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**The Body and Bathing:
Help with Personal Care at Home
Julia Twigg**

To write about the body is to write about the mundane and the everyday, for that is what the body is: something that is with us always and everywhere- both our constant companion and our essence. Nothing could be more mundane or day-to-day than the processes of bodycare. These actions punctuate our daily lives in the forms of dressing, shaving, showering, combing, washing, eating, drinking, excreting, sleeping, providing us with a rhythm and pattern to the day. The bodily rhythms provide a basic experiential security in daily life. We are, however, by and large acculturated to ignore these patterns, at least at the level of polite speech. The processes of bodycare are assumed to be both too private and too trivial for comment, certainly too trivial for traditional academic analysis. They belong with those other aspects of bodily life that we are socialised to pass over in silence. Though such bodily processes form the bedrock of daily life, they are bedrocks assumed, rather than reflected upon. So long as they are there, functioning correctly, we have no need to comment.

But for many older people this easeful state of bodily ignorance and transcendence is no longer available. Their bodies force themselves into the front of their thoughts, posing a mass of practical problems. The body assumes new prominence by virtue of the inability to do things. Among those things can be the tasks of bodycare such as washing, showering and bathing. This chapter explores what happens when older people can no longer cope with these aspects of life but need assistance in doing them. In particular, it focuses on the situation of older people living at home who are receiving help with personal care, typically washing and bathing.

While a discussion of the everyday activities of washing and bathing is, by definition, concerned with micro-processes, these actions are not outside wider discursive concerns. Bathing is located in a wider sets of discourses than the simple discussion of hygiene that tends to permeate accounts in the area. In this chapter I will explore how far the provision of help does indeed draw on these wider discourses and

how far it remains located in a narrower set of preoccupations. Help with bathing also entails negotiating the management of the body; it involves touch and nakedness, and at times verges on the taboo. I will explore how older people feel about this, and who they prefer to help them in these areas. Before doing so, however, I will discuss briefly the paradoxical neglect of the subject of the body in relation to the support of older people.

THE NEGLECTED BODY OF SOCIAL CARE

Though bodycare lies at the heart of service provision, this has not been emphasised in accounts of the sector. There are three primary reasons for this. The first derives from a concern within gerontology to resist the dominant discourses of medicine and popular accounts of ageing that present it in terms of inevitable bodily decline. The excessive focus on the body is seen as damaging - endorsing ageist stereotypes in which older people are reduced to their ageing and sick bodies, which visibly mark them as old. Progressive gerontology by contrast aims to present a more rounded account of age; one that gives due weight to social rather than just bodily elements in the structuring of its experiences. The “political economy” approach, in particular, which has dominated social gerontology in Britain and North America since the 1980s, emphasises the degree to which old age is the product of social structural factors such as retirement age, pension provision and ageist assumptions (Philipson and Walker 1986; Estes and Binney 1989; Arber and Ginn 1991). From this perspective, it is factors like the differential access to resources or social exclusion that primarily determine the social experience of old age not bodily decline. Close, analytic attention to the body from this perspective is thus regarded as a step backwards.

The second reason for the neglect of the body derives from the way in which the field of community care has traditionally been conceptualised within the debate on ageing. ‘Community care’ is the term commonly used in Britain and elsewhere for the support of older and disabled people enabling them to live in the community, typically in their own homes; and it is the principal policy objective in most advanced industrial societies. Community care is not, however, predominantly conceptualised in terms of the body. Partly this is because the dominant professional group in the field is social work, which concentrates on questions of interpersonal and social functioning and whose remit tends to stop short of the body. This territory is traditionally handed over to the care of medicine. As a result, though community care is inherently about the

body and its day-to-day problems, this fact is not foregrounded in accounts of the sector. The evasion is further compounded by the increasing influence of managerialism in the sector. Managerial discourse, constructed as it is out of the disciplines of economics, business studies, organisation and methods, embodies an abstract and distancing form of theorising that is far from the messy, dirty realities of bodily life. When community care is discussed, it is done so in a manner that largely dismisses the body, rendering it invisible as a site of concern.

The third reason for neglect comes from work on the body itself. Since the 1980s there has been an explosion of writing in this area (Williams and Bendelow 1998), but its focus has been on younger, sexier, more transgressive bodies. The roots of much of this literature in feminism, queer theory and cultural studies has not encouraged it to venture into the territory of old age. Indeed, these approaches have displayed a significant degree of ageism in their assumptions about what is interesting and important. More recently, however, new work has begun to address bodily issues in relation to later years (Oberg 1996; Walker 1999; Biggs 1997; Tulle Winton 2000; Gilliard and Higgs 2000). Some of the best of this work has - belatedly - come out of feminism (Woodward 1991, 1999; Andrews 1999; Furman 1997, 1999). It has been marked by a sense of agency and a desire to foreground the subjective, meaning-making experiences of people as they engage in the ageing process. Often these ideas are linked to concepts of the Third Age.

The Third Age represents a post-retirement period of extended middle age in which people who are no longer confined by the labour market and free from direct responsibility for children can pursue leisure interests, develop aspects of their personalities and enjoy the fruits of later life. The emergence of this new social space is often linked to theories about identity and selfhood in postmodernity, particularly ones that emphasise self-fashioning. It is open, however, to the familiar critique that such optimistic accounts of the Third Age are only possible by virtue of projecting the negative aspects of ageing into a dark Fourth Age, a period of declining health and social loss, sometimes also termed 'deep' old age. As Gilliard and Higgs (2000) note, accounts of the Third Age emphasise agency and subjectivity and are described from the perspective of the optimistic self. But accounts of the Fourth Age focus on dependency and are written from the outside. A macro-level perspective dominates this literature. In such accounts, older persons are rarely seen as agents at all, but are often presented as the 'other'.

