

Showers: Discourse, Disability, and the State

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Abstract

Showering is a pleasurable part of a daily hygiene routine for many people. However, for those who are unable to stand or step up into the typical shower unit, it is a space of exclusion. In Aotearoa New Zealand, occupational therapists can apply to the State for funding to modify shower units so that people may wheel into their shower, shower while seated, or be assisted with showering. However, this funding comes from a limited budget in which the need always exceeds the allocation. As such, a system for assessing who is able to get funding has been established. From the outside, it seems that this funding solves the issue of inaccessible showers. Although not everyone can get what they need, one could presume that the system for prioritisation addresses the needs of those whose are the greatest. However, disabled people's access to suitable housing in Aotearoa New Zealand has recently been described as grim. Issues with inaccessible housing and showers appear frequently in mainstream media, and numerous studies have found that the need for accessible houses is far from being met.

In this study, I use a Foucauldian genealogical approach to interrogate the history of the shower. This reveals the discursive construction of the typical shower unit and shows the shower to be a political actor in the exclusion of disabled people from private dwellings. I have gathered texts from the birth of showers through to modern day to show how the government of individuals and populations shaped the shower and produced the idea of showering as an essential everyday activity. I analysed these texts using the concept of the *dispositif* to reveal the governmentalities that have shaped where and how disabled people live. I conclude that the current system of housing modification maintains biopolitical disablism, and is part of excluding disabled people from neoliberal life. I argue that this is an extremely dangerous practice, pushing disabled people (including the elderly) into institutional living where they are excluded from life.

This study provides a unique contribution to the argument for radical change to the way housing is governed. It shows how the shower has become a technology for investment in human capital for those who can stand and step up. While the possibility of showers that can be accessible for all has been realised, the established order has remained; and the very system that is supposed to address problems with access contributes to the dangerous exclusion of disabled people from community life. However, the recent establishment of the Ministry of Disabled People provides some hope that discriminatory practices will be confronted, and practices such as Ministry of Health housing modifications will be rethought or done away with entirely.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Date: 25/01/2023

Co-Authored Works

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Note: View out the window from my desk. Own work.

Prologue

This thesis begins with a story about a problem that I encountered as a community occupational therapist. While it may not be a particularly dramatic story, it raised within me a strong sense that there was something terribly unfair with the way things were that I could not quite grasp and started me on the journey that led to this PhD.

In 2012 I started working as a community based occupational therapist on Waiheke Island. Only a short distance from Auckland, Aotearoa New Zealand's largest city, Waiheke is a fairly small island with, at the time, a population of about 8500. As part of my job, I had a role in applying for government funded housing modifications for adults living in the community who had physical or "age related" disabilities. One day I was sent a referral for "Jay" who was unable to turn the shower on or off because she could not reach up to the showerhead controller. I went to visit Jay at home, observed her difficulties, and we talked about showering and other daily activities. It seemed that her shower may need to be modified. So, we went through the Critical Question Checklist (Appendix A) to see if she might meet the criteria for funding. For the most part Jay was managing independently, and the house (a compact 2-bedroom 1980s single level dwelling) met the criteria. However, in addition to the shower problem, hip pain associated with arthritis meant she found the steps up to the front door impossible, and the stepped path to the back door was becoming increasingly difficult. We agreed that moving the shower mixer to a lower position and providing a rail alongside the stepped path would address these problems and Jay would be able to continue to live at home for many years to come. I completed the required paperwork, which included photographs of the problem areas, and submitted it to the agency that determined if applications would be approved.

It was with a sense of dread that I returned several weeks later to tell Jay that the application for government funded housing modifications was declined. The steps to the back door were deemed "dangerous for anyone" due to the gravel not filling to the level of the upstand (Figure 1). Therefore, the need for a rail was not a "disability related need". Furthermore, given that the access to the house was "dangerous for anyone", the shower would not be modified. She would need to continue to have assistance with her shower; if she could eventually not manage the steps, she would have to move to somewhere more suitable, perhaps a retirement village, pensioner flat, or Rest Home.

Figure 1

Steps that are “Dangerous for Anyone”



Note. Own work.

