The spatial ordering of care: public and private in bathing support at home

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Abstract

Domiciliary care takes place in a special social space: that of the home. Focusing on the provision of bathing in the community, the article explores the spatial ordering of care at home, unpacking a series of interlocking contrasts between the public and the private, and their consequences for the power dynamics of care. These are explored in terms of the ideology of home; the spatial ordering of privacy within the home; and the treatment of the body. Carework trespasses on and re-orders these divisions. The article also explores the contrasting site of the day centre. Baths at day centres are private acts in public places, and in reversing the symbolism of home, they reveal some of the wider meanings of bathing.

Keywords: body, carework, home care, personal care, space, privacy

Introduction

Bathing and washing are private matters, commonly accomplished alone, in dedicated spaces within the home. The coming of disability disturbs these patterns of privacy, and may impose a new social ordering. In this article I explore the ordering of privacy within the home and its implications for the provision of intimate care. This is pursued at three levels. The first concerns the contrast between the private world of home and the public world outside. Domiciliary care takes place in the private world of individuals’ own homes. This has implications for both the recipient of care—in that formal service help has to come into the territory of their private life—and for the careworker—whose primary place of work is the home of another. At the second level, home is itself structured in term of privacy and intimacy, with certain areas remaining relatively hidden from strangers and associated more intensely with personal life. The bathroom is one such space. The article explores how the coming of intimate care affects this ordering. Lastly, the provision of bathing help involves transgressing customary social rules
concerning privacy and intimacy which themselves have a spatial dimension in terms of the body and of its exposure; and the article explores the social rules that attach to these. Throughout, contrasts are drawn with other significant sites of care such as residential homes; and in the last section the article examines the provision of baths in day centres, showing how such forms of bathing operate as a symbolic reversal of the values of home.

The shadowy world of domiciliary care

Though home is the principal site for the delivery of community care, it has remained under-theorised and under-researched. We know relatively little about the day-to-day lives of older people living at home: how they get by, how they respond to the difficulties and challenges that may face them, how they order and experience their lives. Home is shadowy territory for researchers.

There are a number of reasons for this. First and foremost is the norm of privacy itself. Studying the private poses inherent methodological difficulties. Home is private space and the mutual recognition of this puts up barriers between the researcher and his/her subject. To research private space is to disturb and even violate it. The subject of this research—the boundaries of privacy and the intrusion of care—finds its parallel in the process of research. At the simplest level it is hard to gain entry into people’s domestic space. It can only be achieved with their agreement, and even then the nature of the social encounter restricts the methodology, effectively limiting it—as in the case of this study—to interviews, the technique by which the respondent is most able to control the access of the researcher, and to draw a veil across certain subjects. The intellectual traditions that have had most to say about space, boundaries and the day-to-day ordering of life are those influenced by ethnography and social anthropology, but ethnographic and observational studies of older people in their own homes scarcely exist. Such studies as there are have largely been confined to institutional settings where access can be negotiated officially and where the presence of the researcher is sanctioned by the semi-public nature of the space.

Second, the absence of work on home care is the result of research biases that derive from the values of the service world. Most work on community care concerns the world of higher-status actors: policy makers, care managers, social work professionals. The nearer you get to the front line and to the lowly-trained, poorly-paid workers who actually deliver the care, the weaker the evidence gets. There is in addition a halo effect, whereby researchers are themselves ranked in terms of the people they research; and there is greater status in studying those at the top of the hierarchy—MPs, policy makers, senior managers (though these groups pose their own difficulties through their capacity to gatekeep or refuse access)—than in focusing on lowly-regarded social groups like domestic workers: female,
casualised and poorly paid. But it is of course a mistake to assume that the nature of what happens, the care that is delivered, is determined by those at the top. What happens at the front line, how that it structured, is of central importance.

Research is also biased by the scope and intensity of the service gaze. The more service-dominated an area is, the more we know about it and the more we attend to it in research terms. It is service provision that matters from the viewpoint of the policy world. As a result, we know most about institutionally based services and those where service workers are numerous and dominant. We know least about those services that are far from the gaze of the service provider, obscured in the private world of home. Part of the aim of the study on which this article is based is to redress these biases in research knowledge and to understand and elaborate more fully the world of home care.