Physical decline is frequently presented as marking the point of transition between the Third and Fourth Ages; and receiving personal care of a close and intimate kind is a key marker in this transition. In this chapter we focus on just such a situation of personal care. In doing so I am thus attempting to extend the analysis in terms of the body to a group who until recently been excluded from such a perspective. The literature on the body and ageing that has emerged recently has tended to focus on the earlier optimistic stage of the Third Age, exploring the ways in which people negotiate issues of bodily ageing as they make the transitions from middle to later life. Relatively little work focuses on the body in the Fourth Age, precisely because this Fourth Age is perceived to be all about the body, and to be dominated by bodily issues of a discouraging kind. One of the moral tasks of literature on the Fourth Age has been to retain some of the sense of the person behind the body. In this chapter I hope to continue to do this, but in a way that acknowledges the significance of bodily experiences in the later stages of life, and in doing so extends the literature on the body to this previously excluded group.

PERSONAL CARE AS A SOCIAL MARKER

Why is personal care such a marker of social states? The reason lies in the profound social symbolism that relates to the body and its management. This means that receiving help in these areas erodes the personhood and adult status of the subject. Personal care means being helped with precisely those tasks that as adults we do for ourselves: getting washed and dressed, moving, eating and excreting. However rich we are, these are things that - at least in the modern West - we do for ourselves, typically alone or in the company of intimates. Bodycare of this type thus marks the boundary of the truly personal and individual in modern life. Having to be helped in these areas transgresses this boundary and undermines adulthood. Only babies and children are helped in this way; and this underwrites the profoundly infantilising tendencies of 'care'. The effect is particularly strong if the person suffers from incontinence. As Lawton (1998) argues, to have an unbounded body in the context of modern expectations of the clearly bounded, individually defined body is to have one's autonomy and personhood questioned. Incontinence is for many people the last frontier of social life; the point beyond which it is no longer possible to engage actively and equally in society.

Personal care also involves nakedness. Nakedness is not, by and large, part of ordinary social interaction. It is a special state reserved for certain situations and

relationships; and it is a marker of close, typically sexual, intimacy. To be naked in a social situation, as recipients of personal care are, is therefore to be put in a disjunctive context. It is made all the more so by the fact that the nakedness is asymmetrical: the recipient is naked, while the helper is fully clothed. To be naked in this way is to be exposed and vulnerable, and it inevitably creates a power dynamic in which the helper, usually younger and stronger, is clearly the dominant party.

Personal Care and Bathing

Personal care has become an increasingly significant issue for social care agencies across the western world as a result of widespread social and political policies aimed at supporting frail elders living at home. Home care in Britain and elsewhere is no longer primarily a matter of housework and shopping, but of personal care, in which washing and bathing form an important aspect. Historically, in Britain such help was primarily provided by the community nursing service, but is now largely provided within a home care system. This same shift in provision can be detected in other Western welfare systems. The principal driver behind it has been cost reduction, with the desire to move provision away from the relatively expensive health care sector where staff are trained and where provision is often free to the recipient, into the less expensive social care sector where staff are typically untrained and where recipients are often required to fund their care. The shift has, however, also arisen from concerns about the overmedicalisation of older people's lives. Home care services are seen as embodying a potentially more sympathetic and caring approach than that of medically directed ones.

This chapter draws on a study of help with washing and bathing provided to older and disabled people living at home in Britain (Twigg 2000a). The study was based on interviews with recipients, careworkers and managers. In the research, elders received help with bathing from a variety of sources: the local authority home care service; voluntary sector or for profit agencies; or a specialist voluntary sector bathing service (the last is unusual in Britain). Depending on their income, users either received such help free or were expected to meet some or all of the costs.

The Meanings of Bathing

Within public welfare services, washing and bathing tend to be presented narrowly in terms of a discourse of hygiene and cleanliness. The wider meanings of bathing in terms of luxury, pleasure and well-being are not emphasised. There are a number of reasons for this. Partly it arises from a narrow concern with health and

physical functioning, which is regarded as a particularly legitimate aim for such interventions. Bathing in this context is presented as concerned with hygiene; though in reality, dirtiness has to be extreme before health is genuinely threatened. Partly it comes from long established political pressures to ensure that the remit of public welfare remains limited in scope and extent; and this is linked to a related puritanism which regards ideas of bodily pleasure in connection with public provision as – at very least – discordant. Such tendencies are reinforced by the recent dominance of managerialism, which, as we have seen, tends to present the sector in a distant and disembodied way. Recipients are categorised in terms of their ‘personal hygiene deficits,’ and accounts of the work sanitised and confined within the discourse of hygiene. The body – the width of its experiences and feelings – has little part to play in this discourse.

But bathing has much wider meanings. While there is certainly not space here to explore the history of washing and bathing and of the various practices and discourses that have led to its construction (see Twigg 2000a for such a discussion), I will, however, refer briefly here to four recurring strands in that history to suggest some of the ways in which bathing is located in a wider set of discourses that just those of hygiene.

Historically, bathing has long been connected with luxury, pleasure and to some degree, eroticism. For the Romans bathing was a social activity associated with relaxation, exercise, conviviality and pleasure (Yegul 1992). During the Middle Ages it was recurrently presented in connection with images of feasting and courtship (Vigarello 1988). These meanings narrowed by the nineteenth century, when bathing loses its social dimension and becomes a more private affair, more closely connected with the tasks of getting clean, though the sense of luxury and pleasure that derives from abundant hot water remains (Wilkie 1986; Bushman and Bushman 1988). During the twentieth century, luxurious bathrooms, whether presented in the celebratory imagery of Hollywood, or the dreams of real estate promoters, continue to draw on this discourse of pleasure, luxury and only barely suppressed eroticism (Kira 1967).

Bathing is also located in a wider discourse of well-being. Again this has been so since Roman times, when baths were seen as part of a general regimen of health and well-being. Baths have also been prominent in the alternative medical tradition from hydrotherapy to nature cure, and they remain a central element in the recent

revival of spa culture, often in association with diffuse concepts of ‘eastern’ medicine, that has become a feature of modern western life styles, or at least aspirations. Spa treatments are presented as an antidote to stress and others ills of modern living. Through all of this, well being is the key concept; and the focus is on the experiential body, not the medical body.