When I tell this story, I often convey the righteous indignation that I felt, and to a degree still feel, about conveying that news. I must add that the story did continue and that eventually a rail was installed and the shower was modified. Despite, or perhaps because of, this outcome, this particular story drove me to complete this thesis. I needed to know how it had become possible for me to have to tell Jay that the shower controller would not be moved because the steps outside were deemed dangerous? How were these things connected? I could see that there were never any “bad guys” in this story for me to fight. There were just a few people (myself included) trying their best to do a good job, act ethically, follow the rules, and be the kind of person that they thought they should be. At the same time, it all seemed “wrong”. Simple, fairly low-cost modifications to the shower and steps would have made a world of difference to Jay. At the time I could see that the modifications were the difference between privacy, dignity, and autonomy for Jay; and dependence, not coping, pain, and potentially having to leave her home. What I sensed was an urgent need to understand how “good people” doing the “right thing” could create this story, and that in doing so I hoped that we could consider other possibilities. This thesis is the product of this hope.

1. Introduction

For many of us, showering is a pleasurable daily activity that keeps us clean and gives us a chance to refresh or relax. Few would have stopped to consider where the idea of showering came from or the history of the typical shower unit that can be found in most private dwellings in Aotearoa New Zealand. Many would also never consider the possibility or the consequence of not being able to get in and out of the shower or turn it on and off. In this thesis, I uncover a history of the domestic shower and aim to reveal how the shower unit excludes some disabled people from the freedoms the rest of the population take for granted. In this chapter I provide some context for the study, including related research that has come before it, and outline the contribution of this thesis.

Situating the Study

Ministry of Health Funded Shower Modifications

From 1995 to 2022¹ New Zealand's Ministry of Health (MOH) has provided funding to modify showers for disabled people. Prior to this, the Ministry of Social Development had been funding such alterations since the mid-1970s. Part of "Housing Modifications", this funding was, and is at the time of writing, a set annual amount managed by the "Equipment and Modification Services" (EMS) (Whaikaha Ministry of Disabled People, 2022a). To access the funding, individuals must be assessed by an occupational therapist who has been accredited to become an "EMS Assessor". The EMS assessor is tasked with identifying the "most cost-effective options" for "disability needs" and determining if the Ministry "might" fund the modifications (MOH, 2022). The Housing Modification Manual ("the Manual") (MOH, 2014a) defines what housing modifications are, details the processes for accessing housing modifications, and stipulates eligibility and access criteria for funding. The Manual identifies showering as an "essential everyday activity" (p. 13). An inability to access or use the shower is included in all of the three "access criteria" that a disabled person may meet to be considered for housing modification funding (MOH, 2014a, p. 12).

While showering is considered an essential everyday activity, the MOH's capped budget means that not everyone can be funded. The Manual outlines the principles of the funding, which are:

¹ In mid-2022 this funding was shifted to the Ministry of Disabled People; however, the manual stipulating the regulations for housing modifications had remained the MOH's at the time of writing.

Introduction

An effective contribution is made towards helping disabled people to live, as far as reasonably possible, as others do in their own homes and communities.

Decisions represent value for money both now and in the future, and contribute to supporting disabled people of all ages to remain independently and safely in their homes, as is reasonably possible, and not to have to rely more heavily on their families or paid carers or move into residential care.

Services are allocated fairly through a consistent, principled and equitable approach being taken to the way equipment and modifications are allocated across the diverse range of people the Ministry serves.

Decisions reflect a long term perspective, recognising that the equipment and modifications that are most appropriate for a person may change over time as people grow, age and develop, and as their circumstances or needs change.

(MOH, 2014a, p. 7)²

As demand for services regularly exceeds the annual allocated budget, a prioritisation system is in place to ensure that disabled people who have the greatest need for services and the greatest ability to benefit from equipment and modifications are given first access to the available funding.