The research study

The study explored the provision of help with bathing at home for older and disabled people. Funded by ESRC, it was based on in-depth qualitative interviews with both recipients and providers. Thirty older and disabled people and a similar number of careworkers and managers were interviewed. Care recipients varied in level of disability: some were effectively bedbound, others could move around to some extent, and few were able to leave the house unaided. Interviews were recorded and fully transcribed. Some of the interviews with careworkers were conducted in small groups. The careworkers were mostly, though not exclusively, female and 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. As a result the sample encompassed an unusual class range, including upper and upper middle class people, some of whom were or had been quite wealthy. The way class operated in the power dynamics of care, and its intersection with race and gender, is discussed more fully in the main book reporting on the project, Bathing, the Body and Community Care, which also contains a fuller account of methodology (Twigg forthcoming).

Public and Private

The first of the three spatial distinctions is that between the private world of home and the public world outside. Home is a complex cultural construct embodying both material and ideological aspects. Through its structures, it both embodies and produces social reality. A range of work, much of it phenomenological, has explored the social meanings of home (Sixsmith 1990, Gurney and Means 1993, Allan and Crow 1989, Lawrence 1987). Privacy is
a central theme in this. Indeed as Allan and Crow point out, the absence of
it is one of the most disliked aspects of living in hostels or residential homes
(Allan and Crow 1989). This privacy rests on a material affordance of
home: the capacity to exclude—to shut the door on the outside world.
Friends and relations who come to the house do so on a privileged basis as
guests. Restricting access to certain people and to certain times allows you
to conceal the ways in which your life falls short of the domestic ideal. This
relates to another aspect of home, which is its association with ease. As
Sixsmith observes to be ‘at home’ is to be at your ease (Sixsmith 1990).
Home is also a place of security: a haven from the possibly harsh world out-
side. For some of course, as Allan and Crow note particularly in relation to
older people, home can be a place of restriction and on occasion of abuse,
and for many women it is as much a place of work as of leisure, but for
most the experience is one of security, comfort and ease. Lastly, home is a
site of personal expression. The material and symbolic elaboration of the
home in the post-war period with the growth of DIY and home decorating
has underwritten the ethic of individualism, offering an opportunity for the
extension of the self in material surroundings (Crow 1989). For older
people, the objects of home can provide links with the past: who you are
and have been can be expressed in your surroundings and in the deployment
of possessions in them (Rubinstein 1989, Rubinstein and Parmelee 1992,
Belk 1992). Often home contains particularly significant memories in rela-
tion to a close loved one like a dead spouse (Sixsmith 1990).

Home is an almost universally recognised value in modern society and its
principal features discussed above—the ethic of privacy, the power to
exclude and the embodiment of identity—are highly significant in structur-
ing the care encounter from both sides. It is an ideology that is shared by
careworkers as well as older people. Workers regard their own homes in this
way too, so that rules of behaviour are part of the taken-for-granted reality
of their own social lives. The ‘power’ of these structures is thus deeply
embedded socially, and does not have to rest solely on an internalisation of
‘good practice’.

Careworkers in entering the home come as guests. ‘Like, I am a bit of an
intruder’, explained one careworker. They have to be invited in. Some care-
workers described the uncertainty of the first visit, waiting on the doorstep
wondering who and what lay behind the front door. Being a guest means that
you have to ask permission both to enter and to do certain things. Individuals
varied in their sensitivity about this. As one careworker commented:

You can walk into a place that’s like a palace and somebody will be very
free with it and just let you wander around. You walk in somewhere that
is in squalor and they’ll be very precious about everything you touch.

Workers are bound by the general social norms of not being over-inquisitive
or looking openly around and not going beyond limited permissions, partic-
ularly in the early stages of the relationship: ‘you don’t take anything for granted. I mean I wouldn’t just go and get towels or anything’.

From the perspective of the clients, receiving help means having to accept people coming into their homes. Responses to this varied, and class and gender were both relevant. Those with middle and upper middle class backgrounds accustomed in the past to having domestic help, in some cases servants, were unsurprisingly least concerned about the potential intrusion of careworkers. Sir Peter, a retired senior member of the services, interpreted the experience positively:

Interviewer: Do you ever mind all these people coming into your house?
Sir Peter: Not in the least.
Interviewer: So you never feel it’s a bit of an invasion of your—
Sir Peter: No, I was delighted.

Others did feel it an intrusion, though one that they had to accept as part of the cost of staying at home.

For some the very presence of a careworker in the home, particularly if unfamiliar, created a sense of unease. Mrs Sheils commented:

You have to sit and, you know, there’s a stranger in the house, and you feel, well, good they’ll soon be finished, and that will be it.

The ease of home had been disturbed by the presence of someone who is not a friend or relative, but a stranger.

