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Carework as a form of bodywork

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ABSTRACT
The paper argues for the importance of recognising carework as a form of bodywork. It discusses why this central dimension has been neglected in accounts of carework, pointing to the ways in which community care has traditionally been analysed, the resistance of social gerontology to an overly bodily emphasis, and the conceptual dominance of the debate on care. Drawing on a study of the provision of help with bathing and washing for older people at home, it explores the body dimension of the activity, looking at how careworkers negotiate nakedness and touch, manage dirt and disgust, balance intimacy and distance. Finally, the paper draws together some of the key themes of this bodywork: its designation as 'dirty work', its hidden, silenced character, the low occupational esteem in which it is held and its gendered nature.

***KEY WORDS* –** body, carework, intimacy, dirty work, gender.

Introduction

Carework in community care has been analysed in ways that neglect its nature as 'bodywork'. The term 'bodywork' has commonly been applied to the work that individuals undertake on their own bodies, often as part of regimens of health and wellbeing. More recently the term has been extended to cover paid work done on the bodies of others who thus become the objects of the worker's labour. The aim of such interventions can be medical, therapeutic, pleasurable, aesthetic, erotic, hygienic, symbolic. It encompasses a range of practitioners: doctors, nurses, careworkers, alternative practitioners, hairdressers, beauticians, masseurs, sex workers, undertakers. The contexts in which they work are very varied. In this paper I will present carework as a form of bodywork, drawing out certain common features that apply across the field.

The most obvious parallels between carework and other forms of bodywork are found in the health care sector. Though medicine deals

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with the body, it does so in a particular and circumscribed way, constructing it in terms of the object body of science, distant and depersonalised (Lawler 1997). Medical practice is presented in such a way as to limit involvement in the body, and professional status is marked out in terms of distance from the bodily. Doctors perform relatively little direct bodywork and, where they do, it is largely confined to the high-status activity of diagnosis, or is mediated by high-tech machines. Where it is part of treatment (with the exception of the elite virtuosi activity of surgery), it is often delivered by lesser practitioners like physiotherapists or nurses. Nursing ironically shares many of these ambivalences. Though bodywork is at the heart of nursing, it has an uncertain status. Nursing is organised hierarchically so that, as staff progress, they move away from the basic bodywork of bedpans and sponge baths towards high-tech, skilled interventions; progressing from dirty work on bodies to clean work on machines. Dunlop (1986) argues that the recent emphasis on psychological dimensions of the patient and indeed the whole educational project, with its tendency to academicise nursing, represents a further flight from the bodily in pursuit of higher status forms of knowledge and practice.

The second main sector of bodywork centres on trades that aim to beautify the body – hairdressers, beauticians, manicurists (Gimlin 1996; Sharma and Black 1999). Improving appearance is the central aim, but themes like pleasure are also important, and beauty trades are also body-pampering trades, encompassing massage, aromatherapy and other sources of sensuous enjoyment. Many of these interventions are packaged in the language of therapy – 'beauty treatments'. This brings us to a third focus, which is alternative medicine, for the boundary between beauty and health treatments is a highly permeable one. Alternative medicine, in its pursuit of what Sharma and Black (1999) term 'deep health', aims to integrate the lived body with the mind or spirit. They are part of the pursuit of a wider concept of wellbeing that draws on the preoccupations of the body in post-modernity. Wolkowitz (1998) sees such trades as exemplifying the 'new bodywork', in which recreation and therapy are linked. Here, work on the body is non-invasive, confined to the surface, largely pleasurable and freely sought by clients, often in a market place of freelance practitioners.

But bodywork also borders on the more ambivalent territory of sexuality, and lurking in the wings of any discussion of bodywork is the question of prostitution. Prostitution is one of the oldest forms of bodywork, recurringly associated with the bath house, the beauty

trades and the massage parlour as well as, in male fantasy, with that other area of bodywork – nursing. Prostitution is a stigmatised form of work that centres on servicing the desires of a dominant customer. Though it has at times been treated as a form of immorality (where the immoral act is to engage in relationships outside the prescribed limits of marriage, and to do so directly for money), what is low about the work is that it involves body servicing in a directly subordinated way in relation to sex. Subordination, when it centres on the body, takes on a particularly intimate and personal character. It is because of this that the power dynamics of bodywork can tip either way – into the demeaned territory of the prostitute, or the dominant and controlling creator of docile bodies.

Finally, bodywork can also involve the less attractive aspects of the body. Occupations that deal directly with the body and its wastes are recurringly regarded as low in status, on the border of the polluted. In caste societies, sweepers and barbers are drawn from low castes or untouchables. In modern Western societies, such jobs are done by the lowest paid, least regarded workers; being a lavatory cleaner epitomises a low status job, however much people might recognise that it needs to be done. Dealing with dead bodies involves similar ambivalences. Undertakers in Western society often find they are avoided socially, and they traditionally form a self-recruiting, family-based group. Strong taboos adhere to their work. Their role is to process death and decay in such a way that its bodily character is hidden.