The funds are thus a partial investment (or “effective contribution”) that aim to reduce reliance on human assistance or institutional accommodation (“residential care”). They are distributed across the population of “disabled people” using a “prioritisation system” and look beyond the immediate need by using a “long term perspective”. The purpose of this study is to interrogate the history that connected the State to the funding of modified showers in the homes of disabled people, and that established the “consistent, principled, and equitable approach” (MOH, 2014a, p. 7) that could determine those who would be excluded.

There have been a few reports on the effect of the current system of housing modifications on disabled people in Aotearoa New Zealand which I discuss further below. Most recently, the Donald Beasley Institute (2020) published “My Experiences, My Rights: A Monitoring Report on Disabled Person’s Experience of Housing in Aotearoa New Zealand”. This report was produced following a disabled person led monitoring assessment of Aotearoa New Zealand’s performance against the United Nations Convention on the Rights of Persons with Disabilities. The report states:

The evidence reported here paints a very grim picture of disabled people experiencing numerous and insurmountable barriers to housing, demeaning discrimination and human rights abuses. Disabled people report limited choices in accessible housing; difficulties in getting necessary housing modifications; a lack of control over their living situation; affordability barriers and discriminatory

² Please note, source text is inserted as an image which I discuss further in my Methods chapter. These images are referenced as quotes rather than figures. All images are supported with Alt Text.

attitudes from people in power such as landlords, real estate agents and government housing support services. (Donald Beasley Institute, 2020, p. 8)³

The report highlighted issues such as a 30-year-old woman who was sent to live in a residential care facility for the elderly, and depended on staff availability to be able to have a shower. Another was denied the possibility of having a wet area shower installed in the house being built for her because it was not included in the standard home ownership scheme plans. Others highlighted the issue of an extremely limited pool of houses that have accessible features, such as a modified shower, and then being stuck with the one option they could find, even if the house did not meet any of their other wants or needs. The absence of an accessible shower in one person's home meant he had to shower in public facilities once a week. The report also found that unmodified showers could be not only inaccessible, but dangerous. People reported that occupational therapy services could be slow and ineffective, leaving one person unable to shower for months. Grim indeed!

In this chapter I introduce myself as one such occupational therapist (although hopefully not slow and ineffective!) and outline the experience I had at the time I was applying for Jay's modified shower. I briefly discuss the concerns I had regarding choice and control that disabled people report in relation to housing in Aotearoa New Zealand, leading to my research question. Finally, I outline the research related to showers modified for disabled people to date and discuss the significance of my study in relation to the problem of housing disabled people.

An Occupational Therapist EMS Assessor

At the time that I told Jay that she was not eligible for MOH funding for shower modifications, I had been studying and practicing occupational therapy for around 16 years. I had held various roles, including working with elderly people in rest homes; mentally ill, physically and intellectually disabled students in their homes and schools; with young developmentally delayed children in their family homes; and with physically injured adults and children in their homes, schools, and workplaces. Having worked in these various spaces, the contribution of the environment to what was possible for people to do had become of particular interest to me. I could see that some disabled people had the opportunity to do the things they wanted and needed to do, while others did not. It seemed to me that the presence of physical and social barriers was much more significant than the individual person or their disability in determining these opportunities. Indeed, over time, my own definition of occupation shifted from just "what people do to occupy their time", to include "the space that people occupy". For me, the

³ Long quotes are single spaced to help with distinguishing them from the discussion and to reduce the amount of paper used for the print copies of this thesis.

transaction between the person's environment and the person is "occupation". These transactions are the things that we do, they produce the lives we live and the person we are. Thus, housing modifications that could make it possible for Jay to remain in her home, and the system that threatened to move her to an institutional environment, took on a special significance for me. Being forced to move home threatened Jay's very existence as an occupational being.

While I was established as an occupational therapist at the time I assessed Jay's need for housing modifications, I was new to MOH funded housing modifications. I had only been involved in two or three applications prior. Had I been more experienced, perhaps I would have taken photos of Jay's steps from a slightly different angle or shifted the gravel up against the upstands to reduce the appearance of the stairs being "dangerous for anyone". Indeed, in telling this story since, more experienced EMS assessors have pointed out that this would have avoided the situation altogether. However, in my naivety, I presumed that Jay's steps, common on Waiheke and almost identical to my own steps, were not dangerous for anyone. Excluding Jay from funding because of her "dangerous steps" seemed like madness to me. I needed to understand how this practice of exclusion had become possible.

