

It isn't something to yodel about, but it exists!

Faeces, nurses, social relations and status within a mental hospital

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Met behulp van etnografisch materiaal uit verzorgingsafdelingen van een psychiatrisch ziekenhuis laat de auteur zien hoe gevoelens ten aanzien van excrementen worden bepaald door de aard ervan en door de aard van de relaties tussen verpleegkundigen onderling en tussen verpleegkundigen en ouderen. De lichamelijke zorg en de emoties die zij oproept is verbonden met moraliteit en morele zorg. De omgang met lichamelijke en moreel 'vuil' geeft de verpleegkundigen in het hele ziekenhuis een speciale (lagere) positie.

[excrementen, walging, geringschatting, psychiatrische aandoeningen, verpleging, ouderen, sociale relaties, hiërarchie]

In an article on infantilization and the old body I discussed the relationships between the elderly body, care and disgust (Van Dongen 1997). Although the article's focus was not on human excrements *per se*, an important part of the ethnographic material presented data on this subject. My argument was that the disgust that nurses might feel for old bodies and the things that leave this body could be overcome by a positive infantilization.

In this article I focus on the theme of disgust and contempt in relation to body wastes and care. For several reasons, I mainly will focus on the nurses' work in wards for the elderly of a mental hospital. Firstly, the wards are excellent fields for anthropological work, because they are well defined spaces and thus well surveyable. Secondly, after I wrote the article on infantilization and the old body, a debate between the nurses and me started about my interpretations of their 'bed and body work'. This debate made me more aware of the complexities of the practices around the topic of this special issue: human excrements. So, I feel the urge to review my earlier interpretations with the help of the comments and discussions the nurses and I had on this topic (Van Dongen 1998). What is disgusting and contempting – or seems to be – outside a hospital or geriatric wards, doesn't need to be so within those places in the same way. A third reason is that there is little known about the experiences, feelings and definitions of people who have to deal with others' bodily wastes daily.

Writing about disgust is a tricky thing to do. Disgust has suggestive powers that work independently of the author. There always is a risk that the text will be interpreted

as a comic or a vulgar one. Although, as we shall see, the disgusting and the comic sometimes are interrelated, the subject of disgust is a serious one, because it is related to emotion, morality, care, personhood and love. Disgust is not disgust *sec*:

when it is operating in and around the body, its orifices and excreta, a world of meaning explodes, colouring, vivifying, and contaminating political, social, and moral orderings. Disgust for all its visceralness turns out to be one of our more aggressive culture-creating passions (Miller 1997: xii).

Disgust overlaps contempt, but also differs from it. Both are emotions that “assert a superior ranking as against their objects” (Miller 1997: 32), but disgust is an unpleasant feeling, whereas contempt doesn’t need to be so. Both are culture creating emotions, but contempt allows people to feel pity and politeness; disgust overwhelms these attitudes. Disgust is a culture-creating emotion, which has the essence of rejection of social contact (Miller 1993: 711). In contempt social contacts are maintained.

This article explores how disgust and contempt structure the social and moral ordering within the geriatric wards of the mental hospital, and discusses shortly how these emotions also play a role in ranking of nurses and creating hierarchy within the hospital as a whole.

How do things that normally disgust fit in?

Douglas’ well-known structural theory of purity and danger mostly is followed or referred to when one writes about ‘filth’ and ‘dirt’. According to her theory the polluting (Since Douglas does not write about disgust one might wonder if what she terms as polluting is similar to what Millers calls disgusting.) does not fit into the ordering structures of a given society and thus becomes anomalous. Dirt is not absolute, but a ‘matter out of place’. The idea often is that the concept of dirt and its place (if it has a place) on the conceptual grid of a certain culture and the process of producing dirt can be analysed in relation to social boundaries.

Although there is much truth in Douglas’ arguments, it is not the whole truth. Her theory of anomaly, and here I follow Miller’s argument (1997: 44-45), does well for explaining explicit classificatory systems, the object of the formal cultural systems, like the food prohibition rules she presents, but it doesn’t so well for the ‘daily hassles’ around ambiguous substances like bodily wastes in relation to health and sickness. Mostly, human excreta resist “being innocuous substances” (Miller 1997: 44). People are not free completely as to determine what is contaminating. Human excreta are so powerful that they make their own grids and will bend other grids to their own image. In Douglas’ theory it is the anomalous that contaminates. The risk of Douglas’ theory is a reduction and tautology: if something pollutes, it does not fit, if it does not pollute, it fits. Of course, there are things that are disgusting, because they do not fit. But most things that disgust, do fit. One cannot say that human excrements are anomalous; they are necessary conditions of life. This certainly is the case in the nursing wards of the mental hospital.