To sum up, bodywork is ambivalent work. At times it verges on areas of taboo in connection with sexuality or human waste. It is potentially demeaning work, and when undertaken by high status individuals it is typically accompanied by distancing techniques. There is a recurrent dematerialising tendency whereby status in a profession is marked by distance from the bodily. At the same time, bodywork is closely linked with pleasure and emotional intimacy. Therapies and techniques that rest on it create a zone of physical enjoyment and wellbeing. Bodywork is also gendered work, differentially performed and received by women. Lastly, aspects of subordination and domination are of central significance, and can create an unstable, ambiguous quality in its social exchanges.

In this paper I will analyse the element of bodywork in one occupation, that of the careworker, exploring how workers evaluate and manage this aspect of their work with older people. I will conclude by using these insights to reflect on some recurring features of bodywork. Before doing this, however, we need to explore why this central dimension of care has received relatively little emphasis.

Bodywork: a missing dimension in the analysis

The first reason for its absence arises from the ways in which community care has traditionally been described and analysed. Community care for older people has rarely attracted sociological analysis; and the private nature of its main setting – home – has acted as a barrier to ethnographically informed work. As a result there is relatively little writing that explores the front-line realities of community care. The dominant discourses constructing the field are those of social work and managerialism. Social work has, however, never wholly claimed community care (as it has work with children and families) and its emphasis on casework and interpersonal relationships means that its theorising traditionally stops short of the body. Furthermore, since the 1980s and the rise of the New Public Management (Ferlie *et al.* 1996), community care has increasingly been dominated by a managerialist discourse that stresses issues of efficiency and effectiveness, and focuses, in relation to home care, on allocation and targeting, and in which the day-to-day realities of low-level carework are overlooked. Managerialist discourse is itself notably disembodied, drawing on traditions like economics, accountancy, organisation and methods that prize abstraction and emotional distance. The body has little place in these analyses; indeed it represents just those qualities of embedded, messy, concreteness that such forms of analysis aim to transcend. Managerial accounts of home care are notable for their disembodied, aetherialising character. As a result, carework has largely been discussed in terms that sideline its character as bodywork.

The second reason arises from concerns within social gerontology, in particular the desire to combat an excessive focus on the body and its decline that is characteristic of the biomedical model that dominates both professional and popular accounts of ageing. In this model, older people are reduced to their bodies and their malfunctioning. Ageist accounts in the wider culture often dwell on bodily failure, deploying crude stereotypes and humour to objectify and depersonalise older people. To emphasise the body as against the person is to diminish the individual, to lessen and reduce them as social beings. Good practice seeks to get away from this and to stress the person behind the superficial attributes of old age. Furthermore, social gerontology in its desire to distance itself from geriatrics emphasised the sociological, psychological and economic aspects of old age, handing the body over to the territory of bio-medicine (Katz 1996; Kontos 1998).

Just as social gerontology has been slow to take up the issue of the

body (with some notable exceptions like Öberg 1996 and Katz 1996), so too the new sociology of the body which has exploded over the last decade (Featherstone *et al.* 1991; Scott and Morgan 1993; Shilling 1993; Williams and Bendelow 1998), has been reluctant to apply its analyses to older people. With the exception of pioneering work by Hepworth and Featherstone (1991) and, latterly, Turner (1995), writing about the body has emphasised younger, sexier bodies. In part, this reflects the way the subject emerged out of feminist and gay theorising around the construction of sexualities and the status of the body in this, but the bias towards the young also reflects a more general bias in the representation and treatment of bodies in culture: it is not just in academic literature that older bodies are absent.

The literature on the body is also marked by the remnants of an older cultural conflict in which the body's worth and goodness is asserted against what is perceived as an enduring Manichaen strain in western culture. This discourse of the 'good body' is part of a wider 20th century secularising project in which bodily pleasure, desire and freedom are asserted against what is presented as a repressive past; and it has links with the postmodern presentation with the body as a site of consumption and pleasure (Featherstone *et al.* 1991). This consciously up-beat, positive emphasis, however, is ill-at-ease when faced with what I will term the 'negativities of the body' – dirt, decay, decline, death. Carework deals with just such negativities.

The third reason for the failure to emphasise the dimension of the body comes from the conceptual dominance of the debate on care. Much of the work on paid carework derives its central concepts from the mass of work on informal carers and caring that arose in the 1980s and 1990s (Finch and Groves 1983; Ungerson 1987, 1991; Lewis and Meredith 1988; Twigg and Atkin 1994; Parker 1993, 1994). But this literature in many ways distorts our understanding of paid carework. In English, the word 'care' is a notably slippery one that elides normative and analytic elements. Care has a warm and loving quality to it, and it is difficult wholly to detach it from this halo effect. Simply to describe work as carework takes it into a special realm of value. The word care also inevitably emphasises the emotional element in the work to the detriment of physical aspects. Conceptualising care in terms of informal care again emphasises it as embedded in interpersonal relations, in the feelings and emotions (often complex and conflictual) that make up family life. As such it is a diffuse activity that encompasses a range of help, support and interaction. Bodywork is not always part of this caring, and can be quite peripheral to it. The literature on care and carers has itself struggled with these difficulties, notably in

Graham's emphasis on caring as both labour and love, in Parker's distinction between caring and tending, and in the distinction of Ungerson and others between caring for and caring about (Graham 1983, 1991; Parker, 1981; Ungerson 1987). Thomas, in her analysis, however, concludes that there is no overarching concept of 'care' that can be used in an analytic way to conceptualise the activity across all settings (Thomas 1993).