The third theme concerns the frequent use of baths and water as markers of social transitions. This is clearest in relation to classic rites of passage like Christian baptism, but it also operates in secular contexts like prisons, schools and hospitals, where people are commonly compelled to have a bath as part of the initiation into the institution, marking their transition from the status of a citizen outside, to that of an inmate in (van Gennep 1908; Goffman 1961; Fitzgerald and Sims 1979; Littlewood 1991). Individuals also draw on such symbolism in their daily lives, clearly marking out the transitions of the day or week through bodily practices such as bathing and showering. The bedrock of bodycare punctuates the day, providing a framework of time and of social states in terms of eating and drinking, washing and dressing, sleeping and rising. No small part of our sense of ontological security is derived from these practices.

Lastly, bathing also contains darker themes. Baths have been widely used as part of coercive cultures, particularly within institutions. For example, cold plunges, sudden showers, and shockingly cold water have all been used as part of the history of the treatment of the insane. Though the justification for such techniques has often been in terms of shocking the patient back into reason, there is also a clearly coercive, even sadistic elements often intensified by the use of machinery or the enforcement of humiliating bodily postures. Though Michel Foucault does not write of baths in particular, there is a strongly Foucauldian element in such treatments with their emphasis on the disciplining and control of bodies, as well as on the exercise of bio-power by key actors, including welfare professionals.

Though these four themes are not in general articulated within the context of community care, all resonate at some level with the practice of bathing in the wider community and society.

THE ADAPTIBILITY OF THE OLD

Before exploring what people feel about receiving help, it is worth reflecting briefly on the adaptability of the old. Accounts of older people often present them as inflexible and unable to cope with change. In fact, the changes imposed on people in

their later lives are enormous. No amount of jet travel, adaptation to new information technology systems, or learning to appreciate new music, can remotely compare with the changes that older people have to learn to accommodate on a day-to-day basis. The aged may lose their lifetime companion; may have to move home, town, region; may have to learn to live in an institution, among random strangers in a collective way that is wholly at odds with their earlier lives, and under the auspices of a staff whose background and worldview may be completely alien to them. In all of this, bodily experiences can be among the most significant: not being able to move freely, or command your speech clearly, or manage your bodily functions present major changes in life. Having to receive help with personal care in particular breaches some of the most profound of social expectations, requiring people to cope with new situations and new relationships. As we shall see, some of the respondents expressed dismay at what they had to face, but it is testimony to their adaptability that they did indeed manage to cope. The majority approached old age with stoicism, concentrating on the day and trying to make the best of it. Some developed ingenious and innovative ways to circumvent their physical difficulties.

WHAT DOES BATHING MEAN IN THIS CONTEXT?

Within the British tradition, the predominant ways of getting clean have been baths, in the sense of bath tubs, and washing at a basin. This is in contrast to Continental and American traditions where showering established itself much earlier as the main alternative to strip washing at a basin. Showering is now common among younger people in Britain, but is still largely unfamiliar or disliked among this older age group. Few people in the study had showers in their homes. In the context of draughty houses and feeble flows of hot water, showers do not warm the body in the way that hot baths do. One or two respondents of Continental origin did prefer showers, sharing the mainland European view that baths are not an adequate way to clean oneself.

People varied in how important baths were to them. Some respondents had never been great bathers, and relied instead on a strip wash. For others, a daily bath was a long established habit and one that they greatly missed. As Mrs Fitzgerald¹ explained, she loved bathing and continues to see it as a vital part of the day:

¹ Names have been changed.

All my life, up in a morning, throw open the bed, into the bathroom - that's the way I lived... It's always been terribly important to me. And that's when I got panic-stricken when I thought I wasn't going to be able to have any bath.

The care people actually received from the bathing service was not always in line with their hopes. Some individuals did indeed have a 'proper bath,' in the sense of being placed directly under the water, with all the warmth and buoyancy that this could bring. But for many, 'bathing' really meant sitting on a board over the bath while the careworker helped them to wash and poured warm water over their bodies. This was enjoyable, but it was not a 'proper bath', and many regretted this. Mrs Kennelly, whose severe Parkinson's meant that she could no longer have a bath, remembered the experience with a sense of nostalgia, 'I'd love to be able to get in the bath. Just lay there and splash it over...wallow in it. Lovely'. Mrs Bridgeman tells of how wonderful it would be to just once receive a proper bath, 'I long to get my bum in the water. It would be bliss you know'.

The problem was that many recipients did not have sufficient flexibility to get down into the bath or strength to get up, and very few homes had the kind of expensive equipment that would allow for this. Workers were forbidden by Health and Safety legislation from lifting the clients out of the bath (though sometimes they still performed the task). This meant that many had more in the way of an assisted wash than a bath. By and large, recipients were resigned to these limitations and grateful for what assistance they received, but problems did occasionally arise, particularly if clients rebelled and attempted to pre-empt the situation by sitting down fully in the bath. In these cases, the careworkers were instructed to tell the person that they would not help them up, but would instead ring for an ambulance. The potential humiliation of this was sufficient to keep most clients in line.

The Experience of Bathing

For some individuals, bathing did remain a pleasurable, even luxurious, experience. Mrs Fitzgerald, who had most feared the loss, now saw the coming of the bathing service as 'the rose of [her] week'. Mrs Napier also relished the experience as something that brings back pleasurable memories of the past, explaining how, 'we have nice foamy shower gel, ...it's lovely, like being a baby again.' Baths were also a source of pleasure because of the number of aches and pains that many older people suffer from. The warmth and buoyancy of the water restored lightness to limbs that

had become heavy, giving back something of the easy, youthful, bodily experience of the past.

Baths also retained their capacity to wash away more than just dirt. For some they had always been both a source of renewal and a marker of social transitions. As Miss Garfield explained, baths are, 'part of, sort of washing the day away and all the bothers and troubles, and you're there and it's all very comfortable and nice.' But the experience of bathing was inevitably strongly affected by the presence of the careworker in the room. For most people, bathing is a private affair, a time apart, when individuals can attend to themselves and not worry about others. But the presence of the worker changes that, to some degree disturbing the ease. Their presence in the room inevitably refocuses the event on tasks to be accomplished, rather than a state to be experienced; recipients were no longer free to control the timing of the event as they had been in the past. Workers needed to get the job done, and this sometimes meant that time was now of the essence, not pleasure. This acted to limit the nature of the experience, removing luxury, centering it instead on cleaning of the client.