Kristeva (1982) describes abjection¹ as a mechanism which “disturbs identity, system, order. What does not respect borders, positions, rules. *The in-between, the ambiguous, the composite*” (p. 4, italics mine). The in-between, ambiguous position of human excrements is an important notion. They have their place in the wards, but they are ambiguous. They disgust, give pleasure, attack or repulse, they can be unhealthy, but also healthy. Human excrements have a powerful attraction “that bends social and cognitive structures along their lines of force” (Miller 1997: 44). It is not that they don’t fit; they fit at the bottom of a conceptual grid. Or, sometimes, higher in the grid, depending on the nature of their connectness with health. And what is more: when they disgust, they are overdetermined socially, culturally, morally and physically by meanings and never far removed from human (sensory) experience. The lowness on the conceptual grid does not mean that human excrements are polluting, as long as they are in their place; it is the threat of misbehaving, harm in the interpersonal sphere that make them ‘low’. This has to be understood relatively: if they are ‘out of place’, people can make them ‘fit’ into another place. This is the case in hospitals and geriatric wards, when people’s bodies are not able any longer to keep them in their place themselves. The place of excrements within the (sub)culture is redefined.

What is so peculiar to human excrements and disgust is their paradoxical nature. Disgust can attract and repel, because it violates the norms of decorum and modesty. Sometimes, mad people (and artists)² bank on this allure. The crucial opposition in disgust is ‘me’ versus ‘you’ or ‘we’ versus ‘them’, so disgust defines the boundaries between me and you or between us and them, and – what is more – it prevents that my way of being is subsumed into your way of doing. Disgust helps us to preserve our dignity. Disgust also involves love (because the disgusting can attract; often by its relation with vulnerability). It marks the boundaries between ‘me’ and ‘you’ or ‘us’ and ‘them’, but relaxing those boundaries marks intimacy, love, and care (Miller 1997: xi). This is precisely what is the matter in care for the elderly. Our boundaries are not defined by the limits of our skin. If this would be the case, it would be impossible for carers to do ‘bed and body work’, because this work involves a lot of contact ‘beyond the skin’. It would be alarming, dangerous and disgusting if elderly simply would be ‘them’ and not ‘we’, because many elderly come very close to their carers. If disgust marks the boundaries between ‘me’ and ‘you’, then disgust also depends on the degree of ‘me-ness’/‘youness’, on ‘opening up’ the boundaries between carers and patients. The delicate balance between preserving dignity on the one hand and intimacy on the other hand also is important. So, disgust is – like the place of excrements the conceptual grid of a culture – by no means fixed.

Excrements mostly do not pollute the nurses from an insider’s point of view. However, they are so powerful that their position equals the people who have to deal with them (Rozin et al. 1986; Rozin & Nemeroff 1990). Being a nurse in a nursing ward of a mental hospital is far less desirable (in other psychiatric nurses’ mind) than being a nurse in emergency psychiatry. This hidden “law of sympathetic magic” (Rozin et al. 1986) structures the hierarchy among nurses within the mental hospital. Here, disgust and contempt are closely related and mutually reinforcing (Miller 1997: 206).

The place of 'dirt' in geriatric wards

Although the composition of the population in the geriatric wards of this mental hospital presently is changing, most of the seventy-five inpatients are elderly women in their sixties, seventies and eighties. These women spent a greater part of their lives in mental hospitals and were transferred to the geriatric wards when they couldn't care for themselves any longer. They are what Goffman would call "hospitalised". They often suffer from a double burden: being mentally and physically ill. Their illnesses are by no means the same similar to each other: they suffer from schizophrenia, psychosis, mania, depression, but also from mental retardation or epilepsy. Many of them have to contend with problems of old age like dementia, Alzheimer and physical problems like incontinence. Some of them suffer from diabetes mellitus, heart problems, blindness, deafness, or cancer. Thus, the health situation of the elderly women is very complex and varied. As a result, the nature and intensity of care mostly is defined individually. In general, there is a particular focus on physical care. Bodily changes in old age with incontinence as a result mean that carers (nurses) continuously are confronted with the elderly's excrements. But in the geriatric wards, nurses also can be confronted with human excrements in other cases than incontinence. In madness, excrements are important means to communicate.³ Psychiatry acknowledge this by giving the 'obsession' or ways of dealing with dirt a place in its nosological system.⁴ Human excrements have their place on that conceptual grid. The place of the elderly's excrements in the nurses' job depends on the elderly's individual physical and mental health situation.

When I walk through the wards, I will not notice their important place immediately. The places where nurses have to deal with human excrements are situated (bathrooms, showers, elderly's bedrooms) along the sidewalls of the wards. When these places are not in use, doors are open and one can observe what is used to deal with 'dirt'. But when I spend my days in the wards, I observe that the places where nurses have to deal with dirt also change continuously. They are not limited to the 'sidewalls'. Places are re-defined too. They can be everywhere: in the living room, the hall, the corridors, the nurses' office, the kitchen, the coffee shop. Why? Of course, this is a matter of the elderly's loss of control over their bodies and body functioning. But the 'relaxed' way nurses deal with dirt needs another explanation.