It is noticeable that those analysts who approach the subject from the perspective of work and employment, present a different and, by-and-large, harsher account, in which carework is just another, low-level bottom-of-the-heap job (Bates 1993; Skeggs 1997; Lee-Treweek 1998). Lee-Treweek argues that feminist analyses, in presenting carework as an extension of domestic and family roles, fail to engage with the ways in which it is a work activity shaped by similar factors to those affecting other paid employment: pressure of time and production; dealing with recalcitrant materials (the bodies of the old); resisting formal definitions of the work. All three analysts present care as work that is physically hard and dirty, poorly regarded and poorly rewarded. Though bathing, washing and other forms of personal care are central to the day-to-day realities of carework, they have received little attention. Accounts of carework, for the reasons recounted above, have tended to play down these bodily aspects emphasising instead the social, emotional and interpersonal elements of carework, and avoiding direct reference to the less attractive aspects of the body and its decline. In this article, however, I argue for the centrality of these elements in carework, introducing the concept of bodywork as a means to foreground these aspects. At the end of the article, I will return to the nature of bodywork more generally, reflecting on the ways in which carework sheds light on this concept.

The study

I draw on a study I have undertaken of the provision of help with bathing and washing for older and disabled people living at home. In-depth qualitative interviews were undertaken with 30 older and disabled people, 34 careworkers and 11 front line managers. All names are anonymised. Eight of the interviews with careworkers were conducted in small groups; some respondents were interviewed both alone and in a group, some simply alone. Thirty-one workers were female, three male. They were employed by a variety of agencies: social services, voluntary sector and private. The research was undertaken in

two contrasting areas: a wealthy part of inner London, and a relatively deprived coastal area. The study is discussed more fully in Twigg (2000).

Bodywork in care

We now turn to the element of bodywork in care, exploring three dimensions in this. Carework involves dealing with human waste. Though workers manage these aspects, they do so in a culture that has become increasingly sensitised to bodily failures or transgressions; and I will argue why that is so. Secondly, carework involves negotiating nakedness, and I will suggest how access to ageing naked bodies poses questions for careworkers about their own lives and futures. Lastly, carework involves direct touch. Workers evaluate the touching element in their work in ambivalent ways that are carried through into their coping strategies. These coping strategies will be the subject of the second part of the article.

Dealing with dirt and disgust

Carework is about dealing with human wastes: shit, pee, vomit, sputum; and as such involves managing dirt and disgust. Miller (1997) in his analysis of disgust notes that it is the most visceral of emotions. The idiom of disgust evokes the sensory experience. Taste is the core sensation, mouth the core location and rejection via spitting and vomiting the core actions – actions reflected in our facial expression of disgust. Disgust is rooted in fear of contamination, whether directly through oral incorporation or touching, or more remotely through visual images or moral pollution. Societies vary in what they regard as disgusting or taboo, and in their overall threshold of disgust. Miller argues, echoing Douglas, that the more rule-dense a culture is around food, class, bodily comportment, the lower this threshold is likely to be. For Douglas dirt is matter out of place (Douglas 1966, 1970). It is a by-product of order and classification: where there is dirt there is system. Miller accepts this account, but argues that is insufficient to capture the element of squeamishness in our responses; and it does not allow for certain recurrences cross-culturally in what is deemed disgusting. Disgust, Miller argues, is rooted in the organic, and above all in the bodily. Disgusting things are slimey, oozing, slithering, moist, clinging; not dry, cold or hard. At its core, disgust relates to other people. Our capacity for self-pollution is limited; and it is other people's dirt that is of most concern.

If we explore the aspects of care that the workers found hardest to cope with, they clearly reflect the category system that Miller describes. Dealing with shit was recurringly identified as most difficult. Smell was also hard to bear. It had an all pervasive, stomach turning quality, and it lingered about the person:

Susan: Someone in a mucky bed, you know, you just – you can put all the protective clothing on, gloves, your plastic apron and everything, but you sometimes feel unclean.
Vicky: The smell stays with you.

Beyond that, individuals varied in what they found difficult. In one group of workers, Sharon described how she could not cope with teeth: 'Give me a dirty bum any day than teeth.' The other respondents chimed in:

Petra: Toenails is mine. I don't like them.
(all speak at once)
Val: Washing feet and legs when the skin is flaking off, that always gets to me.
Tracey: What gets to me is when they're coughing up phlegm and put it in a bowl.
(Groans all round)

Other interviews expanded on the list: 'one thing I can't do is if they need their noses blowing'; 'false teeth'; 'when you hear somebody being sick, you never get used to it, I don't think, anyway.' All share a common source of disgust in the category system recounted by Miller and Douglas. It is other people's bodies and especially the by-products of bodies, or the parts of bodies that are anomalously connected that are the main focus of revulsion.