Responses tended to reflect gender. The sense of intrusion was more strongly expressed by women, unsurprisingly since women are more closely associated with the territory of home, and more accustomed to controlling and ordering it. Mr O’Brien, an Irish working class man caring for a wide with dementia, was happy to hand over the space of the flat to the careworkers when they came to give his wife a bath and clean the flat.

Mr O’Brien: I get to know them very well, yes. Of course, when they come here they’re in charge of the flat, they’re in charge of the kitchen, they can help themselves to whatever they want. I make it quite clear to them that the kitchen’s there for them.

Interviewer: So you hand it over to them, as it were?
Mr O’Brien: Yes, entirely, yes, yes—oh yes, yes.
Interviewer: And that’s OK, you don’t feel they kind of come bustling in and
Mr O’Brien: No, no, no, no—no, they’re quite, quite good [used here as a positive emphasis]

For him, domestic territory was naturally female, and receiving help there in tune with normal gender expectations.
For Mr Young, however, the coming of help was an intrusion. He cared for a wife with MS and the steady progress of her disease meant that more and more of the space of the home was dominated by her care needs. Careworkers came and went all day. He sometimes had no sense of who would be in the house.

Interviewer: Do you ever feel that your house is a bit taken over by all sorts of people from all these agencies I mean,

Mr Young: Well sometimes, I hate it, it doesn't feel like my own house, I've never really settled here to be honest

As a defence he had instituted an informal reordering of the house, recasting the kitchen, where his wife no longer went, as an office-cum-sitting-room for himself; and there at least he was able to control the space.

The power of home

The ideology of home plays an important part in the power dynamics of care, endowing older people with an element of control, and making it possible in some degree to resist the dominance of careworkers and professionals. At the simplest level you can refuse them entry. You can tell staff to leave. There are a number of examples in the study where older and disabled people had effectively ‘dismissed’ a careworker or successfully asked that they should not be sent again. Though I would not want to exaggerate this aspect of control, it does ultimately rest on the capacity to exclude, the material affordance of home; and it is hard to believe that the exercise of these kinds of preferences and the control of staff employed would be possible within institutional settings where clients are no longer in their own home.

For community-based careworkers, their place of work is another person’s home. It is never fully their territory. This contrasts with the residential home where the space belongs not to the residents but the staff. It is they who are in charge; they who determine the rules. Significant areas of the residential home—offices, rest rooms, staff toilets—belong solely to them (Gubrium 1975). In the private space of home, however, workers cannot establish this sort of spatial exclusion and dominance. If anything, it is the other way round and it is they who have to ask permission.

It is the power that adheres in home that supports the often-observed pattern whereby it is easier to refuse medication or medical intervention if one is at home. In relation to maternity care, for example, part at least of the desire for home births comes from this sense of being in your own territory and therefore more able to resist professional domination. In a similar way, it is easier for people with mental health difficulties to refuse medication if they are living at home. In the days before community care, medication was
commonly imposed in the hospital, though in the absence of a ‘section’, there was no legal basis for this: the social setting was sufficiently all embracing and all powerful to override such considerations. The shift to home-based care has made such practices difficult and exposed their lack of legal sanction.

Home as the embodiment of identity is also central in the struggle of power. It puts a limit on the degree to which the individual can be depersonalised. To be depersonalised is to lose your name, your history, your identity; it is to be literally and metaphorically stripped, made subject to anonymous and collective regimes, the process classically described by Goffman in his account of the Total Institution (Goffman 1961). But at home, surrounded by your possessions—family photographs, pictures of yourself when young, holiday momentos, books—it is not possible to be wholly reduced to anonymity. In this context, it is hard for someone to be treated like a cypher, an object to be cleaned and ordered. The surroundings of home are therefore a powerful buttress to the individual. As one foreign-born respondent, Mrs Ostrovski, who had worked as a translator explained, personal possessions around you establish your social status. This is important because being dependant is depressing, and your possessions help you to maintain your sense of self. She contrasts this process with what goes on in hospital:

Mrs Ostrovski: Because maybe at home, when you are at home and around all sorts of rubbish of yours so they don’t think you are exactly, you know, bad you know, but in hospital you are just coming out of the crowd, you are aged seventy five—‘Yes dearie, yes darling, good show, jolly good.’ [mimicking a silly patronising tone]

Interviewer: Right, do you think having home around you makes a difference?

Mrs Ostrovski: Well yes I think it gives you the—it gives you, because to need somebody’s help, it’s already—you need to concentrate your strength not to go down, not to become depressed.