The geriatric wards are considered as 'homes'. Elderly are not 'patients' nor 'clients', they are 'occupants' (residents). The 'home-philosophy' is stressed by management and nurses. The elderly, who lived many years in mental hospitals, feel at home (or have to feel at home). At home, one deals with excrements and orifices in a different way than one does outside the home. Home is the place where one takes an active interest in them, pride in healthy production, suffer, and where one also is anxious and disappointed when one 'fails' to produce in a proper way. Belching, farting, picking one's nose; this behaviour generally is more tolerated within the home. They even are common subjects of conversation, more than we generally admit. They are a matter of care and intimacy. This doesn't mean that they are not recognised as belonging to the disgusting, but they are a privilege of intimacy (Miller 1997: 132). As in the home, the body in the geriatric wards is defined as a more open body than in the public spaces.

The closed body of the public space is a body which can control its openings and – more generally – its affections (Elias 1978). For different reasons, the elderly's body cannot be controlled so easily, neither can their emotions. The nurses say that elderly need intimacy and personal contacts with the nurses, because they often are the only contacts they have. This also would mean that emotions, like aggression, dissatisfaction, anguish, disgust, love, are expressed, because it is believed that those feelings “must come out anyway”. This is a reference to the well-know hydraulic metaphors in our culture. Note that there is a parallel between the idea that people have to express their emotions to stay healthy and the consideration that defecating, urinating, etc. is good for people's health.

The body has to be open for the good health of the elderly. The aged body is characterised by its openness and flexible boundaries, allowing it to have ‘accidents’, ‘failures’ and emotional expressions. Rules of disgust are relaxed. Disgusting behaviour and substances which would be an offence outside the wards, is tolerated.

There is no fixed place for excrements in the wards, because “it always can happen”. There also is no fixed place on the conceptual grid within this (sub)culture. They can be considered as dirt and thus contaminating, but they also are considered as healthy. Moreover, nurses define wastes by their place on a continuum: from ‘filthy’ to ‘normal’, depending on the nature of the substance. They can be ‘low’ or ‘high’. Human excrements weave their own grids in the geriatric wards.

If there is no fixed place for excrements, how then is a place defined? In the article's next section I will go into this matter. I will mainly present the nurses' definitions and experiences, for reasons I already mentioned in the introduction.

Between a professional approach and intimacy

In the beginning of my research I noticed a gap between the space and time that nurses in practice spend on body care and cleaning elderly's wastes, and the space and time this kind of care had in the conversations I had with them. In the talk about body care the nurses would say: “This is something that has to be done”, or “They cannot do it, so I have to do it”, or “It's a part of my job”. Nobody said that she/he liked to clean. One nurse says: “It isn't something to yodel about, but I have to do it, it belongs to what I do.” Talking about the nurses' emotional feelings connected with matters as excrements and cleaning is unusual. Recently, some literature discusses problems like incontinence and problems with stool (Van der Bruggen 1991; De Lange 1990; Staat et al. 1998), but the focus is on patients and elderly within institutions, not on nurses. The recommendations which are made, point to the necessity of better professional and technical attitudes, and more knowledge of the emotions and experiences of patients. Emotional reactions – like disgust – of nurses and how to deal with them mostly are not discussed. This inattention “may follow from something threatening about the disgust” (Miller 1993: 711). Emotions like disgust, shame, uneasiness certainly belong to the hidden meanings of caring. They are not unconscious meanings, because these mostly are blocked, while the emotions connected to human excrements are not blocked.

Through observation and participation I discovered that body work was not always something “that has to be done” or just “a part of the job”. Deeper probing of the subject and the article on disgust and infantilization brought emotions to the surface. There was no unanimity among the nurses about what is disgusting and what not; there were contradictions in meanings, feelings, acting and talking.

The following fragments from a conversation with an experienced nurse show how human excrements and other ‘dirt’ have different meanings and places.

The boundaries (between me and the elderly) are very vulnerable. I don’t experience those naked bodies as sensual, like young children. I think they are beautiful, but not sensual, so... some elderly kick like horses with younger nurses when they do intimate care. I am accepted as an older woman. I think I am very intimate in my relationships with elderly. (...) It depends a little; I have to be careful. When I talk to a colleague and we wash somebody together, we’re washing a thing. Working together is fun, but the elderly undergo... My mother died in the night. She was found the other day. I went there. She lied there, her teeth out of her mouth, her face purple. I wouldn’t touch her... I felt ashamed, because I was a nurse who couldn’t touch her mother. My brother did it ...