Though such bodily disintegration has no doubt always been a source of disgust, Lawton (1998) suggests that it has become increasingly problematic in contemporary society. Modern individualism rests on the construction of persons as self-contained, bounded entities. Incontinence and bodily disintegration threaten this. In her analysis of the hospice, Lawton identifies a sub-group of patients, whom she terms 'unbounded', who by virtue of incontinence, smell or disfigurement cannot be accommodated either symbolically or practically in the community and who as a result are sequestered in their dying days in the hospice. Hospices, in containing such processes of dying, she argues, act to 'enable certain ideas about living, personhood and the hygienic, sanitised, somatically bounded body to be symbolically enforced and maintained' (Lawton 1998: 123). In the contemporary west, selfhood is dependent upon the possession of a

physically-bounded body. In other cultures and societies identity is more a relational concept; personhood is less fixed and individual, more fluid and permeable, and with this goes a different attitude to the body and its boundaries. In cultural contexts where people are not thought of as having a singular authentic identity mapped on to a singular separate body, substances emitted from the body are not seen as waste or dirt in quite the same way as they are in the contemporary western paradigm. This is why smell is particularly significant. It extends the patient's corporeality in such a way that intrudes and seeps into others' spaces. Odours by their nature cannot be easily contained; they escape and cross boundaries. This boundary-transgressing quality acts 'to threaten the abstract and impersonal regime of modernity' (Classen *et al.* 1994: 5). It runs counter to our modern world view with its emphasis on discrete, defined divisions and on individual privacy. Smell and disintegration undermine individualistic constructions of the person as stable, bounded and autonomous. Careworkers, in dealing with bodies, have to negotiate their way through these ambivalences and deal with aspects of bodily existence that modern society is reluctant to acknowledge openly.

Negotiating nakedness

Modern western culture provides us with few images of ageing bodies. The bias in the media towards youthful attractiveness means that images of older people are rare, and largely confined to a narrow set of stereotypical roles. Though modern society has become freer in its treatment of the naked body, it is only certain bodies that are permitted to be on show: slim, fit, toned and youthful ones (Bordo 1993). Older people are expected to keep covered up; and depicting the naked and ageing body is largely taboo. As a result for some careworkers, particularly the younger ones, the sight of old bodies was a novel and, to some degree, shocking experience. Sophie found seeing old people naked: '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'. She was surprised at the variety of ageing:

> they're so different. Some of them I think they're not […] so different. They're old and they look different from me but I don't know why, what is different, cos they weren't that saggy or that wrinkled or whatever. Whereas some of them if they've got arthritis, they get very twisted and some of them really are very wrinkled. […] I think people age really differently.

Zara also found naked old bodies a bit of a shock, particularly:

like you know, vaginal area and they don't have any hair or it falls off and then you're seeing the whole thing for what it is, you know. That's the only thing that really surprised me really. That's it, cos I just didn't think that hair would, you know, fall off there, and the breasts saggy, you know, and really sag and stuff.

It was noticeable how as a young woman her comments focused on sexual areas. In contemplating old bodies, she implicitly reflected on her own body and on issues of sexual attractiveness and its demise. 'It was a shock how, you know, I look at a person's body and say gosh their body was like mine and look what it deteriorates to'.

These encounters with bodies bring workers face to face with the realities of ageing, and present them with a vision of their own future. For some of the younger ones, ageing remained a mystery, something that was hard to grasp and that did not by and large directly impact on their lives. For them the distance between the ageing bodies of their clients and their own bodies was too great to contemplate. Many experienced old people as a fixed category – as if they had always been old – and though they knew intellectually that they had once been young, they found it hard to grasp on an emotional level. The one thing that brought them up short were the photographs. Joshua described his feelings on looking at these:

they'll show you their married pictures in their younger days, how they used to be, you know you think, oh this man was a soldier, he was an RAF officer or so energetic. And now here he is and I have to bath him, he has no more strength. Am I going to be like this too when I get old, you know? You think of all those things [...] it worries me.

The older careworkers identified more directly with the ageing process and its impact on their own bodies. But it offered a glimpse into a personal future that was discouraging and unwelcome, and many chose to push such thoughts away.

Bodywork as touching work

Part of the intimacy of carework is that it involves direct skin-to-skin contact with older people. Sophie was surprised by the impact of this on her:

it was really weird when you feel the skin. Sometimes you budge them with your arm and you feel their skin, but actually to feel someone's skin it's quite different than having the gloves over your hand. It's *much* more intimate.