Having a worker in the room also removed much of the spontaneity of bathing; it was no longer possible to draw a bath when you simply felt like it. With this also went much of the capacity of baths to act as personal rites of passage or markers of social transitions. Bodycare still marked out the rhythm of people's days, in the sense of dressing, washing, eating, but baths now had to be taken at the times they were scheduled, and this could mean otherwise 'meaningless' times, such as eleven-thirty in the morning, that disrupted rather than underwrote social patterns. For some people this was less disjunctive than expected. This was because those who receive such bathing assistance are often among the most frail and dependant, people who rarely if ever leave the house. For them, the world of conventional timings had become less significant. To quite an extent they had reordered the pattern of their lives around the provision of care. Care work had come to operate as a social structure in itself.

The Gaze of Youth

Much recent work in gerontology has emphasised the ways in which we are aged by culture - by the meanings that are ascribed to bodily ageing, rather than the ageing process itself. Gullette (1997) has described the subtle and omnipresent means by which such meanings are conveyed. We inhale this atmosphere daily, imbuing

doses of its toxicity waft from cartoons, billboards, birthday cards, coffee mugs, newspaper articles, fiction, poetry: 'The system is busy at what ever level of literacy or orality or visual impressionability the acculturated subject is comfortable with'(p. 5). Consumer culture, with its emphasis on youth, is particularly saturated with such messages (Featherstone 1991; Gilleard and Higgs 2000). The dominant theme in all of this work is that old age is constructing as a negative entity and the bodily process of ageing seen in the same light. Ageing represents a form of Otherness, on to which culture projects its fear and denial. As Woodward (1991) argues, our cultural categories here are essentially reducible to two, youth and age, set in a hierarchically arrangement. We are not judged by how old we are, but by how young we are not. Ageing is a falling away, a failure to be young. Like disabled people, the old are evaluated as 'less than...'. The bodily realities of aging thus create a version of Erving Goffman's spoilt identity, something that people are, at some level, ashamed of and marked in terms of.

We are accustomed to the idea of the medical gaze in the context of professional power, or the phallic gaze in the context of gender relations, but there is also a gaze of youth. It too is an exercise of power in which the Other – in this case older people – are constituted under its searching eye. Nowhere is the gaze of youth more evident than in relation to bathing care. Here the bodies of older people are directly subject to the gaze of younger workers. From the workers' perspective this sometimes presents them with a shock. Modern culture, though saturated with visual images of young perfect bodies, rarely permits old imperfect ones to be on show. As a result, the way in which the body looks in old age was something that the younger workers were unprepared for. As one careworker explained, seeing old people naked was, 'weird, and I just had to stop myself staring at people, because I hadn't really seen... because you don't really see people naked'.

At times this element of gaze was itself part of the professional task. Nurses who do bathing work often comment how the activity is useful in assessing the general state of the older person, both in terms of illness and physical condition, but also more widely. To be bathed is indeed to be made subject to – very directly subject to – the professional gaze. It is indeed a kind of developed, intimate surveillance.

So how did older people feel about this? It was certainly the case that many respondents appeared to have internalised the wider cultural denigration of the bodies of the old. They constituted their own bodies under the gaze of youth, presenting

them as something that it might be unattractive, even distasteful, for people to see or handle. As Mrs Fitzgerald once remarked of the careworkers, 'They're so young and beautiful, it must be awful for them to have to handle old, awkward bodies'. At the same time, she added that, 'they're wonderful people. ...I must say, I mean they must have something inside them because - it's not the sort of thing - I don't know when I was young whether I would have wanted to have looked after old people.' For some, the contrast between their aging bodies and the youthful flesh of the workers was painful to see and experience:

Mrs Kennelly: I say to them, 'I feel sorry for you, getting up in the morning and this is the kind of job you've got to do,' You know, not very nice. ...This young girl, Amanda it was, came in - twenty eight, beautiful girl. She's very pretty. And there's the ugly lump. Oh dear!

To be caught within the youthful gaze was disturbing and many of the elders had turned its corrosive force back upon themselves, in turn disciplining their own bodies in the course of assistive practice.

Embarrassment

Receiving help with bathing was potentially embarrassing, but respondents varied in the degree to which they experienced it as such. Some never lost this sense of unease, but the majority adapted. As Mrs Elster once explained :

Mrs Elster: Well, at the beginning I didn't like being personally washed of course, but after six years I haven't got any more hold ups about that, you know. You just get on with it. Get clean is my main thing ...

Interviewer: Right so you get used to it or you just have to learn to put up with it?

Mrs Elster: Well pretty well learn to put up with it. And really you do put up with a helluva lot.

The exchange once again points to the adaptability of the old. Mrs Elster had been literally confined to her bed for six years and was determined to remain independent. She had learned to accept what could not be changed.

For many, the experience of being in the hospital had been a watershed in their feelings about their bodies. After being pulled and pushed about on the wards, they had lost any sense of modesty. As Mr Wagstaff once commented, 'once you've been

in hospital for a while, all ideas of privacy disappear straight down the drain.’ In these cases the sense was less one of bodily ease than of detachment and distancing of the self from the body, its pain, and embarrassment.

Some elders, however, seemed genuinely unbothered by the new situation they now found themselves in. As one careworker recounted: ‘most of them aren't shy at all, they just come in and take their clothes off and walk around, they don't really mind’. Mrs Napier said that she was never embarrassed in front of the careworker, stating, ‘Oh gracious no, I've walked round in my birthday suit without any trouble at all.’ Listen as one careworker described how a client still loved to show off her zest for living.

[She] just stands up in the bath and goes like this, you know, does a little dance...The whole thing is kind of a pursuit in proving how agile and full of life she is ... It's that kind of love of just being in that little wicked body of hers, and doing a dance with a towel right in the middle of the bath.