When I started here, those slobbering people with nasty pimples in their face, some have that, you know, those contorted faces, I almost was scared. But within a half year I took them on my lap. (...) Acceptation of myself and the elderly. (...) Sometimes the shit stinks foul. Also vomit. I part with vomit, because I will puke myself. The smell of vomit is harrowing. (...) When somebody eats very filthy, I don’t sit at his table. (...) I don’t care if shitting oneself is an accident or not. Yes, I do care!! When Rose shits herself and she touches it with her hands, I say: Wash it yourself. I don’t. I will give her a bucket with water and say: Clean yourself. I do care then. Because she can go to the toilet. So, I don’t wash her; she must do it herself.

In these fragments one discovers that body care is experienced somewhere on a continuum of professionalized care (more distanced and rationalised) and intimate care (bodily contact, emotional). Nurses’ age, acceptance of the self and the elderly, habituation, closeness, intention; all these things matter in the definition of the disgusting.

Cleaning is perceived as a consequence of the profession, although nurses don’t like it. Nurses feel that they cannot blame the elderly. “It’s part of the job.” They clean without comments and often work very fast. They hold their breath. To illustrate how this works:

Anthr: What do you think about body work?

Nurse: To do it?

Anthr: Yes, washing, cleaning, diapers...

Nurse: I think it’s part of the job, but it is not the main thing I do.

Anthr: But you do it.

Nurse: Yes, I don’t like it that much. You clean. It’s a part of the care you give.

Anthr: You say that you don’t like it?

Nurse: Yes, sometimes it turns my stomach.

Anthr: But how can you still do it?

Nurse: By breathing more often.
Anthr: Maybe, it doesn't smell so good and you breath more often?
Nurse: Through my mouth.
Anthr: Yes.
Nurse: Work super fast!

However, many nurses do not see such work as a job which has to be done as quickly as possible, without talking and treating the elderly like 'things'. They also think that even in those moments of cleaning social, intimate contact is necessary:

Sometimes I clean without spending much words on what happened. I clean without comments or I deliberately talk about something else, like what are you going to do later?, do you have plans for today?, and in the meantime I am cleaning and gagging on it, but I will try to hide that.

Elderly are not non-persons when nurses are cleaning them. Nurses also know that the 'accidents' are a part of the person. The elderly's body lost control over itself or elderly can have an obsession with excrements:

It belongs to the person. People are mentally disturbed. Faeces are an obsession. There is no physical cause for incontinence, but a mental cause. People smear. [Anthropologist: Do you make any difference between this and physical problems? Is this more disgusting to do maybe?] Yes, but it is a part of the person. So, I think that I have to respect this person, but when someone bothers another occupant with this problem, I have more troubles with it. I don't tolerate that. I have to say something about it.

An important aspect of cleaning and dealing with excrements for nurses is humour, the comic. Elderly people and nurses laugh together about the accidents. An anecdote of a man, who uses to say "Quiet! Quiet!" when there is commotion in the ward, will illustrate this. The expression is used by everyone in the ward when something is going on. This leads to a hilarious event. The man is used to sleep with his shirt. One afternoon he wears a indigo shirt. He went to bed in that shirt, but unfortunately he wet himself 'up to his ears'. He goes to the shower with a nurse. The nurse put off his shirt, looks at him and starts to laugh. Another team member enters and sees the white body standing out against the print of the indigo shirt. All laugh together. In between the man shouts: "Quiet, Quiet!" Nurses still have to laugh about this event. But why is it that things that can disgust also can be transformed into something comic? Firstly, we have to look upon the comic within the context of madness and the mental hospital. Joking both dramatise the violation of a norm and reaffirm the norm. It binds nurses and elderly together, while negotiating the seriousness of an event (cf. Coser 1963). But there is more to say about the comic in a mental hospital, which cannot be done within the frame of this article.⁵ "I love madness", one nurse says. Secondly, the thought of the ward as a home certainly makes joking, teasing and humour possible. Nurses and patients know each other for a long time. Laughing and joking are more relaxed ways to tell the elderly that something is not normal or decent. Thirdly, nurses do not play with urine or other dirt, they *talk* about it (the fragments of the conversations quoted here show abun-

dantly speech about disgust and dirt). “The transgression is limited to suspending the rules of decorum regarding *talking* about such things (...) The fascination and curiosity (...) we evince towards the disgusting often arise very close to home” (Miller 1997: 118). So, if there was no intimacy between nurses and elderly, there would be no homely feelings and no humour. However, the comic is not always possible.

There can be different ways of dealing with shit: “One has cleaning shit and cleaning shit.” Depending on substance, form, smell and nature of excrements nurses also can disgust the excrements. The dirt is “really worse” than it is normally the case. Nurses eventually will put on gloves, because they disgust it and have emotional problems with it. Their professional attitude is that they always will explain to the elderly why they wear gloves: “I don’t know where to start, so I will wear gloves. I will tell them why I do this, because elderly might feel that they are too dirty to touch.”

