge and identities, in order to re-learn and transform into a new (externally defined) professional identity. Thus the care aides' position at the margin seemed to be sustained because the introduction of the working expert set them back as a type of worker who needs 'higher-qualified' experts to teach them how to conduct their work 'more professionally' and limit their space of autonomy, yet in very subtle ways.

References

Ahuja, M.K. 2002. Women in the information technology profession: a literature review, synthesis and research agenda. *European Journal of Information Systems* 11, no. 1: 20–34.

Alvesson, M. 2010. Self-doubters, strugglers, storytellers, surfers and others: Images of self-identities in organization studies. *Human Relations* 63, no. 2: 193–217.

Alvesson, M., and H. Willmott. 2002. Identity regulation as organizational control: Producing the appropriate individual. *Journal of Management Studies* 39, no. 5: 619–44.

Ashcraft, K.L. 2005. Resistance through consent? Occupational identity, organizational form, and the maintenance of masculinity among commercial airline pilots. *Management Communication Quarterly* 19, no. 1: 67–90.

Ashcraft, K.L. 2007. Appreciating the 'work' of discourse: Occupational identity and difference as organizing mechanisms in the case of commercial airline pilots. *Discourse & Communication* 1, no. 1: 9–36.

Ashcraft, K.L. 2013. The glass slipper: "Incorporating" occupational identity in management studies. *Academy of Management Review* 38, no. 1: 6–31.

Ashcraft, K.L., S.L. Muhr, J. Rennstam, and K. Sullivan. 2012. Professionalization as a branding activity: Occupational identity and the dialectic of inclusivity-exclusivity. *Gender, Work & Organization* 19, no. 5: 467–88.

Ashforth, B., and G. Kreiner. 1999. 'How can you do it?': Dirty work and the challenge of constructing a positive identity. *Academy of Management Review* 24, no. 3: 413–34.

Ashforth, B., G. Kreiner, M. Clark, and M. Fugate. 2007. Normalizing dirty work: Managerial tactics for countering occupational taint. *Academy of Management Journal* 50, no. 1: 149–74.

Austin, J.L. 1962. *How to do things with words*. Oxford: Oxford University Press.

Bruni, A., S. Gherardi, and B. Poggio. 2004. Doing gender, doing entrepreneurship: An ethnographic account of intertwined practices. *Gender, Work & Organization* 11, no. 4: 406–29.

Butler, J. 1990. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.

Butler, J. 1993. *Bodies that matter*. New York: Routledge.

Butler, J. 1997. *Excitable speech: A politics of the performative*. New York: Routledge.

Butler, J. (2004), *Undoing Gender*, Routledge, New York.

Butler, N., S. Chillas, and S.L. Muhr. 2012. Professions at the margin. *Ephemera: Theory and Politics in Organization* 12, no. 3: 259–72.

Cabantous, L., J.P. Gond, N. Harding, and M. Learmonth. 2016. Critical essay: Reconsidering critical performativity. *Human Relations* 69, no. 2: 197–213.

Callon, M. (2008) Economic markets and the rise of interactive agencements: From prosthetic agencies to habilitated agencies. In *Living in a material world*, ed. T. Pinch and R. Swedberg, London: The MIT Press.

Cheney, G., and K.L. Ashcraft. 2007. Considering 'the professional' in communication studies: Implications for theory and research within and beyond the boundaries of organizational communication. *Communication Theory,* 17, no. 2: 146–75.

Chiappetta-Swanson, C. 2005. Dignity and dirty work: Nurses' experiences in managing genetic termination for fetal anomaly. *Qualitative Sociology* 28, no. 1: 93–116.

Dahl, H. 2000. *Fra kitler til eget tøj: diskurser om professionalisme, omsorg og køn*. Politicas ph.d.-serie.

Dahl, H. 2009. New public management, care and struggles about recognition. *Critical Social Policy* 29, no. 4: 634–54.

Davies, A., and R. Thomas. 2002. Gendering and gender in public service organizations: Changing professional identities under New Public Management. *Public Management Review* 4, no. 4: 461–84.

Davies, C. 1996. The sociology of professions and the profession of gender. *Sociology* 30, no. 4: 661–78.

Dick, P., and S. Nadin. 2006. Reproducing gender inequalities? A critique of realist assumptions underpinning personnel selection research and practice. *Journal of Occupational and Organizational Psychology* 79, no. 3: 481–98.

Emerson, R., 1995. *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.

England, K., and I. Dyck. 2011. Managing the body work of home care. *Sociology of Health & Illness* 33, no. 2: 206–19.

Fleming, P. 2005. Metaphors of resistance. *Management Communication Quarterly* 19, no. 1: 45–66.

Fleming, P., and A. Spicer. 2003. Working at a cynical distance: implications for power, subjectivity and resistance. *Organization* 10, no. 1: 157–79.

Glaser, B.G., and A.L. Strauss. 1967. *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine.

Hansen, A., and A. Kamp. 2018. From carers to trainers: Professional identity and body work in rehabilitative eldercare. *Gender, Work and Organization* 25, no. 1: 63–76.