Later we returned to the theme:

Interviewer: You said something about all the things around you, and as I sit here I can see, you know, all these books and pictures and things.

Mrs Ostrovski: That gives you identity, as I say, and you are not at a disadvantage. I think in hospital you are at a disadvantage. You are just a nonentity who came from the street, you know, and you are treated as they please. […] Here you are not the one lost. The other person is coming
from outside. So you sort of speak, if we are talking of who is up and who is down, you are up. You are on your own ground.

This aspect of power and control was endorsed by the careworkers also. As a careworker commented, again drawing on the contrast between home and residential care:

them being at home they feel more confident. In their own surroundings. And it’s like, not saying that I am an intruder, but it does, like I am a bit of an intruder so I have to do things the way they want it done. [. . .] if they’re in the residential home I have to do for them what should be done and what I think is good enough for them.

Spatial ordering within the home

I now turn to the second set of contrasts between public and private. This concerns spatial ordering within the home. As Gregory and Urry argue spatial structures are: ‘not merely [. . .] an arena in which social life unfolds, but rather . . . a medium through which social relations are produced and reproduced’ (Gregory and Urry 1985: 3). We are familiar from a number of theorists with the ways in which domestic space is structured, and in particular how it is ordered along the public/private axis (Lawrence 1987, Pearson and Richards 1994, Allan 1989, Munro and Madigan 1993). Certain areas of the house are public areas, relatively open to strangers and guests; others are private, used only by those who live there. There is a privacy gradient in which halls are more public than sitting rooms, which are in turn more public than bedrooms. Though the exact nature of this ordering has altered historically, the basic pattern of public/private, Lawrence argues, has been present at least since the industrial revolution. He suggests that these public/private oppositions link to a series of other binary categories: front/back, clean/dirty, symbolic/secular, special/day-to-day, in which the parlour exemplifies the clean/front-symbolic/special and the kitchen the back/dirty/secular/day-to-day. Rooms upstairs are more private than down. Bathrooms are now located by preference upstairs, separated from other forms of washing and cleaning which take place downstairs at the back of the house. Disability and its consequences disrupt this traditional ordering, in some cases imposing a radical reordering. In this study, this applied most strongly to those who were severely disabled and lived alone. In two cases, this meant living one’s entire life on or in the bed, that had become the total living space. For others, it was more a question of skills that would enable them to continue living at home and to some degree order their space in a traditional way. Here the internal contrasts of private and public were by and large maintained, though somewhat blurred.

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Careworkers were relatively free to move between these territories. Part at least of their task was to assist the older person in maintaining the structure of what Goffman terms front and back stage (Goffman 1969). Careworkers here took on a liminal character working across the social boundaries: work in the bedroom and bathroom enabling the person to be presented clean and dressed in the sitting room. There was not always an audience for this, but it maintained morale and a sense of the proper structure of life. The presence or otherwise of a spouse or family member in the home was significant in the degree to which the traditional ordering was maintained. This was particularly significant if the other household member was a spouse, for here, as we shall see below, the ordering of the house was linked to the structured intimacy of the couple themselves.

I will explore these themes in greater detail by looking at two contrasting examples: Mrs Elster, where the order of the house was radically re-ordered around care, and Mr Hedges and Mrs Sheils, where the traditional order was strongly defended and maintained. Mrs Elster is totally bedbound. She lives, sleeps, washes, dresses on and in her bed. As she says: ‘I’ve been sitting here like this for six years.’ By the bed she has an elaborate set of tables on which are arranged all her needs: books, papers, pills, cushions. She has a stick to reach objects, and she also uses this to haul her legs up and manoeuvre them on to the bed when she wants to lie down. She has a chemical toilet next to the bed, and careworkers bring basins and cloths, so that the bathroom and lavatory are brought to her and arranged around her body.

Effectively, her life has been condensed around the bed. From this vantage point she commands the flat. She has extended her control even to cooking and gardening. She has food and plants brought to her and she chops and sorts them on a table, replanting pots and dicing vegetables.

I have the girls bring in on a large tray what is it left in the fridge, not milk and that kind of thing, but food, eatables, perishables and then I pick over that. Well now, I would say to them, oh yes do this you see and also I will have a, what’s the name, bread board and a small saucepan please.

She looks out into the basement space at the front of the high Victorian Italianate house and sees the plants and flowers. Social life is limited but she can wave at those neighbours who see her, though this only happens at twilight when her lights are on and the curtains are not drawn.