Most of the nurses experience vomit as the most disgusting substance, more as faeces and urine:

That smell. It smells so sourish. One can compare it to sputum, all those sticky threads and things. You cannot pick it and —it’s gone. It’s everywhere and nowhere and you have to remove all the clothes. And you grab it a hundred times. So, I wear gloves, I really disgust. It slithers and slides. I rather clean shit than vomit, but it belongs to the job. (...) Especially that smell; it’s dirty, penetrant, especially when there is gall in it.

Elderly’s excrements are not only ‘dirt’. They are tokens of good health and defecating is a necessary condition for well-being. When elderly have problems – constipation –, they will be helped by medicines. This ‘unnatural way’ has consequences in the domain of the nurses’ feelings and social relationships:

We have a gentleman here; he gets three times a week laxation, because he would get stuck and that is bad. Well, when he gets it, it asks a lot of him, but it also asks quite a lot of us (the nurses). He has the runs the whole day. At a certain moment you cannot master your irritation. You can take it out on the man, but you also can help him through that difficult day at expense of yourself. When it is my first day on duty, I can stand all this very well, but after five, six days I will become irritated. I ask myself: What am I doing? I mean: it’s dirty, it stinks and it is foul and you don’t change a diaper like that. It might squirt out from all sides. You have to jump or you will be full of it. It happened once. So, it’s just dirty. At a certain moment, it’s very difficult to remain gently. But he cannot help it, he has no control. But he is a very nice man. He is very nice indeed. You can take it from him. Thank god, those two go together. He often says: Why me? But when you don’t do it, he will get an infection and he will die. Actually, it is very sad. But it’s important to share it with colleagues. So that you are not the only one who will clean shit the whole day. You say: It’s your turn, or the other says: You already did it too often, it’s my turn now.

The kind of elderly’s personality and the nature of relationships influence the nurses’ feelings and their willingness of cleaning. Feelings of disgust and irritation can be played down more easily when somebody is ‘nice’ and helpless, and other nurses share the difficult job.

Intimate contacts and 'body work' are embodied care: they are matters of the senses: touch, smell, vision and taste. The skin is the chief organ of touch. However, sometimes the skin is the 'pièce de résistance' (Kristeva 1982) and nurses need a second skin to overcome this resistance: the gloves. Although it is believed that it is nearly impossible to keep bad smells out the moral domain (bad smells are evil, Synnott 1993), nurses don't connect bad smells with elderly's 'evilness' or 'immorality'; it's the substance that is evil. They distance themselves from the evil by breathing through the mouth and in their language by using 'you' instead of 'I'. They connect dirt with feelings of shame and sexuality:

When I started as a nurse, I sometimes felt shame, especially for men. But I got accustomed to naked people. I often see that people here don't feel shame, but sometimes they do. Then I say: Well, it can happen, I will clean it or I will help you. It doesn't matter. But sometimes somebody feels ashamed. Then I see if there is somebody else who can help him more easily. I also have a way of dealing with shame: I wash people so that I don't see it, in an underhand way, sneaky... He has to wash his willie himself. I will not control if he does it well, although I know he doesn't do it all too well. I will respect him and not touch his willie.

Boundaries between bodies, between nurses and elderly are defined in a loosely way. Nurses say that they "stay cool" in intimate situations; they accept dirt and give it a place within their care. Nurses relate body work and cleaning with professionalism and intimacy, but they also make clear distinctions between the 'hows', 'whys', 'whos' and 'kinds' of what has to be cleaned. They sometimes feel as if their boundaries are too flexible. An older nurse:

When you are young and then see people naked. Touch everything and turn everything inside outside. I was very prudish. But when you have to do it, it becomes different. Years ago —it's a nice example — we had a team meeting here. One of the men masturbated in front of the window of the room where we were. We watched the man together and went on with the meeting at the same time. Thus, this is what one becomes in the long term. For many years I had no problems with it at all. But I am getting older and now I feel that sometimes I have the same feelings I had when I started. I am more aware of it: it is foul actually. Yes, of course, it is a kind of habituation. You do it without batting an eyelid. One becomes slightly cracked.

However, 'becoming slightly cracked' and having flexible boundaries have their limits too, as we have seen. Except in extreme situations and in cases of vomiting, the elderly's excrements are not all too contaminating in the perception of nurses. The nurses' tales are those of tolerance for old bodies, of loyalty and willingness to excuse their helplessness and vulnerabilities, as well as to indulge their problems with 'dirt'. However, this only can be tolerated because nurses often have a long-standing relationship with the elderly. An important facet of their tolerance also is that they can control with the help of each other, and all kind of assistive devices. Their personal space and boundaries are defined by other criteria like aggression and sexual harassment:

Well, shit has something comic too, but I never will tolerate that someone beats me. Or curse or sexual abuse. Those are my boundaries! Do I have more boundaries? It must be... when I think about it, I have damned few boundaries... Yes, behaviour. No manipulation, no this, no that, you know. Then I will work on it.