Parts of the Body

The body is a landscape on to which meanings are inscribed. These are not however, evenly distributed over the body, and certain parts come to be more heavily freighted with significance than other bodily parts. In general, there is a familiar privacy gradient whereby certain parts of the body are deemed more personal and private. Access to them by sight or touch is socially circumscribed, and varies according to relationship and situation (Jourard 1966; Jourard and Rubin 1968; Henley 1973; Sussman and Rosenfeld 1978; Witcher and Fisher 1979; Routasalo and Isola 1996). Areas of the body such as the upper arms and back are relatively neutral and can be touched by a range of people. Knees and thighs are less so. Breasts and genitals are in general off limits in all but erotic relations. Touch is also a vector of status and authority with the powerful accorded more leeway to touch than the less powerful. There is a gender dimension, with women more likely to receive touch than men. Within a service provision context, women are more likely to interpret touch from a service provider in a positive way, while men are more inclined to see it negatively, interpreting it as a marker of inferiority and dependency. In addition, men are also more likely to see touch as sexual.

These sensitivities affect the experience of bathing. Receiving hands-on help with soaping, rinsing, washing is more tolerable in relation to some parts of the body than others. Arms and legs, feet and hair are all fine. Matters become more sensitive,

however, in relation to what was often termed ‘down below’: the genital and anal areas. In practice nearly everyone in the study could manage to wash these parts themselves, at least with some indirect assistance; and a number of respondents expressed relief that they were able to do so. Having to be washed in these areas was seen as humiliating and embarrassing, yet another twist in the spiral of dependency. Maintaining one’s independence in relation to these intimate areas was an important part of self-esteem. Careworkers were also reluctant to involve themselves with these parts of the body, which they too regarded with a certain amount of ambivalence. In general, bathing was practically managed in such a way as to limit direct contact in relation to more sensitive bodily parts.

Conflict sometimes arose, however, in a small number of cases where male clients attempted to ‘try it on’ and get careworkers to touch their private parts. One female careworker recounted how when she was new to the work, one man, ‘was always trying to get us to wash his private parts ... and I think I did it the first time, [because] I was quite new.’ But her manager explained such ‘help’ was rarely necessary, telling the careworker that, ‘He could do it, and I realised this when he turned the shower on. I thought, if he can do that, then he can do it. He's just trying it on.’ Attempts of this sort are usually met by refusal or transfer to a male careworker.

There was one part of the body that was recurrently mentioned in the interviews by both recipients and workers: this was the back. In the context of bathing and the ambivalent intimacies it creates, the back has a special meaning, coming to stand for the body in general, or at least for an acceptable version of the body, one that has a certain neutrality about it. In the interviews, the back was the only part of the body that was spontaneously named by recipients, and they sometimes talked about the process of bathing as if it were confined to the process of washing the back. The back was also the one part of the body where pleasure in touch was openly acknowledged. A number of recipients described how they enjoyed having their backs scrubbed. Expressing pleasure in such touch was acceptable. Careworkers joined in this account. One in particular commented that, ‘they do enjoy it, that you know, a lot of people really, “Oooh”, you know, “give my back a good rub”’. In general, expressing pleasure in touch was something that recipients were reluctant to do. It seemed to suggest in their eyes something that was not quite right, an ambivalent element that did not belong in this context of relative strangers and of public provision. Presenting bathing in terms of scrubbing the back was one means of

deflecting an otherwise disturbing intimacy on to a relatively neutral and public part of the body.

The back is also significant in the bath encounter in that it is the part of the body that is both offered to the gaze of the worker and also used to shelter more private and sensitive parts. It stands in for the public presentation of the body in the context of an otherwise discordant intimacy. The back also offers a safe setting for the expression of affection and closeness. Putting an arm across the back while giving the recipient a hug, fits easily with the way bathing disposes the body, while at the same time providing a relatively neutral form of physical contact. Touch could thus be used to express closeness, but in a manner that does not transgress social codes.

BOUNDED RELATIONSHIPS AND ACCESS TO THE BODY

Bathing makes for a strange relationship: in one sense intimate and close, involving physical contact, nakedness and access to the private dimensions of life; and yet in another a meeting of strangers in which the worker is paid to do a job and may never have met the recipient before. The intimacy, moreover, occurs in a context that is forced. It arises from disability, not choice. The closeness is imposed, not sought. As a result there is an inherent discordance in the relationship. It is transgressive of normal social codes, and effort is needed on both sides to define the character of the relationship and to put limits on the nature of its intimacy.

How the relationship was experienced was clearly affected by who the helper was. What were people's preferences in this regard? Did they, for example, prefer to be helped by close relatives? An assumption of this sort is often made, resting on the idea that kinship closeness renders the negotiation of bodily closeness easier. While this can certainly sometimes be so, often it is not. We have evidence from other studies (Parker 1993; Daatland 1990) that suggests that while people may like to receive more neutral forms of help from relatives, personal care is different. In these cases many people prefer the formal service system. The reason is that bodily care threatens the nature of a relationship. In particular it erodes the status of the recipient and with that their identity in the relationship. What older people fear is that the person that they once were – and in their own eyes still are - will be lost, and that person, by and large, is someone with their clothes on, managing their own bodily functions and relating to their families in a sociable way. We should not thus make any easy assumptions about kinship closeness translating unproblematically into bodily closeness.

Even less do people want friends to perform this activity. It is in the nature of friendship that it rests on equality and reciprocity, and few friendships survive marked change in circumstances when these occur on only one side of a valued relationship. Intimate care represents just such a change. Lawler (1991) notes how nurses experience similar unease if cared for by a friend and colleague. Though recipients wanted the careworker to be 'friendly', they were quite clear that this was a different and defined sort of relationship. These were not friends in the full sense of the word. As Mrs. Ostrovski said to me, 'Friend is a very big word.'

Bath work involves a kind of intimacy, though it is of a different nature from that of kinship or friendship. What recipients want is a bounded intimacy, something that is close, but in a specialised and limited way. For these reasons they preferred someone whom they had got to know in these particular circumstances, and where the relationship was defined by them. This is not to say that that it was not close, or friendly, or based on a kind of trust. In most cases it was all of these, but the relationship was of a special kind, in which bodily closeness played a part, but one that was defined and limited.