Maintaining this regime requires considerable mental effort. She has a complicated set of practices, and she orders herself and the flat closely:

Because my routine is a little bit like a plan you know, general’s plan of his army, got to do that, so we can do this, and if we don’t do that, then we can’t do that.
She constantly thinks ahead. It is by dint of this and her determination and courage that she has been able to remain at home for six years in such difficult circumstances. To do this she requires the help of careworkers, and they have to follow her directions closely. This can be a source of difficulties as they tend to resent such close ordering of their work:

They don’t like it, being told, although, I try and do it as nicely as I can. Like today I, somebody doing something and I, what did I say, on no not that, and she said [imitates someone making squealy niggly reluctant sounds].

Her immobility however enables them to escape, and they can use the space against her. She described how they hid in the kitchen, pretending to be working, while they called their friends on their mobile phones. They thus establish their own private territory of her flat, out of sight of her managing gaze.

Next to consider is the opposite extreme, where the traditional ordering of public and private was fully maintained and careworkers were closely limited in where they could go. This is most characteristic of situations where there is another family member living in the house. Mr Hedges and Mrs Sheils were the clearest example of this. Mr Hedges was disabled and lived in a rather dark housing association basement flat. A former hospital porter, he had come to Britain from the Caribbean in the 1950s. His partner, Mrs Sheils, was white. They both had a strong sense of the territoriality of the flat and of the parts of it that were private. As Mr Hedges commented: ‘This lady [Mrs Sheils] has two places don’t let nobody go—in the bathroom and her kitchen.’

This ordering of space even applied to close family like grandchildren. He did not mind a stranger coming in to help, provided they did not attempt to go anywhere they liked:

Mr Hedges: There’s certain place they can go, but certain place nobody, where I don’t like—in our bedroom or our kitchen or anything—no way—not even our own children do it.

When the careworker came to give him a bath, the clean clothes were laid out in the bathroom, so there was no need for the careworker to wander about looking for things in the bedroom, and he did not go into that space:

Interviewer: So you get your clothes out in advance, presumably, what you want . . .

Mr Hedges: Oh yes, my clothes is out, at the bathroom just before, hung on the door inside the bathroom—when I bath he can just take them up. So we have no problem there. Anybody want to come here can come, but they must know what their place is, because if they don’t, then they know where the door is.
Unusually in the sample, Mr Hedges was always dressed when the careworker arrived—most people waited in their night clothes—again part of maintaining normal life and its proprieties.

It was notable that this pattern even applied to John, the careworker with whom Mr Hedges was close. They had a lot in common, including the experience of being black and coming to Britain as young men, and they laughed and joked together. Mr Hedges spoke of him warmly as like a son, one of the few people in the study to use a familial model for the relationship. Even this closeness, however, did not erode the structures of privacy, and John did not move freely about the flat.

Much of the strength of these structures related to the fact that Mr Hedges and Mrs Sheils were a couple. This capacity of couples to assert their privacy against helpers and professionals is an added dimension of the power of home. As we have noted, home is a power base for older disabled people containing both ideological and material resources that can underpin their independence and power of determination. This is strengthened in the case of couples who are better able to assert their privacy against the intruding eyes and judgements of workers and professionals. (This barrier applies also to the process of research itself. It proved hard to ask questions about intimate care in the presence of the other member of the couple. To do so became a violation of their own privacy and the partner typically put up a barrier that was not present when the disabled person was interviewed alone.) This is one of the reasons why couples pose difficulties for institutional care. A number of studies have noted the way institutions discourage the development of any physical relationships between residents (Wilkin and Hughes 1987). In large part this arises from negative attitudes to sexuality among the old. But it also reflects a recognition that the existence of a sexual, marital relationship creates a territory of privacy into which workers feel it awkward to intrude. The bedroom of a couple is private in a way that no other resident’s can be. Although in theory single residents have their own private space, this is in practice constantly trespassed upon. In the case of a couple, however, the dominant norm is sufficiently strong to create unease and embarrassment among care staff and managers.

The body in space

Seeing the house in a fixed sense, as embodying gradations of privacy and public access can, as we have seen, be fruitful. But the approach has been criticised for presenting an over-formalistic and static account of social relations within the home. Gurney (1998) questions the overspatial concept of privacy it implies, with certain areas of the home presented as public or private in fixed, determined ways, arguing for a more complex categorisation that draws on the additional dimension of corporeal vulnerability. Privacy, he argues, inheres not just in spaces but in the body and the self (1998). The
public and the private need therefore to be reconstituted around the body and its vulnerability; and the presence of the body and its state can determine the ordering of space. Such an approach is particularly relevant in relation to the private space of the bathroom.