A regulating passion: Disgust

Human wastes have an undefined place within the geriatric wards, but how then is their place defined? How is the 'fit-in-the-grid' made? The regulating mechanism is an emotion: disgust. Disgust is interpersonal: "the experience of forcefully rejecting emotional and often physical contact with someone with whom a close association exists" (Miller 1993: 712). There is no need to view upon disgust as a purely negative emotion: it expresses the nature of a relationship and recognises and rejects bad experiences (Miller 1993: 715). It reduces intimacy. So, when nurses say that something is dirty or disgusting, they inform others how a relationship is experienced. Of course, the disgust is communicated indirectly. When a nurse tells that she can deal much easier with excrements on her first day on duty than on the fourth or fifth day, she also informs us that an important aspect of the relationships among nurses is mutual support when dirt becomes unbearable. Dirt becomes unbearable when nurses are tired and irritated. Nurses communicate their disgust to the elderly indirectly. They "do the job as quickly as possible", they breathe through their mouth, and when "it's really bad" they wear gloves.

Changing diapers, cleaning and caring is a part of the nurses' profession, but these also are activities of tolerance, loyalty and intimacy. Miller (1997: 132) describes intimacy and love as a state in which disgust rules are relaxed or suspended. In the geriatric wards nurses pardon deeds and things that are otherwise disgusting. Substances and behaviour lose their disgusting aspects (mostly). Body work defines a special status of the nurses. But it is more: "As an act it is so fundamentally emblematic of the type of commitment involved in the relationship as to bear a symbolic and constitutive significance" (Miller 1997: 133). Nurses will care no matter what; they risk to get dirty. They humble themselves and by doing so they acquire the right to care, to be specialists in the care for the elderly. Here, power comes into play. One might compare this power – the right to care – with parental love. But the nurses' love for the elderly⁶ can be distinguished from parental care. Parental love is unconditional and selfless. Nurses' love is not. They can and will leave the wards when their time is over. They mostly don't "take the ward's sorrows home". They have professional support, whereas parents mostly don't. For example, one condition of care is that the caregivers in the wards are supported by many other things: intervision, education, specialisation, mutual assistance and material provisions like assistive devices, computers, etcetera.

A team manager:

People want to be seen, people want to be appreciated. If one knows how to do that in time, it will work. People feel supported. Then they behave different to the elderly.

Provisions and short courses connected to bed and body work are important and have a central place in the wards.

Nurses acquire inurement in order to manage their disgust. This habituation arises by familiarity. However, inurement is finite, even for nurses who work decades with elderly in the mental hospital. Inurement ends when a relationship between an elderly occupant and the nurse worsens, or when relationships among nurses are bad. Intimacy also has its boundaries. Those boundaries of inurement and intimacy can be observed in moments of transgression of the nurses' "territories of the self" (Goffman 1959). Although the boundaries of these territories are more loosely defined as outside the hospital, there are markers: violation of individually determined rules, aggression, and most of all sexuality.

Sexuality? I take it into account. You see, I can joke with it verbally. Like: Hey nurse, come into my bed or jerk me. Mostly, I have a joke like: Do it yourself, I'll be back in a minute, I don't come into your bed. I have no problems with that. Once, I was tying shoestrings in a wrong position and I was grabbed in my crotch. Then I exploded! Afterwards I thought: I should stay in eye contact, I shouldn't bend over like that, but I was sick to death of it!

Mostly, nurses are very aware of what they are doing and saying. They deal with improper sexual behaviour verbally. But they also have moments of inattention. In such instances, elderly might succeed in making the nurses squirm with discomfort and disgust.

That man (an elder man in one the geriatric wards) was after me. I thought that he did the worst with me. I thought a while that I was guilty. I paid extra attention to my clothes. That didn't work. Then I talked about it with another nurse, who I selected very carefully, because I was ashamed.

A nurse may feel disgust for an elderly man or woman (and for herself) who transgresses certain boundaries. The vices that prompt disgust are aggression, sexuality, purposeful mad behaviour, and also little things that might nurses turn off, depending on for example their irritability when they are tired. For example, it is not just sexuality which can be very broadly defined, but crossing certain sexual norms or behaviour. Then, the elderly don't act 'mad' but 'bad'. Disgust has a moral dimension.

Thus, nurses also deal with the moral order in the wards. They could be called "moral menials" (Miller 1997: 184): people who perform functions in the moral order. They deal with two interconnected kinds of dirt: bodily and moral dirt.

It depends on the person if I can tolerate certain behaviour, but I also have my own norms and values. If the behaviour flies in my norms and values, I will say something. But the boundaries are broader as in normal life, because you look more into the norms and values of the elderly. But I stay alert, take care that it doesn't go too far...