However, as mentioned in the prologue, Jay's exclusion from funding was not the end of the story. Alongside being a community occupational therapist and EMS assessor, I was a lecturer in the Auckland University of Technology's Department of Occupational Science and Therapy at the time I met Jay. In that role I taught ethics to third-year occupational therapy students, resulting in my having somewhat mastered the language and legislation of practical ethics for our profession. It is possible that this experience led me to dispute the decision to deny Jay's funding, and to meet with the funders to express my view that they were being paternalistic and prejudiced. Perhaps from a distance the steps may seem dangerous; however, these steps had never demonstrated their dangerousness by causing anyone to slip or trip. While gravel steps with uprights may seem strange and threatening to urban dwellers, these were common steps in this community. Common, harmless steps. Furthermore, these were Jay's private steps at Jay's private house and surely if they were safe for Jay the State had no business claiming otherwise. The funder representatives subsequently agreed to review the decision and eventually decided that provided gravel was added to the steps to the level of the upstands, that funding would be approved. While I recognise now that the situation was vastly more complex than I had understood it to be at that time, my sense of the injustice of the system has remained.

Showering, Privacy, and Autonomy

Although it was the steps that were the problem for funding, perhaps the worst part was telling Jay she could not have her shower modified. She would continue to need help to have a shower. At the time this seemed such an unnecessary invasion of privacy, an unjustifiable loss of independence, and a waste of resources. Jay would be dependent on having her shower when the state funded carers were available to assist. She would rely on them to set the temperature of the shower and then to be there to turn it off. As an occupational therapist tasked with promoting independence in activities of daily living and creating autonomy for my clients, it was the shower that was the problem.

While I would come to critique the ideas of independence and privacy in this study, my concern regarding the ability to have some autonomy or choice and control over oneself in the shower, to be a “Showerer” rather than a “Showeree”, has remained important.⁴ While the philosophy that I follow for this study has called on me to reconsider my initial position that denying the funding was madness, the difference in possibilities for the Showerer versus the Showeree could be considered “dangerous”.⁵ Such danger is evidenced by the current system which continues to produce showers that are inaccessible, that depend on someone else’s availability to be used, and that limit the choices that disabled people have regarding where and how they live.

At the time I applied for a modified shower for Jay, I took for granted that showering was an essential everyday activity, something one could expect to do independently in the privacy of one’s own home. However, as I embarked on my study, I came to wonder how this had come to be. How had showering within one’s own home come to be an essential everyday activity? How had the shower come to take the shape that it did, necessitating the need for it to be modified; and how did the State come to be involved in any of it? Following the decision to employ Foucauldian discourse analysis to my questions (discussed further in the Methodology chapter) I established my research question as:

What are the discourses that have established, ordered, maintained, or disrupted the Ministry of Health’s funding of showers modified for disabled people?

⁴ The idea of autonomy can easily be critiqued as a western concept that privileges the idea of free willed individuals independently pursuing their interests. Such ideas are in opposition to Foucauldian discourse analysis, the philosophy I use in this study, which can be considered anti-humanist and highly critical of the idea of such freedom. I discuss this topic further in this and the discussion chapters. However, I will mention here that my interest is not in free will; rather, in the subject who may act or speak (the Showerer) and those who are subjected to the actions of others (the Showeree).

⁵ As Foucault (1983/2003d) has said, “My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. So, my position leads not to apathy but to a hyper- and pessimistic activism” (p. 104).