At the same time, recipients disliked the experience of having to deal with strangers. Bathing involves both a literal and a psychic unwrapping of the self. Having to participate in this process repeatedly with strangers was exposing and dispiriting. Recipients wanted the ease that comes with familiarity; and they did not want constantly to have to readjust to a new person. But agencies could not always be relied upon to send the same person; and indeed the constant staff turnover that is characteristic of low wage sectors in cities like London meant that it was quite difficult for them to do so. Some recipients subverted the problem by refusing to have a bath if an unfamiliar worker was sent, diverting them into other household tasks rather than facing the unwelcome process of self disclosure. What recipients wanted, therefore, was someone they knew, who was friendly and sensitive, and who would offer emotional support, but who understood the limits of the relationship.

Among formal service providers, it is sometimes thought that nurses are the most appropriate people to do this work since they are the group traditionally associated with the direct management of the body and the negotiation of interventions involving bodily fluids, nakedness and other sorts of bodily vulnerability. With their sacralising uniforms and professional manner, they are well placed to deal with the profanities of the body in a neutral way (Wolf 1988; Lawler

1991). Perhaps surprisingly, older people in the study did not endorse this view. By and large they preferred to have ordinary careworkers. Some indeed held negative views of nurses who were seen as bossy, interventionist and hurried. Many had had bad experiences in hospital where their bodies had been pushed and pulled about by nurses in the course of diagnosis and treatment. Although holistic accounts of nursing (Lawler 1997) stress the importance of bodycare and the role of nurses in integrating the object body of medicine with the experiential body of the individual, the realities of nursing care on busy wards with an increasing division of labour, as well as the invasive and unpleasant nature of many hospital procedures, mean that the body in nursing is largely the object body of bio-medicine.

The body in social care is different. As I noted at the start of this chapter, within social care there is no consciously articulated language of the body. Indeed the discourses of community care and of ageing that have constituted the field have traditionally avoided the subject. However, there is most certainly a body within social care. It is a version of the social body in that it is to some degree managed, as we have seen, within discourses of sociability and personal relationships, tempered by conscious attempts to limit and neutralise the connection. The body within social services is managed within a more homely discourse than that of nursing, one in which uniforms and titles are not used as distancing techniques, and where familiarity replaces professional authority in the negotiation of intimacy.

The social body is, of course, also a gendered body, and gendered assumptions affect the negotiation of social care. Carework is profoundly affected by issues of gender. Like nursing, the job is effectively constructed around gendered identities in which qualities associated with women in the private, domestic sphere are carried over into the public world of work. Carework is archotypically women's work, and this underpins a number of its key features: the unbounded character of the work and its links to the ethic of care; its association with the body and with emotion; society's schizoid valuation of it, at the same time inestimable and yet discounted; and the ways that it is naturalised in the persons of women, so that what is needed to do the work is 'good' women, rather than a trained or qualified workers, with the financial and other rewards that such workers can command. (Hochschild 1983; Waerness 1987; Bates 1993; Tronto 1993; Davies 1994; Skeggs 1997; Twigg 2000b).

The recipients also made assumptions about gender. This invariably focuses on who was appropriate to do the carework. Responses varied according to whether

the person was a man or woman. In general, women-to-women care was regarded as 'natural' and unproblematic. Issues arose, however, in relation to cross-gender tending, and to some extent, in relation to same-sex male tending.

What underpinned this asymmetrical pattern was wider assumptions about the meaning and management of the body. Within Western culture, men's and women's bodies have traditionally been treated differently (Young 1990; Connell 1995; Brook 1999; Watson 2000). Women's bodies tend to be regarded with greater circumspection. Access to them, both physical and visual, is more guarded. They are seen as more private, something that is secluded and hidden. Women's bodies are also often presented as more sexual, indeed often coming to represent the principle of sexuality more widely within culture. Women's bodies are also subject to greater control. There is more constraint over what they may do and express. Men's bodies are, by contrast, presented as more public and neutral in character. They tend to embody active principles rather than the passive ones circumscribed on the female body. They desire, rather than are constituted by the desire of others.

These cultural patterns underwrite responses to bathing help. In general women preferred not to have a male worker, and some expressed their feelings very strongly in this regard, 'Oh, no. I wouldn't have a man. No thank you'! This was not universal, and some said that they would not mind. But in practice this situation only rarely arose. The majority of workers are female, as are clients, and this 'naturally' delivers a pattern in accord with dominant values. Most agencies also have a policy against men giving personal care to women in their own homes, partly out of respect for client's assumed preferences and partly to avoid accusations of abuse. Running through attitudes towards male careworkers were a set of assumptions about the nature of male sexuality as something that is active and potentially predatory. This is contrast to the assumptions that are made about women. These present them as passive or asexual in this context, dominated by the values of maternity, not sexuality.

For men, the experience of receiving cross-gender tending was, by its very nature, different. Men are accustomed to being helped by women from childhood onwards, and many saw such assistance in old age as a natural extension of that. Such care contained no sense of threat. Indeed, for many men the idea of being helped by a woman was pleasant. As one manager remarked:

A lot of the men quite enjoy having a woman. And honestly I think, you know, specially a nice young girl come to help them have a bath, they like it. You

know, not in any sort of perverted way, just, just in a you know, they like the attention

As Mr Lambert said, provided the women were married – that is where women were accustomed to seeing men naked – there was no difficulty in cross gender tending. Mr Wagstaff concurred with this sentiment.

Interviewer: Did you find it embarrassing at first or ...?

Mr Wagstaffe: Well not really. I thought it might be more embarrassing for them than for me, but they don't seem to mind a bit.

Interviewer: Why did you think it would be more embarrassing for them?

Mr Wagstaffe: Well, the first girl I had she was only about eighteen I think. She was a sort of punk, she'd got bright red hair and earrings in her eyebrows. Sort of girl that a person of my age looks at and thinks Gawd Almighty. But she was absolutely sweet, she was a lovely girl. It turns out that they nearly all live with their boyfriends or something, so I don't bother about it now...And young ladies in their early twenties these days are rather different from when I was the same age.