Nurses are 'guardians' of a moral ordering in the wards. They feel that they have "to steer" the elderly:

I often think: How can I respect the elderly's norms and values. Because they often are different from my own values and norms. Can I let things go? Can I overlook this behaviour? To give a concrete example: a woman will sleep in someone else's bed. The others don't mind. Some will throw her out. This is possible here, not in a nursing home. She was tied up there... She can do things here, we are specialised to take care of such people. What is not tolerated in a nursing home, is tolerated here.

Disgust signals the nurses being appalled. It lets them know that norms are truly violated. So, disgust helps to define the boundaries between persons in the wards.

From disgust to contempt

Boundaries within the geriatric wards are defined differently compared to those of the outside world. This might mean that nurses as moral menials risk contamination and getting morally dirty in the eyes of the outside world. Haidt et al. (1997) suggest that rejections due to disgust rejections follow two laws of sympathetic magic. The first law is the law of contagion – once in contact, always in contact – which refers to the tendency to act as if contact causes permanent transfer of properties from one object to the other, even when no materials are transferred (Rozin et al. 1986). Following this law, it would mean that nurses are perceived as 'polluted' because they deal with dirt. The second law – the law of similarity – holds that the image equals the object (Rozin & Nemeroff 1990). Within the context of the mental hospital this second law is the most important. The nurses' work is necessary and society need to attract people to do this work. Although one doesn't like to talk about this issue openly, there are some clues that nurses are held to be accountable for being so attracted to what disgusts in normal, public life. Nurses choose to do this job: "Their having so chosen, however, is not what disgusts; their choosing is only cited as a partial justification for blaming them for disgusting us on other grounds" (Miller 1997: 184). We understand nurses in such wards to be working; they are fulfilling a moral function, though distasteful and menial. Nurses sense this mechanism:

Hard work, little money, little appreciation, the image... I felt a long period that I worked in these wards. People said to me: You have this School of Higher Vocational Education, what are you doing there? Even within the hospital the others think: Those wards, it is just a refined nursing home, or so. ... Once I gave a workshop in the hospital. I got questions like: Is your care high-quality care? You have to do bed and body work, haven't you? How can you do that? These people are nurses!... I really get angry then.

Working in the geriatric wards was and sometimes is perceived as menial, even within the hospital among the nurses. In a way, both, nurses and elderly of the geriatric wards are in the margin of our society and of the hospital. We don't need to mention for example bodily wastes as disgusting; instead the elderly's role is sufficient to elicit disgust: being mad and old. Nurses undertake body work, cleaning, and also deal with moral 'dirt', often by moral compromise. It's this necessary evil that invokes disgust in others

(cf. Miller 1997: 185). Contempt goes hand in hand with it. It manifests itself in the policy of the hospital and evokes frustration and feelings of being downgraded in nurses:

I will tell you something. When I was working in the emergency wards, doing treatments, day treatments and the like, I had a very bad period in my life. I didn't work during a year. Then they said to me: You cannot return here, go and start on "care" (the geriatric wards, EvD). Speaking about culture.... I couldn't stand up for myself then. Nobody must say to you: Don't come back and go to "care". But I couldn't stand up for myself, so I slinked away to "care". I could say "yes" because I was rather frustrated and thought: What the hell is emergency anyway? The nice thing was... I went to the geriatric short term ward and they thought that I only worked in "care", but I could do Goldstein-training, I could write good patient-plans, so they stare at me with their mouth open, like: Can you do that? Yes, I can. Do you understand how they look at you?

Contempt of others in the hospital is a claim of superiority, a downward mechanism. It contains feelings of pity for those nurses who cannot "function" well in emergency wards or short term wards, where "real psychiatry" is.

The hospital preserves this. By saying when somebody doesn't pull through in the short term wards: Try it in the geriatric wards... Those wards are "quiet"... When I listen to the students, I hear: "A nice start in those wards, one starts nice and quietly and then you will do the more difficult work..."

With "quiet" one means that one only has to do bed and body work, cleaning and caring. This focuses on the moral issues that involve the body, bodily failings, or sexuality. It also focuses on the moral compromises the nurses in the geriatric wards make, and which disgust others outside the ward. For example, nudity is not accepted in shortterm wards. Nurses act strictly in such cases. But in the geriatric wards, nurses look for a compromise, which eventually will lead to improvement of the patient's situation. An example: one woman always undresses herself and walks naked in the ward. She refuses to eat. Other elderly react very negative, but she beats the nurses and others who say something about it or try to dress her. Before her transfer to the nursing ward, she was send to her room when she was naked. However, the staff felt this was not a good idea. The first idea in the nursing ward was to give her a swimming suit. She wears the suit, tied in every possible way. Suddenly, at one afternoon she wears normal cloths.