For Stella, a young careworker influenced by New Age ideas, touch was an important element in the work, part of a deeper form of relating that

lay below the level of words. She enjoyed the close intimacy that hands-on work gave; and in her account she described the process of bathing in terms of creating a silent space, of a contact below and beyond the verbal. For her, this tactile level existed in parallel to the ordinary world of conversation. She described the bathing process as:

> Peaceful. It's kind of entering, it's like entering an inarticulate space and it's just like being there with somebody and sharing that intimacy and cutting through the chaos of every day. It's like everything stops you know, I mean, because there is just a certain ritual pattern of how things have to be in order for a bath to be accomplished.

Stella was unusual in her open articulation of the importance of touch. Many of the careworkers did not emphasise this dimension in their accounts. By and large, they did not see personal care as a route to greater closeness, indeed some saw it as a barrier. Roz: 'it's a bit more *personal* [said with a negative emphasis] than giving somebody a cuddle'. Such intimate touch could disrupt friendship, and many careworkers had ambivalent feelings about it. Bodycare was seen as something that was by its nature transgressive: that needed to be done, but that was not viewed in a straightforwardly positive way. Careworkers made a distinction between this intimate touch and emotional closeness. In general they were warm and tactile in their responses to clients, but they preferred to emphasise the social touch of cuddles and kisses, rather than intimate bathing help, as a route to emotional closeness.

How do careworkers cope with bodywork?

Workers get little help in managing these aspects from their employers or from the wider culture. Bodywork is on the borders of the taboo. All cultures have patterns of belief and practice which govern and proscribe behaviour relating to the body. In the west, our way of dealing with the body, sexuality, dirt are to take them into a privatised context that makes them relatively inaccessible to us as a subject for social enquiry (Lawler 1991). There is little or no public discourse of the body and its functioning. It is rarely referred to directly beyond the world of childhood, intense intimacy or crude jokes. The body occupies a territory where language itself becomes problematic, awkwardly polarised between the medical-clinical and the vulgar-demotic. Lawler notes how nursing texts are coy about what the basic work of nursing entails. It is regarded as 'obvious', and the actual embodied reality,

either glossed over or fragmented into a series of what are termed 'personal care deficits'. In this way the body and its embarrassments are rendered safe, abstract, subdivided and scientific.

Social care managers in the bathing study employed similar distancing techniques in their discourse, referring to 'personal hygiene work'. Diamond in his vivid ethnographic account of becoming a nursing home aide recounts the difficulty such evasions can pose for new workers. In California, aides are required to receive training, but their male trainer was an ex-nurse and, keen to professionalise the area, emphasised medical knowledge (the student aides were forced to struggle with anatomy) and technical language ('Don't say touching, say tactile communication') (Diamond 1992: 26). Soiled linen was to be 'thrown away', in other words sent to the laundry, but before this could be done the shit and vomit had to be scraped off, a process obscured by his dismissing, distancing language. Despite such 'training', Diamond found himself wholly at a loss when he arrived at the nursing home to be faced with a patient mired in his own shit. Careworkers are on their own in these areas, their practice is rendered invisible, something beyond the limits of official discourse.

To some degree careworkers concur in this implicit valuation of their work. In describing their work they tended to play down the aspect of bodywork, and to emphasise 'care' instead. Though it is the body element that marks personal care off from mere domestic cleaning (something that careworkers feel they have moved above in terms of status), it is not the element that they stress. Rather they emphasise the emotional and interpersonal aspects, and the skills required to negotiate and maintain these. As Abbott (1994) comments, home carers are one of a number of women workers at the bottom of the pile competing for worthwhile work; and stressing the element of care is part of this. The emotional, interpersonal side of the work is also the most enjoyable and personally rewarding for most staff, and the part they want to bring to the fore.

As part of this, careworkers were sometimes circumspect when exposing the realities of their work to public view, as the following exchange illustrates:

> Interviewer: How do you find dealing with that [shit], is it difficult?
> Jay: *Interesting* (laughter) – it depends where they put it!

Her use of 'interesting' was partly irony but it also contained a sense of guarded constraint in exposing these aspects of the work. As a colleague added:

> Pat: They all guess, they all know the sort of job you do, don't they –

Jay: That's right.
Pat: I mean you don't go into details, but they just – I mean different people say: 'Oh, I couldn't do that'.

Bates and Lee-Treweek report a similar reticence among careworkers in exposing the realities of their work to the wider world (Bates 1993; Lee-Treweek 1998).

Mostly, careworkers accept that dealing with shit is part of the job, and that they have to buckle to and suppress any sense of disgust:

When Mrs Jones isn't quite so well one day, and you've got diarrhoea from the toilet to the front door, you know. You've got to be able to have a bit of a stomach for the job to actually be able to clear that up.

Some workers internalised the situation and managed their feelings by thinking themselves into the position of a recipient of care. Others consciously reordered the client as a baby – sweet, innocent of intent in making a mess, and vulnerable. Though such techniques could help the worker, they underlie the general infantilisation of older people. Some workers saw dealing with dirt as part of women's inevitable role in life, linking it back to motherhood: 'true there is some dirty aspect of it, but as a woman, you know, you don't bother'.