Studying Showers Modified for Disabled People

It is possible to study the problem of shower modifications from various points of view. For example, an economic analysis of the costs and benefits was suggested to me as a more worthwhile pursuit than the study I proposed at my public PhD confirmation of candidature presentation. However, Aotearoa New Zealand research analysing costs have already been done, such as Davey et al.'s (2004) assessment of the costs and benefits of various forms of housing for older people, which found investment in modification and maintenance of dwellings could lead to health savings. Page and Curtis (2011) found that the cost of meeting the unmet need for accessible housing in the current system was “significant”, and that the cost of modifying houses was significantly more expensive than building homes with accessible features. There have been other substantial reports into the issue of housing for disabled people in Aotearoa New Zealand, such as McDermot Miller's (2005) comprehensive literature review and mixed methods study. They found that 13-25% of disabled adults had an unmet housing modification need. Saville-Smith et al. (2007) reiterated the finding that modifying dwellings is more expensive than supplying accessible houses, and that stakeholders in housing for disabled people in Aotearoa New Zealand consistently identify the issue of unmet need. This finding regarding the perspective of unmet need has been supported by numerous reports (Barnett, 2015; Brown & Johnson, 2021; Clark et al., 2021; Davey et al., 2004; Donald Beasley Institute, 2020; Farha, 2021; Howden Chapman et al., 2021; Independent Monitoring Mechanism, 2020; Kaiwai & Allport, 2019; McIntosh & Leah, 2017; Mills et al., 2015; Saville-Smith et al., 2007; Saville-Smith & Saville, 2012; Smellie & Robertson, 2019; Weenick et al., 1995). In 2001, a survey of 7256 disabled adults and children living in family homes and 928 disabled adults living in institutions found that “6700 adults indicated they needed wet-area showers” (MOH, 2004, p. 281). One study has described the difficulties Occupational Therapists face accessing funding for their clients for housing modifications (Cathcart, 2019). Despite these comprehensive reports finding that the current system is expensive and does not meet the need, the status quo has remained, and it was (and is) my job as an EMS assessor to maintain it.

Over the past 22 years, international research into the subject of housing modifications has covered a wide range of topics such as the perceptions of those needing them (Ahn, & Hegde, 2011; Aplin et al., 2013; Aplin et al., 2020; Bishop et al., 2015; Krus et al., 2010; Li, 2006; Owen & McCann, 2018; Roessler et al., 2012; Wu et al., 2022); the role of the occupational therapist in housing modifications (Klein et al., 2000); and the information they should consider when recommending them (Auriemma et al., 2000). Researchers have also addressed the connection between disability and

the need for housing modifications (Hamer-Small, 2015; Johansson et al., 2007; Uppal, 2005); the effect of modifications on falls prevention (Cumming et al., 1999; Keall et al., 2015; Pynoos et al., 2012; Turner et al., 2011); and the “adherence” of people to occupational therapists’ recommendations for the same (Cumming et al., 2001). Housing modifications have been studied in relation to ethics and dignity (Gibson et al., 2012) and there have been many studies on the effect of housing modifications on aging and remaining in one’s own home (Hutchings et al., 2008; Hwang et al., 2011; Hwang et al., 2019; Kaul et al., 2020; Kim, 2021; McCullagh, 2006; Molinsky & Herbert, 2020; Oswald et al., 2007a; Oswald et al., 2007b; Peace & Darton, 2020; Perry, 2015; Pettersson et al., 2020; Slaug et al., 2020; Stone, 2018; Tanner et al., 2008; Tenenbaum & Kimmel, 2020). The costs and benefits involved with housing modifications and funding them have been studied in the United States (Pynoos & Nishita, 2003) and Australia (Carnemolla & Bridge, 2011). Policy in relation to housing modifications has been studied in the United States (Bercaw, 2020; Lewis, 2021) and Sweden (Lilja et al., 2003).

Unsurprisingly, there do not seem to be many studies specifically relating to shower modifications. Two studies from the United Kingdom (UK) have analysed the views of people and their carers who have received a grant for a shower installation (Pain, 2003; Whitehead & Golding-Day, 2019). These studies found that the shower made a positive impact on the life of the recipients, although Pain (2003) reported some issues included the showers being too small and water spilling out of the shower area. Another article provided information and advice about showering aids to help occupational therapists empower individuals who need assistance with showering to “make the right choice for themselves” (Swann, 2006, p. 36). There was also a recent report on a “robotic shower” that was found to make elderly living in an “assisted living facility” more independent (Bäcckman et al., 2020). Another study exploring access for disabled people to hotels highlighted the importance of accessible showers in their experiences (Stasell & Bathje, 2021).