The bathroom as private space

Washing and bathing in the modern home take place in a dedicated space: that of the bathroom. Bathrooms emerged as specialised spaces in bourgeois homes in the 19th century, spreading down the social scale in the 20th until by the post-war era they were a standard feature of all new and most older housing (Bushman and Bushman 1998, Swenarton 1977, Wright 1960, Gideon 1948). Since the 1970s there has been a growing elaboration of bathroom provision in the home. The increasing use of daily or frequent showers and baths as the predominant method of getting clean, as opposed to earlier techniques of strip washing, has resulted in more elaborate bathing provision. It is now commonplace for larger newly-built houses to contain two or three bathrooms (Chapman and Lucas 1998). People appear to be increasingly unwilling to share communal facilities; and hotel bedrooms of even a modest character now have en suite facilities. Wiles’s (1993) study of women’s preferences for private as opposed to NHS hospital care found that not having to share a bathroom or toilet was an important factor for respondents. Gurney (1998) and Chapman and Lucas (1998) all argue that expectations of levels of privacy around washing, bathing and excreting are increasing, suggesting that Elias’s Civilizing Process may still be advancing in this area (Elias 1978).

The meaning of the bathroom is also shifting. No longer just the small utilitarian spaces of the past, these new bathrooms are increasingly presented as places of luxury and bodily pleasure. In the imagery of house sale promotions, there is a clear eroticisation of the ensuite bathroom attached to the master bedroom (Chapman and Lucas 1998). The emphasis on frequent showering and bathing also links to modern preoccupations with secular regimes of body purification and control, exemplified in dieting, exercising, weight training (Featherstone 1991, Shilling 1993, Lloyd 1996). The elaboration of bathroom goods, cosmetics and treatments that focus on the whole body (as opposed to just the face and hands), point to similar developments. There are further parallels in the marked modern preference for regimes of eating that favour light, pale, raw, vegetarian foods (Twigg 1983, Bordo 1993, Lupton 1996). Modern preoccupations with washing and hygiene are thus part of wider social changes associated with the body in post- or high-modernity (Featherstone 1991).

Within the spatial ordering of the home, the bathroom is semi-private space—less personally private than the bedroom, but still part of the semi-private upstairs zone. Strangers may ‘visit’ it but only on licence. The pri-
vacy derives partly from temporal factors relating to the way in which the home operates during the periods of time (for example bedtime) when strangers are not present. (Spatial ordering has its parallels in temporal ordering; and indeed Urry (1996) argues that the two are rarely distinct in the modern world. The temporal ordering of care is discussed more fully in Twigg (forthcoming).) It also derives from the bodily privacy that bathrooms imply, what Gurney (1998) referred to as ‘corporeal vulnerability’. Bathrooms are the one room in the modern house that has a door lock. People using them either do so alone or in the company of close intimates.

We now turn to the use of the space of the bathroom by clients and care-workers. Careworkers in managing bathing have to negotiate their presence in this ambiguous space. Some careworkers consciously maintained an aspect of spatial privacy for the client. One worker would deliberately go out of the bathroom and wait in the hall, allowing the older person to retain some of the sense of being at their ease and alone:

[I] put them in the bath and leave them for a while [. . .] try and just come out of their sight, so they can relax, you know. Or just stand outside the bathroom and then ask them if they’re ready. When they say they’re ready, just go back in.

One older woman made a clear spatial distinction between careworkers who were strangers and whom she preferred to stay outside the bathroom within call, and those whom she knew and classified as friends, whom she would allow to sit with her.

The spatial ordering of the body

I now examine the third level at which public and private are spatially ordered: that of the body. I will not attempt in this article to give a general account of the body and its management in the process of bathing: that is explored more fully in Twigg (forthcoming). Here I will simply note the ways in which the body is itself arranged spatially according to gradations of privacy.

Work from the 1960s established how touch in relation to the body is structured according to gradations of intimacy and power (Jourard 1966, Jourard and Rubin 1968). Different parts of the body may be touched by different people according to the closeness of the relationship. Upper arms and thighs are relatively neutral and may be touched by most people. Knees and thighs less so. Breast and genitals are off limits in all but erotic relationships. Touch is also related to power and status with the more powerful touching the less powerful (Henley 1973). This pattern is sometimes used to explain the gendered pattern of touch with women more likely to be touched than men, thought there may also be factors connected to the
greater emotional and bodily expressivity of women's lives. Men are more likely to regard touch in a sexualised way, or to interpret it negatively in service context, associating it with an unwelcome form of dominance something they are socialised to reject (Sussman and Rosenfeld 1978, Whitcher and Fisher 1979).