Hearn, J. 1982. Notes on patriarchy, professionalization and the semi-professions. *Sociology* 16, no. 2: 184–202.

Hoyer, P. 2016. Making space for ambiguity: Rethinking organizational identification from a career perspective. *Scandinavian Journal of Management* 32, no. 3: 166–77.

Hughes, E.C. 1958. *Men and their work*. Glencoe, IL: Free Press.

Jensen, M. 2017. *Boundaries of professionalization at work*. PhD-series, Copenhagen: Copenhagen Business School.

Jensen, M. 2018. Gender stereotypes and the reshaping of stigma in rehabilitative eldercare. *Gender, Work and Organization* 24, no. 6: 656–74.

Jervis, L. 2001. The pollution of incontinence and the dirty work of caregiving in a US nursing home. *Medical Anthropology Quarterly* 15, no. 1: 84–99.

Just, S. N., S.L. Muhr, and T. Burø. 2017. Queer matters: Reflections on the critical potential of affective organizing. In *Dialogues in critical management studies*, *Vol. 3*, ed. A. Pullen, N. Harding, and M. Phillips, Bingley: Emerald Group Publishing Limited.

Katz, S. 2000. Busy bodies: Activity, aging, and the management of everyday life. *Journal of Aging Studies* 14, no. 2: 135–52.

Kjellberg, P.K., R. Ibsen, and J. Kjellberg. 2011. "Fra pleje og omsorg til rehabilitering." *Dansk Sundheds Institut.*

Kunda, G. 1992. *Engineering culture: Control and commitment in a high-tech corporation*. Philadelphia: Temple University Press.

Kunda, G. and J. van Maanen. 1999. Changing scripts at work: Managers and professionals. *The Annals of the American Academy of Political and Social Science* 561: 64–80.

Laine, P., and E. Vaara. 2007. Struggling over subjectivity: A discursive analysis of strategic development in an engineering group. *Human Relations* 60, no. 1: 29–58.

Lee-Treweek, G. 1997. Women, resistance and care: An ethnographic study of nursing auxiliary work. *Work, Employment & Society* 11, no. 1: 47–63.

Lemmergaard, J., and S.L. Muhr. 2012. Golfing with a murderer—professional indifference and identity work in a Danish prison. *Scandinavian Journal of Management* 28, no. 2: 185–95.

Liamputtong, P. 2011. *Focus group methodology: Principle and practice.* London: Sage.

Meara, H. 1974. Honor in dirty work: The case of American meat cutters and Turkish butchers. *Work and Organizations* 1, no. 3: 259–83.

Muhr, S.L., and L. Kirkegaard. 2013. The dream consultant: Productive fantasies at work. *Culture and Organization* 19, no. 2: 105–23.

Muhr, S.L., M. Pedersen, and M. Alvesson. 2012. Workload, aspiration, and fun: Problems of balancing self-exploitation and self-exploration in work life. *Research in the Sociology of Organization* 37: 193–220.

Nielsen, J., and G. Andersen. 2006. *Hjemmehjælp: Mellem myter og virkelighed*. Odense: Syddansk Universitetsforlag.

Rankin, J. 2001. Texts in action: How nurses are doing the fiscal work of health care reform. *Studies in Cultures, Organizations and Societies* 7, no. 2: 251–67.

Rasmussen, B. 2004. Between endless needs and limited resources: The gendered construction of a greedy organization. *Gender, Work & Organization* 11, no. 5: 506–25.

Ryberg, M., and A. Kamp. 2010. "Hjemmeplejen: Standardisering, faglighed og indflydelse." Bredderapport. Center for Virksomhedsledelse, CBS og Center for Arbejdsmiljø og Arbejdsliv, RUC Oktober 2010.

Sullivan, K. 2012. Producing professionals: Exploring gendered and embodied responses to practicing on the margins. *ephemera* 12, no. 3: 273–93.

Thomas, R., and A. Davies. 2005. What have feminists done for us? Feminist theory and organizational resistance. *Organization* 12, no. 5: 711–40.

Tracy, S.J. 2004. The construction of correctional officers: Layers of emotionality behind bars. *Qualitative Inquiry* 10, no. 4: 509–35.

Tracy, S.J., and C. Scott. 2006. Sexuality, masculinity, and taint management among firefighters and correctional officers: Getting down and dirty with 'America's heroes' and 'Scum of law enforcement'. *Management Communication Quarterly* 20, no. 1: 6–38.

Twigg, J., C. Wolkowitz, R. Cohen, and S. Nettleton. 2011. Conceptualising body work in health and social care. In *Body Work in Health and Social Care: Critical Themes, New Agendas*, ed. J. Twigg, C. Wolkowitz, R. Cohen, and S. Nettleton, 1–19. Oxford, UK: Wiley-Blackwell.

Wickert, C., and S.M. Schaefer. 2015. Towards a progressive understanding of performativity in critical management studies. *Human Relations* 68, no. 1: 107–30.

Wilkinson, S. 1998. Focus groups in feminist research: Power, interaction, and the co-construction of meaning. *Women's Studies International Forum* 21, no. 1: 111–25.