Perhaps even less surprisingly there do not seem to be any other studies that undertake a critical history of showers or of showers modified for disabled people. There are, however, several general histories of bathrooms and bathing that include reference to the emergence of showering. *The Clean Body – A Modern History* (Ward, 2019) provides a comprehensive assessment of keeping one’s body clean from mid-17th century Europe and North America. The history of bathrooms has been described in detail in books such as *Clean and Decent: The Fascinating History of the Bathroom* (Wright, 2005). Giedion’s (1948) chapter “The Mechanization of the Bath” in *Mechanization Takes Command* details discursive, architectural, and technological developments of the bath and bathroom from ancient civilisations to the mid-1900s.

Penner's (2013) book *Bathroom* details the design and use of the bathroom and the objects confined within through nations and history, with a focus on discursive, governmental and material shifts. Gerhard (1908) outlined the materialisation of "rain baths" in Europe from the mid- to late-1800s. In addition, the history of the water industry is well documented (e.g., *The History of the London Water Industry, 1580-1820* [Tomory, 2017]). Osborne (1996) offered a fascinating assessment of governmentality and domestic water supply in his chapter titled "Security and Vitality: Drains, Liberalism and Power in the Nineteenth Century". The Royal New Zealand Army Ordnance Corps have photographs and stories outlining their history of bathing in the field (McKie, 2017). A publication from my own studies, *Showers: From a Violent Treatment to an Agent of Cleansing* (Cox et al., 2019), explored the origins of showers as a technology designed to cure mania.

Finally, the government of disabled people has also been a subject of interest to academia. I found several useful studies related to my thesis. *Foucault and the Government of Disability* (Tremain, 2005) offers a variety of analyses of governmentalities associated with disability. Texts that I have found of particular interest in relation to where disabled people live include Braddock and Parish's (2001) chapter titled *An Institutional History of Disability* which can be found in the *Handbook of Disability Studies* (Albrecht et al., 2001). Burt's (2013) dissertation, *To Be Made Disabled: A Discourse Analysis of Intellectual Disability in New Zealand*, details discourses from 1900-1960 that advocated for and resisted institutional living amongst other things. Foster (2020) recently conducted a Foucauldian discourse analysis of gerontology knowledge in Aotearoa New Zealand and includes commentary on the architecture and practices associated with the discursive construction of older people. Sullivan and Stace (2020) give a comprehensive overview of the government of disabled people on their web page *A Brief History of Disability in Aotearoa New Zealand* as did Tennant (1983) in *Elderly Indigents and Old Men's Homes 1880-1920*. Finally, the practice of eugenics in New Zealand, which I discuss in this thesis, has been explored in depth by Fleming (1981), Tennant (1996), Moore and Tennant (1997), Wanhalla (2001), Coleborne et al. (2015), and Paul et al. (2017).

Significance of Study

While many studies and reports have identified that housing access is a significant issue for Disabled-People, research has yet to closely investigate the system that has established and maintained the problem. As an occupational therapy EMS housing modification assessor, I have an important role in trying to address access issues for disabled people while also contributing to the grim picture revealed by the 2020 Donald Beasley Institute report. With this study, I hope to uncover how a

basic level technology (the shower) has become part of a story in which I could apply for, and be denied, state funding housing modifications. While the shower might seem an unusual or insignificant subject, being able to shower within one's own home is, for non-disabled New Zealanders, a taken for granted privilege that has become a pleasure and a necessity (Mahon-Heap, 2022). Exclusion from such privileges highlights stark differences between the government of disabled people and everyone else, revealing that the current system for housing modifications is not just inadequate or unfair, but is dangerous.

2. Methodology

The Pursuit of Knowledge

There are many fine ways in which one can learn about our world. One may measure things such as width, depth, or frequency. Or one can contemplate the world and seek out the contemplations of others. However, when one loses faith in the tools that measure and believes that contemplations are tainted by unknowns and the taken for granted, the world becomes shaky and the path to knowing more questionable. It is a comfort to me that this shaky ground is inhabited by researcher-writers who have created ways to know about the world outside of the space of measurement and contemplation. One of these ways is called Foucauldian discourse analysis.