Avoiding direct language is one of the techniques deployed by careworkers in negotiating the body taboos. Careworkers described how they chatted away on the surface while getting over the more difficult or embarrassing aspects in silence. In this way naming the unnameable could be avoided; and language was used to distract and ease rather than to express. Jokes were also a useful distraction.

Susie: If you have a joke with them.
Moira: You get things done.
Susie: You're getting it done before they realise because they're busy laughing.

Humour was a means of coping, both for themselves and the client:

We joke – I joke, specially if you're actually washing them and they start having a motion and, you know, you say: 'Oh, we've got a surprise here – one minute!' You know, but you just, you can't do it any other way really.

The body and humour are closely linked: dirty jokes, sexual innuendo, 'lavatory' humour – the body is the focus of all these. Mulkay sees discordance and incongruity as at the heart of humour; jokes occur where the single vision of the serious, official account is disrupted by the intrusion of other parallel interpretations and realities (Mulkay 1988). Douglas (1975) similarly sees jokes as generated by ambiguity in the social system. The body is a ripe source of this, partly because in

Douglas's system, it is the symbolic embodiment of the social order generally, and partly because there is an inevitable discordance between the aspirations of formal social life and the desires and failings of the body. The more formal the occasion, the more embarrassing or humorous the body's lapse. In the case of carework, joking was largely used as a means of easing situations that were otherwise embarrassing.

Sometimes, however, the joking was less kindly. In one or two of the group interviews where respondents were more at ease and less concerned to present an idealised account, a different, harsher, tone emerged, one of black humour in which 'horror stories' were shared as part of a collective release of feeling in which the solidarity of the workgroup was asserted. Mostly these related to sexual incidents, but the disgusting habits of clients were also recounted. Desirée joked how some of her clients were obsessed with their bowel functions, demanding that the workers give them suppositories: 'one morning he had two and it wasn't working and he wanted me to put my hands up there and help it along. I told him, no way, I'm not doing that.' The group, continuing the vein of black humour, went on to recount other such cases:

> Desirée: And Mr Jones, he takes medicine every single night, to go, so in the morning you sit him on the commode and he has to, you have to be there 'til he's done something.
>
> Lara: Yeah and he must have a look at it.
>
> Desirée: Yeah, you have to show it to him. Honestly! If you throw it away without him knowing, there's a big argument [talking in background] He'll say, half, quarter or a full load. Every morning, that's what I'm faced with at nine o'clock in the morning, every single morning.

Workers do not necessarily lose their sense of disgust or their underlying feelings of resentment and anger at what they are required to do. These were predominately black workers caring for upper-middle class white people, and the interview was shot through with tensions in relation to race and class that were reworked into bodily expression. In these more transgressive interviews elements of disgust were not hidden, but used against clients.

Bounded intimacy

Carework has a curiously intimate character to it. Direct physical contact, access to nakedness and the sharing of bodily processes are all powerful mediators of intimacy, containing a capacity to create

closeness and dissolve boundaries between people. We noted earlier, in the discussion of massage and prostitution, the ambivalences this can create in the bodywork sector more generally. In relation to carework, though some form of intimacy is written into dynamics of the exchange, it is not one that is necessarily sought or welcomed. This is most obvious from the perspective of the cared-for person who in accepting body care is required to enter into a relationship of physical and personal exposure that is often unwelcome. But it applies also in reverse to the careworkers themselves who can find the emotional and physical closeness of carework something that they want to resist. The process was most obvious in relation to the emotional aspects of carework, but it has a bodily dimension also. Careworkers can find the physical intimacy of care too strong, and they sometimes take steps to maintain bodily distance. Roz reflected on how she found washing a person in the bath, where there was a barrier provided by the side of the bath and the water, easier than the more intimate process of getting them dry where contact was more direct and involved the whole body:

> I think that part of the bathing is more embarrassing than actually being in the water […] if you're drying somebody you're drying them all over […] if somebody's sitting in a bath you're usually standing or kneeling by the side of them, when they're out of the bath they're actually usually standing up and I don't only think it's touch 'cos touch can be in the bath, I think it's that, it's more likely a physical contact and nothing between you, you've got the side of the bath, you've got the water in the bath, you haven't when they're out of the water and they're holding onto the sink or whatever, it's you and that person.

The desire to put limits on the physical intimacy of the work arose most strongly in relation to the negativities of the body. Careworkers have little or no symbolic protection against the polluting nature of their work, unlike nurses who are traditionally invested with a special purity in managing the body and who are able to draw on their quasi-religious status symbolised in the habit-like uniform (Littlewood 1991). Careworkers by contrast do not, by-and-large, wear uniforms and their presentation is homely rather than distant or professional (something incidentally that the clients liked). One way in which they do protect themselves is through the use of gloves.