For men, therefore, cross-gender tending contains no sense of threat. The issue is one of managing the encounter in such a way as to avoid embarrassment, in which they had some remaining sense of responsibility for not disturbing the innocence of the young. Even in old age, men experience a residual sense of the power of the phallus.

For men being cared for by men, the assumptions were slightly different. In many cases this occurred without comment or problems. But for some men the idea was unwelcome. Men construct other men as sexually predatory in relation to themselves (Connell 1995). Intimate care by a man raises the possibility of a homosexual encounter, a concern reinforced by ideas that carework was not proper work for a man at all.

THE DISCOURSES OF BATHING REVISITED

How far does bathing provided at home embody the wider discourses of bathing that I referred to at the start of this chapter? With regard to luxury and pleasure, we saw that these experiences are, to some degree, found within the service, particularly the service as provided by the specialist bathing project. They were slightly less characteristic of provision located within a general home care service where bathing had to be fitted in as possible, and where the worker came to clean both the house and the person. Luxury was also somewhat limited by the nature of what was offered, and as we have seen throughout the chapter, often fell short of the desire of recipients for a 'proper bath'. This was further complicated by the character of many older people's bathrooms, which were often cramped and old fashioned. For those who were well housed however, either as a result of their own money or some form of social housing, bathing could be a source of bodily pleasure. How far it could be articulated as such was however much more questionable. Many recipients seemed inhibited in expressing such hedonistic thoughts in the context of public provision.

Eroticism was present, but only in a muted form, and more as a shadow than an active principle. Some of the difficulties around nakedness, embarrassment and intimacy clearly had their roots in the potentially erotic nature of the exchanges, and some of the boundary maintenance work that went into defining the relationship was concerned with resisting or limiting these meanings. The element of the erotic was most strongly present in relation to questions of cross-gender tending and the differential construction of this as between men and women. On occasion such issues did emerge overtly, and dealing with unwanted sexual expression is one of the minor tasks of carework. By and large, however, the erotic was more present in its exclusion than its action.

With regard to well-being and wider concepts of health, it was certainly the case that the provision of bathing, though officially justified in terms of hygiene in a fairly narrow way was, in practice, provided on a wider basis that acknowledged its significance in a larger sense of well being. Cleanliness of a strictly medical kind could have been achieved by more limited interventions; and most people who received a bath did not require one by narrow criteria of health. Care managers recognised that baths were sources of bodily well-being that went beyond this, and were willing to allocate them on that basis.

Baths also act as rites of passage and markers of social transitions. As we have seen, they retain something of this aspect even when provided within a service context. What is lost however is the capacity to control the timing in such a way that underwrites transitions. Too many people are forced to have baths as ‘meaningless’ times, and certainly the element of spontaneity is lost. For some, however, the provision of help itself comes to form the basis for a new framework for the temporal and social organisation of the week.

Lastly, bathing has sometimes been located within a discourse of power and domination, and these elements are in some degree present whenever someone is taken and given a bath - where the bath is something that is done to them. The bathing encounter certainly contains aspects of this, in potential at least. The client is naked, weak and seated, while the worker is clothed, strong and above the client. The situation enshrines a powerful dynamic of subordination in which bodies are potentially observed, corrected and disciplined, according to the principles of Foucauldian bio-power. That the clients did not feel that this was in fact how they were treated was in large measure a tribute to the kindness and good practice of the workers who went to considerable efforts to ensure that they were accorded respect and dignity. In doing so, however, they had to override what was a powerful dynamic inherent in the exchange.

CONCLUSION

Throughout this chapter, I have argued that bathing and washing exemplify day-to-day and mundane activities of the old. As a result they have received little in the way of academic attention, often considered too practical, too banal, to be of interest. But it is in these ordinary and banal patterns that much of the texture and meaning of life exists. The life of the body is the bedrock on which our existence rests. Tending, caring for, managing our bodies, using and presenting them in social life are central to our day-to-day experience, though it is not often brought to the front of our consciousness. Until, that is, some disruption in these taken-for-granted activities forces them and the existential life of the body into conscious consideration. Old age is one such source of disruption. Though we are indeed aged by culture as some theorists suggest, we are also aged by our bodies, and the body can impose its own constraints, as we have seen in regard to the practical difficulties some people experience in relation to personal care. The ways in which personal care is managed,

however, the meanings it contains, and the discourses that encode it, significantly affect how these bodily constraints are experienced.

Among the discourses within which personal care is encoded are those relating to bathing. As we have seen, the official account of service provision presents the activity in a fairly narrow, utilitarian way – as the achievement of adequate standards of hygiene. The discourse of social welfare is a constrained one in which the scope of interventions are limited and in which health and hygiene have a privileged status. But as we have seen, baths and bathing are about more than this. They touch on other matters; their meanings are wider and more diffuse, and the experiences they offer more various. Bathing is part of the experiential life of the body, and as such is drawn into a variety of discourses and sets of meanings around pleasure, luxury, eroticism, renewal, initiation, and power. Echoes of these wider meanings reverberate through the experience of bathing in the community. Hearing them enables us to set community care in a wider social and cultural context, and thus to rescue it from too narrow a policy context. It also allow us to hear something of the voices of some of the most disabled older people, people whose bodily experiences have received little analytic attention in our overarching focus on the body.