In terms of the bodies of older people, everyone in the study recognised this structured ordering of privacy. In nearly all cases, genitals were washed by the person themselves—a preference endorsed by both clients and careworkers. Clients were often openly glad that they had at least been spared that embarrassment or, as some saw it, humiliation. Careworkers were similarly reluctant to be involved in such intimate touch. They rationalised this by saying that nearly all clients could manage that much of their care and it was good to encourage independence. Attempts by male clients to get careworkers to wash their private parts were not uncommon and were treated as a form of ‘trying it on’. Careworkers had two categories of behaviour by clients that they regarded as unacceptable and exploitative, and this was one. (The other was treating the careworker as a servant.) Beyond this, touch in bathing was fairly free. Careworkers, unsurprisingly, focused in particular on the remoter parts of the body that clients found it hard to reach such as the feet.

One part of the body was however repeatedly emphasised by both clients and careworkers: this was the back. In the interviews the back was deployed metonymically to designate the whole body, and washing the back came to stand for the process of bathing itself. This seemed to present a more acceptable way of talking about an otherwise intimate process. In the hierarchy of touch, the back is not a sensitive area; it is somewhere, in conjunction with the upper arm, that can be touched in a relatively open way by most people. Touching the back, giving it a vigorous unrestrained wash—something reported with pleasure by many clients—putting an arm across the back, around the body, are thus relatively neutral ways for the careworker to make human contact. The back is also, in the nature of the bath encounter, the part of the body that faces the careworker and that shelters and hides more vulnerable and private parts. So the back can come to stand for the body and for the person, providing an opportunity for an intimacy and closeness that retains a certain neutrality about it.

Alien spaces: baths at day centres

I can now turn to the ways in which these ideas of public and private find their symbolic reversal in attitudes to bathing at a day centre. The idea of having a bath at a day centre was almost universally rejected by respondents, often in vehement terms. For some the very idea was abhorrent, and for most it held little appeal. The reason lies in the themes discussed above. Baths in a day centre represent the reversal of all that gives domestic
bathing its meaning. Bathing at a day centre is a private act in a public
place. An activity that is normally undertaken in private, in the part of the
house that is reserved for the inhabitants, is transposed to a public space
where people come and go, and in a setting that would normally be
regarded as outside.

Part of the resistance to a day centre bath is dislike of the bother of getting
dressed and undressed yet again, and in a sample with disabilities this is a
serious consideration. But resistance to undressing is more than just the
inconvenience and effort. It is also about resistance to the idea of unwrapping
the self in a public place. Getting dressed to go out involves the preparation
of a street persona and presence. For some in the sample this presentation of
self was still important. Being able to put on a proper appearance was a sig-
nificant aspect of esteem and something worth working at. Mrs Maxwell who
had suffered very distressing and disfiguring operation scars said:

I don’t like my body any more, I don’t like anybody else to see it, but if I
can dress properly and, you know, and I can put stockings on and I’ve
still got decent legs and get away with it—but I know I’m getting away
with it, I know it’s not true—[. . .] a hoax, yes. But I can get away with it,
but a lot of trouble.

For another lady, having her hair in a presentable state, however disabled
her wheelchair bound body, was something that mattered when she went
out. Having a bath at a centre meant dismantling this public persona, and
not in the safe space of home.

Baths at day centres were regarded as semi-public acts. The space was not
secure and there was a sense of being on show. ‘You might as well sell tick-
ets’, as one upper middle class man commented disdainfully. Day centres
did not offer the security of home. ‘You don’t know what you are letting
yourself in for,’ he continued. They are busy places where people come in
and out. Respondents conveyed a sense of unease that they might be
intruded upon at any moment. As Mrs Hartley, a middle aged woman with
MS, said in contrasting a bath at home with one at the centre:

Mrs Hartley: It’s nice sort of privacy in your own home sort of thing, cos
I find a place like West House, doors don’t get locked
which, it’s a good idea I suppose, but people wander in and
if you’re laying prostrate on, with nothing on and the
doors opened and somebody, a total stranger’s standing
there, can be a bit, you know.
Interviewer: Yes, so its more, its nicer at home?
Mrs Hartley: It is, it is nicer at home yes.