Gloves

Nearly all the careworkers in the study used gloves when bathing clients, and most of the agencies required this. At the simplest level gloves protected workers from some of the less attractive aspects of the

work: 'it's nice not to get somebody's faeces under your fingernails'. However, the gloves clearly had other, more symbolic meanings, that went beyond the rationale of hygiene. They provide an example of the processes explored by Douglas (1966) in relation to food avoidance whereby 'modern' scientific explanations in terms of hygiene are used to explain practices that have their roots in social categories and symbolism. Gloves were used by workers to protect themselves from the full intimacy of bathing work, and to put up a barrier of professionalism between the client and the worker.

Sophie a young worker in London reflected a complex of feelings she had about using gloves:

> When they first said we had to wear gloves, I kind of thought, you know, that's a bit weird sort of thing, a bit, I don't know, I didn't, I thought the clients might feel funny that we thought they were dirty, that we didn't want to touch them sort of thing, but when [the manager] explained it to me why we wore them then I thought it was ok and when it came to actually doing the baths and having the gloves I was really glad to have them on.

She went on to reflect on the intimacy of direct skin-to-skin touch:

> its much more intimate and I suppose, with men in particular, I think it's quite appreciated to wear, I appreciate wearing them [...] you know they might get into it having a nice girl rubbing their back with bare hands [...] Having the gloves, it's kind of like wearing a badge saying: I am here for a reason, this is what I'm doing. I'm not just here with you naked, washing you [...] I felt better about it.

Sophie's feelings were fairly typical. Gloves operated as a mark of professionalism and distance; they underlined the limited character of this kind of touching; and they protected the worker from a contact that was too direct and too intimate.

Gloves bear a symbolic charge, evoking a sense that the person being handled is contaminated or subhuman. Putting on gloves, protective clothing and masks are all part of the repertoire of frightening, symbolic acts. The use of gloves has been particularly emotive in relation to people with AIDS/HIV; and when the New York police drew on the gloves to deal with gay demonstrators, the messages were strong and clear, and 'take off the gloves' became a rallying call for activists. Some of the sense of this symbolism was caught when one careworker recounted an incident when she and another careworker had gone in to an elderly woman who was not expecting them, and who usually had a cup of tea before her bath, but when she saw them come in drawing on their gloves and aprons, became upset and disturbed. The story conveyed some of the visceral response that putting the

gloves on can evoke: nightmare images of being taken away, or of being dealt with in a frightening alienating way. Careworkers are aware of these aspects and some, as a result, felt guilty about using them.

We now turn to the ways in which carework illustrates recurring themes in an emergent category of bodywork.

Carework as hidden 'dirty work'

So far we have discussed carework as dirty work in the obvious sense. But carework is 'dirty work' also in a second, sociological sense. The term was developed by Hughes and others to cover degrading tasks that are integral to society, but that society does not want to acknowledge, and are by common consent hidden. Emerson and Pollner (1976) extended the term to encompass aspects of the job that are shameful, disliked or counter to the self-image of the worker; and they cite getting rid of the drunks from the psychiatric clinic as an example of the 'dirty work' of mental health nursing.

Dirty work is managed by society through a variety of strategies: by delegating distasteful tasks to lower level staff; by hiding the activity from view; and by otherwise bracketing off the work mentally and socially. The treatment of bodywork illustrates these themes. In nursing, for example, the basic bed and bodywork of the ward is commonly delegated to the most junior staff – trainee nurses or auxiliaries – and as nurses rise up the hierarchy they move further from the shit and vomit of illness and from directly handling the patient. In a similar way the bodywork of personal care in the community has increasingly been transferred out of the nursing sector into that of low-paid untrained careworkers – the staff that have been the subject of this study. Cost reduction is the principle driver behind this transfer, but it also represents a recurring pattern whereby dirty work is transferred down the occupational hierarchy.

Dirty work is also managed by hiding it from view. Much bodywork takes place out of sight and in the back bedrooms of institutions. We owe to Lawler and her pathbreaking analysis in *Behind the Screens* (1991), the important perception that this work is obscured not only to protect the privacy of the patient, but also the status and public esteem of the worker. Bodywork is potentially demeaning work, and nurses go offstage to perform it. It can involve inflicting embarrassing or painful procedures; and this needs to be hidden if the image of the nurse is to be maintained. In a similar way Lee-Treweek's account of careworkers in a residential home shows how aspects of the work that are at odds

with the caring image are managed spatially by being confined to the privacy of the bedrooms (Lee-Treweek 1994). It is here that the basic work of washing, ordering and at times disciplining residents takes place. This 'dirty work' of care is hidden in order that the institution can display the 'product' of its caring regime in the form of the 'lounge standard' resident. Carework in people's own homes requires less in the way of such spatial stratagems, since it is by its nature more hidden. But as we have seen, careworkers tend to play down this aspect in public accounts of their work.

Fundamentally, carework is hidden work, 'dirty work', because it deals with aspects of life that society, especially modern secular society with its ethic of material success and its emphasis on youth and glamour, does not want to think about: decay, dirt, death, decline, failure. Careworkers manage these aspects of life on behalf of the wider society.