But contempt in the hospital also is shown towards individuals higher up in the hierarchy (upward direction). Then, the nurses of the geriatric wards express their contempt in sneering, ironic or sometimes sarcastic ways:

I always said to the newcomers, especially the students, who just had their teaching practice and had to separate patients – that's really psychiatry!! – I always said: Here you can learn how to contact people. Because it is very easy to react on patients' actions, that's easy. You only have to observe what is happening and then... action! Here, it is different. Action often is zero and what then? I always say: You can learn to make contact here, that's a very great specialism!

At the end of this section I will follow Miller's argument on contempt (1997: 220-235). Downward contempt in the hospital is an active passion, it acquires and maintains status and rank by stating that 'care' is nice and quiet, an easy work compared to other kinds of work in psychiatry, work for "those who don't function well elsewhere". It is coupled with disgust for body work, menial work and elderly. Upward contempt is less coupled with disgust. Nurses in the geriatric wards are not concerned with dirt when they express their emotions in this case. They know that they are below in the eyes of others; they claim superiority regarding a particular attribute —social contact and relationships with elderly—, and they are defensive in an ironic way: "What the hell is emergency anyway?" "We are a kind of refined nursing home." However, by claiming particular expertise or superiority regarding a professional attribute, a downward contempt is expressed to certain nurses outside the hospital: those who work in nursing homes. Contempt is coupled with disgust again. Bed and body work in nursing homes is viewed as almost the only activity of nurses in a nursing home. Those nurses are exposed to dirt exclusively. Geriatric nurses say that they "have more" (talk, contact, psychiatric care) than body care. So, disgust and contempt work as "a feedback loop in which [they] help create and sustain the structures which generate the capacity for contempt [and disgust]" (Miller 1997: 217).

Final remarks

Disgust and contempt are emotional complexes that maintain and create hierarchy, status and feelings of respectability within a mental hospital. Care in geriatric wards is typically embodied care. It is something in between professionalized, distanced attitudes and intimacy. And it also is moral care. In a sense, it is a privileged way of violating norms and rules that are vigorous outside a mental hospital. I am well aware that I didn't discuss opinions of old people and madness in society, which often are expressed in an idiom of disgust (ranging from humour via indifference to blistering). I wanted to focus on the nurses within the article's brief scope. However, those opinions within our culture certainly play an important role in the work of disgust and contempt.

Excrements and the way nurses in geriatric wards deal with them are an expression of a specific (sub)culture. Body wastes are 'matters in place'. They give information about health and the process of ageing. But they also inform nurses and elderly how nurses perceive their relationships with elderly. This is expressed in disgust and relaxation of the rules of disgust. Thus, ideas about excrements are formed within social relationships of care. Self-humiliation maintains the status of the nurses within the wards. Nurse also are 'moral menials', because they deal with madness. Elderly's mad behaviour is accepted to a certain limit, which is set by the nurses. The 'domain of shit' parallels the moral domain. Both are ambiguous and have flexible boundaries. The 'open bodies' of the geriatric wards stand against the closed bodies of the outside world.

Within the hospital one can observe downward and upward contempt. Downward contempt also is included in the hospital's policy. Upward contempt could create a new ordering. It would be interesting to investigate how recent changes in psychiatric care

for the elderly – which I shall not discuss here – are of influence on the perception and ideas of the embodied care and excrements.

Writing about emotions like disgust and contempt is problematic. My interpretations might not be shared by the nurses. It is not the ‘shit’ that belongs to the hidden domains of our culture, it are disgust and contempt which are so deeply buried. But ethnography must go beyond the ‘native’s’ point of view. It must “disturb, shock, or jolt [us] into an awareness that [we] did not have before” (Obeyesekere 1990: 224).

Notes

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1. Which is related to but not quite the same as disgust.
2. Herman Brood, a Dutch singer and painter, works with human excrements. See also Hadolt, this volume for the political use of shit.
3. In an article on infantilization and the old body I made a distinction between ‘accidents’ (incontinence) and ‘non-accidents’ (purposefully, strategically defecating or urinating) (Van Dongen 1998a).
4. In psychiatry paraphilia are sexual disturbances. Among paraphilia one reckons for example: coprophilia (faeces), Urophilia (urine), Clismaphilia (enema), partialism (exclusive attention for a body part).
5. The comic and laughter in a mental hospital mean a split in the world view, norms and values of a culture. In their jokes and humor mad people often paint the world as incomprehensible, paradoxical, crazy, or normless. In relation to the body, mad people give an image of *the grotesque body*. They stress the sexual, eating, defecating, urinating body of people. They often use a popular or vulgar language. They can do so, because they are not punished, because they are insane (cf. Bakhtin 1968).
6. When I talked with the nurses about the reasons they had to work in the geriatric wards, ALL of the nurses answered that they have special feelings for those elderly, that elderly are beautiful, but also that care in geriatric wards need special skills.

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