In this uncertain context, it is difficult to relax. This is particularly impor-
tance because it undermines one of the primary potential advantages of the
centre. Day centre baths by virtue of their more elaborate equipment are able to offer people a 'proper bath', lying down, fully under the water, able to move with freedom and ease—something that is rarely possible even with help in the constricted circumstances of many private bathrooms. But if the social reality is one of unease, in which you get the process over as quickly as possible, these advantages are lost.

Day centre baths are found in a variety of venues. Some are provided in specialist health service units with white tiles, elaborate equipment and a technico-medical feel. Others, such as those in voluntary sector centres, can be more makeshift, but still with the feeling of the laundry room or utility space. Whatever the venue, there is an inherently clinical feel to them, with their pipes and drains, levers and hoists. This accentuates the alienating quality of the experience. The space is not domestic and comforting, it is medical and hard. As Mr Wagstaff commented: 'I'd rather go into a car wash'.

This mechanical quality was present also in the account of Mrs Hartley who had experienced a bath in a specialist centre, and she conveyed both the sense of vulnerability it produced and the alienating quality of the experience of being exposed and washed down in the shower trolley:

Well it's like a bath, it's in plastic and, well you're laying down you know what I mean, and they shower you on it and then its got a drainage hole one end [. . .] You feel a bit vulnerable cos you're laying flat on your back, but its quick, its quick and its thorough.

There is a sense here of making the person into an object to be cleaned, to be hosed down in the trolley. This alienating aspect is potentially present whenever people are taken and washed by others, but much less so in the venue of home, where domestic surroundings and personal associations tend to nullify the effect.

Lastly, for some the idea of a day centre bath itself suggested an unwelcome collectivism and a promiscuous social mingling. One well-off woman caring for an elegant 81-year-old mother (black leotard, gold slippers, white carpet, glass tables) reacted strongly to the idea of a day centre bath:

Daughter: I don’t think my mother would go to a day centre and have a bath—no way.
Interviewer: No, well that’s interesting to hear the view, because obviously everybody’s different.
Daughter: What! municipal bathing, is it?
Interviewer: No.
Daughter: It sounds dreadful to me.
Mother: That would be the last straw.

Shortly after, in the context of more general talk and after having mulled the subject over in parallel, the daughter interjects
Daughter: Listen, I don’t even have a shower in the gym when I go up—I wouldn’t dream of using the showers round there. They’ve just spent a hundred thousand quid on the place.

Interviewer: Really.

Daughter: I think it’s very demeaning to people when they get older to think that they don’t have their dignity and their pride and should suddenly be divested of all that because they don’t have the mobility or are unable to get around—I’m absolutely against that sort of treatment. It smacks to me of authoritarianism and I don’t like it, I don’t like it at all.

The daughter ran her own business and had strong private-sector values. The day centre bath for her represented an authoritarian collectivist ethic that she abhorred. Keeping oneself apart, especially from the low status social groups who used public provision, was important for her. Mr Wagstaff expressed similar feelings when he said in the context of day centre baths:

I’m not very potty about these public places, that’s why I never used to use swimming baths or something like that. I used to think I don’t want to go in there after all the small boys have gone in and piddled in it in the morning. Well that’s how it is. [. . .] I don’t really like using public lavatories.

As Douglas has argued, the treatment of the bodily margins—whether in relation to washing, excreting or eating—cannot be analysed in isolation from other margins (Douglas 1966, 1970). Comments about pollution, attitudes to dirt, anxieties about bodily mingling, are expressive of other, more social concerns. For some respondents, baths at a day centre operated in this context, threatening social exclusivity and undermining attempts to keep oneself apart from the polluting contact of the general public and its dirt. They represented the very reversal of the meaning of home with its ethic of particularity and individualism and its capacity to control and exclude strangers.

Conclusion

Domiciliary help needs to be understood in the context of the structured intimacy of home. I noted at the start of this article how the world of domiciliary care has remained a shadowy one. Part of the aim of this article has been to throw some light on this major site for the delivery of care, and to explore the social consequences that arise when disability disrupts the normal ordering of home. Home is about privacy, security and identity. It embodies the self, both in the sense that it is the concrete extension of the
self and in that it contains and shelters the self in its ultimate form of the body. Formal care services in entering this territory need to negotiate their way through these structures, transgressing boundaries and reordering social categories, but in ways that recognise the power that lies within them.

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Notes

1 I am grateful to the Economic and Social Research Council for funding this work under grant R000236731.
2 All names have been changed.

References


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