REFERENCES

- Andrews, M. 1999. "The seductiveness of agelessness." *Ageing and Society* 19: 301-18.
- Arber, S. and J. Ginn. 1991. *Gender and Later Life: A Sociological Analysis of Resources and Constraints*. London: Sage.
- Bates, I. 1993. "A job which is 'right for me?': social class, gender and individualisation." Pp 14-31 in *Youth and Inequality*, edited by I. Bates and G. Riseborough. Buckingham: Open University Press.
- Brook, B. 1999. *Feminist Perspectives on the Body*. Harlow: Pearson.
- Bushman, R. L. and C. L. Bushman. 1988. "The early history of cleanliness in America." *Journal of American History* 74: 1213-38.
- Connell, R.W. 1995. *Masculinities*. Cambridge: Polity
- Daatland, S. 1990. "What are families for?: On family solidarity and preference for help." *Ageing and Society* 10: 1-15.
- Davies, K. 1994 "The tensions between process time and clock time in carework: the example of day nurseries." *Time and Society*. 3: 277-303.
- Estes, Carroll L. and E. A. Binney. 1989. "The biomedicalization of aging" *The Gerontologist* 29:587-96.
- Featherstone, M. 1991 "The body in consumer culture" Pp. 170-96 in *The Body: Social Process and Cultural Theory*, edited by M. Featherstone, M. Hepworth, and B.S. Turner. London: Sage.
- Fitzgerald, M. and J. Sim. 1979 *British Prisons*. Oxford: Blackwell.
- Furman, F.K. 1997. *Facing the Mirror: Older Women and Beauty Shop Culture*, New York: Routledge.
- Furman, F.K. 1999 "There are no old Venuses: older women's responses to their aging bodies." Pp 7-22 in *Mother Time: Women, Aging and Ethics*, edited by M. U. Walker. Boulder: Rowman & Littlefield.
- Gennep, A. van 1908. *The Rites of Passage*, translated by M.B. Vizedom and G.L. Cafee 1960. London: Routledge Kegan Paul.
- Gilleard, C. and P. Higgs. 2000. *Culture of Ageing: Self, Citizen and the Body*. London: Prentice Hall.
- Goffman, E. 1961. *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates*. New York: Doubleday.

- Gullette, M.M. 1997. *Declining to Decline: Cultural Combat and the Politics of Midlife*. Charlottesville: University Press of Virginia.
- Henley, N.M. 1973. "The politics of touch". Pp 421-33 in *Radical Psychology*, edited by P.Brown. London: Tavistock.
- Hochschild, A. 1983. *The Managed Heart: The Commercialisation of Human Feelings*. Berkley, CA: University of California.
- Jourard, S. M. 1966 "An exploratory study of body accessibility." *British Journal of Social and Clinical Psychology* 5: 221-31.
- Jourard, S. M. and Rubin, J. E. 1968. "Self disclosure and touching: a study of two modes of interpersonal encounter and their inter-relation." *Journal of Humanistic Psychology* 8: 39-48.
- Kira, A. 1967. *The Bathroom: Criteria for Design*. New York: Bantam.
- Kontos, P.C. 1999. "Local biology: bodies of difference in ageing studies." *Ageing and Society*, 19: 677-90.
- Lawler, J. 1991. *Behind the Screens: Nursing, Somology and the Problem of the Body*. Melbourne: Churchill Livingstone.
- Lawler, J. 1997. "Knowing the body and embodiment: methodologies, discourses and nursing." Pp31-52 in *The Body in Nursing*, edited by J.Lawler. Melbourne: Churchill Livingstone.
- Lawton, J. 1998. "Contemporary hospice care: the sequestration of the unbounded body and 'dirty dying.'" *Sociology of Health and Illness*. 20: 121-43.
- Littlewood, J. 1991. "Care and ambiguity: towards a concept of nursing." Pp 170-89 in *Anthropology and Nursing*, edited by P.Holden and J.Littlewood. London: Routledge
- Neysmith, S. M. and J. Aronson 1997. "Working conditions in home care: negotiating race and class boundaries in gendered work." *International Journal of Health Services*. 27: 479-99.
- Oberg, P. 1996. "The absent body – a social gerontological paradox." *Ageing and Society*. 16: 701-19.
- Parker, G. 1993. *With This Body: Caring and Disability in Marriage*. Buckingham: Open University.
- Phillipson, C and A. Walker 1986. *Ageing and Social Policy: A Critical Assessment*. Aldershot: Gower

- Skeggs, B. 1997. *Formations of Class and Gender: Becoming Respectable*. London: Sage.
- Swenarton, M. 1977. "Having a bath: English domestic bathrooms, 1890-1940" Pp 92-99 in *Leisure in the Twentieth Century: History of Design*. London: Design Council Publications.
- Townsend, P. 1986. "Ageism and Social Policy." Pp 15-44 in *Ageing and Social Policy: A Critical Assessment*, edited by C. Phillipson and A. Walker. Aldershot: Gower.
- Tronto, J. C. 1993. *Moral Boundaries: A Political Argument for an Ethic of Care*. London: Routledge.
- Tulle-Winton, E. 2000. "Old bodies" Pp 64-83 in *The Body, Culture and Society*, edited by P.Hancock, B. Hughes, E.Jagger, K.Paterson, R.Russell, E.Tulle-Winton and M.Tyler. Buckingham: Open University.
- Twigg, J. 2000a. *Bathing – the Body and Community Care*. London: Routledge.
- Twigg, J. 2000b. "Carework as a form of bodywork." *Ageing and Society*. 20: 389-411.
- Vigarello, G. 1988. *Concepts of Cleanliness: Changing Attitudes in France Since the Middle Ages*. Cambridge: CUP.
- Waerness, K. 1987. "On the rationality of caring" Pp 207-34 in *Women and the State: the Shifting Boundaries of Public and Private*, edited by A. Showstack Sassoon. London: Hutchinson.
- Watson, J. 2000. *Male Bodies: Health, Culture and Identity*. Buckingham: Open University.
- Whitcher, J. S. and J. D. Fisher. 1979. "Multidimensional reaction to therapeutic touch in a hospital setting." *Journal of Personality and Social Psychology*. 37: 87-96.
- Wilkie, J.S. 1986. "Submerged sensuality: technology and perceptions of bathing." *Journal of Social History*, 19, summer: 649-54.
- Williams, S.J. and G. Bendelow 1998. *The Lived Body: Sociological Themes, Embodied Issues*. London: Routledge.
- Wolf, Z.R. 1988. *Nurses' Work, the Sacred and Profane*. Philadelphia: University of Pennsylvania Press.
- Woodward, K. 1991. *Aging and Its Discontents: Freud and Other Fictions*. Bloomington: Indiana University Press.

Woodward, K. (ed) 1999. *Figuring Age: Women, Bodies, Generations*. Bloomington: Indiana.

Yegul [* umlaught over the u] F. 1992. *Baths and Bathing in Classical Antiquity*. Harvard: MIT Press.

Young, I.M. 1990. *Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory*. Bloomington: Indiana University Press.