Bodywork as work of low esteem: the dematerialising tendency

Bodywork is, in general, low status work. There is a recurring pattern whereby as an individual or an occupation rises in status, so it retreats from direct body contact. The roots of this 'dematerialising' tendency lie in a deep set of cultural assumptions about the relative statuses of the body and the mind, and of work that concerns each. This produces a tendency for status in employment to be associated with distance from the bodily. Carework is a low-level occupation that is badly paid, with poor terms and conditions. People who do it tend to have limited purchase on the job market; and it is differentially performed by women and people from black and ethnic minorities (Feldman *et al.* 1990; Ford *et al.* 1998). Though often lauded, it is, as Skeggs and Bates show, poorly regarded, demeaned work (Bates 1993; Skeggs 1997). The body element is part of this. Careworkers in their presentation of their activities stress the emotional, interpersonal aspects of the work. As we noted earlier, though bodywork is what marks care off from domestic cleaning, it is not the aspect that they emphasise or value. Its character is too ambiguous.

Bodywork as gendered work

Resonating through the concept of bodywork is the issue of gender. There is a complex set of reinforcing influences that together construct

bodywork as female. First, these are tasks that are naturalised in the bodies and persons of women. Women have traditionally represented the Body in culture (Jordanova 1989; Lupton 1994). They have been presented as more bodily than men, bound up in and defined by the processes of reproduction, and prey to the shifting tides of emotion. Women also represent the Body in terms of male desire, the form of desire hegemonic in culture. They thus come to represent sexuality itself, something that can be controlled through the control of women's bodies. Confining desire (at least in its legitimate forms) and the needs of the body to the domestic sphere allows the public world to be constructed as disembodied, rational and male. Bodywork is also intimately linked with women's bodily lives through motherhood and nurturance. Because women do this work for babies and children, these activities are generalised as female. Ungerson (1983) has suggested that the association of women with bodywork and in particular with dealing with body wastes reflects a wider sense of women as polluted. Women, she argues, are assigned by culture to deal with these matters because they themselves belong to the realm of the body, its fluxes and wastes. Presenting carework as natural for women also reinforces the perception of it as unskilled. As such, it does not require training or qualifications, nor justify the better wages that skilled work traditionally enjoys.

Though bodywork is poorly regarded in terms of pay and employment esteem, it is also often extravagantly praised, particularly by men who do not have to do it. Home helps, like nurses, are traditionally described in glowing terms, and this often includes a sense that the speaker could not – *i.e.* would not want to – do this work. There are similarities in the way in which mothers and housewives are presented in conservative discourse: their work is sidelined, lowly regarded and unsupported, and yet at the same time presented as of supreme value. Porter (1992) presents this in terms of the patriarchal feminine which, while seeming to value and praise female work, in fact reinforces female subordination.

Bodywork involves reasserting order, restoring the person to the desired state. Like housework, it is a tidying process that is only visible in its absence. As such it is one of a range of female jobs found at the bottom of organisations which, through their assisting and tidying up function, allow the work of higher status, male occupations to go forward. Secretaries – office wives – are a classic example of this (Pringle 1989); though the gendered division of labour in health care illustrates it as well. Ward work, as Davies (1995) argues, is unbounded work. Nursing's role is to enable the 'masculine' work of medicine to proceed; and part of the definition of nursing is that it performs tasks

that medicine rejects, or fails or refuses to see. Women's work is here constructed out of the rejected and unacknowledged aspects of men's lives; and bodywork is part of this.

Lastly, women's association with bodywork derives from the greater freedom that women are accorded in their access to bodies compared with men. Hegemonic masculinity constructs men as sexually predatory; and limits are placed on male access to bodies, male or female (Connell 1995). Female sexuality by contrast is presented as passive, waiting arousal and more limited in its scope. This together, with the dominance of the maternal model, means that women are allowed greater leeway in performing the transgressive acts of bodycare without their being constructed as threatening or sexual, as might be the case with a male worker. There are, of course, male careworkers (and nurses) but they are in the minority and their practice is circumscribed. Male careworkers do not, by and large, give personal care to female clients, at least not in their own homes (practice in residential settings is less circumscribed). Female careworkers by contrast are culturally sanctioned to do this work for both men and women. Carework is female gendered work even when performed by men, in that the work is constructed around gendered assumptions about women. It is, however, the job that is gendered, and this need not always conform with the gender of the person who does the job. (The work of male careworkers is discussed more fully in Twigg 2000.)

Conclusion

In this article I have argued that bodywork has been a neglected element in the analysis of carework. There are a number of reasons for this. Some relate to the historical emergence of social gerontology and to the particular dominance of the debate on care. Others are more deeply rooted in western culture and in the evaluation of the bodily, particularly those aspects of the body that run counter to modern preoccupations with autonomy and individualism. Carework is closely connected with the negativities of the body, and these are aspects that modern culture tends to shy away from, in analysis as much as in day-to-day life. I have argued in this article that the concept of bodywork is helpful in allowing us to recover these aspects for analysis. The body and bodywork are central to community care, and they deserve to be recognised more fully.

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