When embarking on a Foucauldian discourse analysis, it became quickly clear that researchers using this methodology within a post-structural space are reluctant, at best, to tell anyone else how they should proceed. Unlike other methodologies, where there are textbooks with tables, bullet points, diagrams, and graphs that map out the research process, post-structural researchers prefer not to define their boundaries in this way (see for example Augustine, 2014; Brinkman, 2014; Mazzei, 2007 and St Pierre, 1997 who I discuss further in this chapter).⁶ Therefore, rather than providing a stable foundation against which rigour and validity can be measured, they must stake out their territory for themselves. Such territory may be recognised by the appreciation and application of the ideas of philosophers who shook, and still shake, the ground that more prescriptive methods of research rest upon. For those who subscribe to the epistemological position of uncertainty that is characteristic of post-structural studies, this lack of demarcation is imbued with possibilities; rather than lacking in measurability or creating a crisis of replicability that other methodologies may concern themselves with.

What Did I Want to Know About?

While I accept the shifting and uncertain terrain of post-structural studies, my research began with a very terrestrial problem. As outlined in the prologue, I came to question the accepted practices of the housing modification application process. It was an encounter very familiar to other community occupational therapists, in Aotearoa New Zealand at least, but which to me seemed strange and dangerous.⁷ Jay clearly

⁶ Indeed Kendall and Wickham state “there is no such thing as a ‘Foucaultian method’” (1999, p. vii)

⁷ In my discussion I detail the dangers of the current housing modification process, however from the outset I could see that constructing Jay’s stairs as “dangerous for anyone” and thus excluding her from funding had broader implications. In particular I was concerned that Jay and others with steps like her may have to leave their homes and communities to live in distant institutions. For me, this was a serious loss, as discussed above in relation to “occupational being”.

wanted and needed to access a shower; however, the funding was declined due to a small riser at the front of her gravel steps deemed to be “dangerous for anyone”. While initially I felt a desire to try to solve the problem of housing modification eligibility, I believed (and continue to believe) that I needed to understand the problem, deeply and widely, to be able to confront it or accept it or find some place in between. The current system is being justified by claiming that although the demand exceeded the budget, funds were distributed using a “consistent, principled and equitable approach” (MOH, 2014a, p. 7). I wanted to understand how it had come to be this way, how it had remained unchanged despite the apparent problems, and what the effect of this ongoing practice was. In the words of Foucault, “People know what they do; they frequently know why they do what they do; but what they don’t know is what what they do does” (Personal communication, cited in Dreyfus & Rabinow, 1983, p. 187). I hoped that by using Foucauldian discourse analysis I would be able to learn why we were denying Jay’s housing modification, what this denial would do, and answer my research question:

What are the discourses that have established, ordered, maintained, or disrupted the Ministry of Health’s funding of showers modified for disabled people?

Why Foucauldian Discourse Analysis?

While I had only a very superficial knowledge of discourse analysis at the time I embarked on my study, during the process of arguing for Jay’s modifications I recognised that objects were being discursively constructed to justify and contest eligibility. The statement that the steps were “dangerous for anyone” justified exclusion from funding for a shower modification; while I employed the idea of “Paternalism” to challenge the ruling. It seemed to me that various actors could draw on ways of explaining what we could do, and what we should do, and that produced possibilities for what would be true.

With this sense of discourse shaping our current reality, I began my journey into understanding discourse from a Foucauldian perspective. I started out reading books about discourse, reading about reading Foucault, and then reading Foucault. One of Foucault’s “methodological weapons” (as Kendall and Wickham [1999, p. 29] put it) that I learned about while reading about Foucault was “genealogy”. What particularly appealed to me was the idea that:

History of the present... is... a methodological device with the same effect as a precocious child at a dinner party; genealogy makes the older guests at the table of intellectual analysis feel decidedly uncomfortable by pointing out things about their origins and functions that they would rather remain hidden. (Kendall & Wickham, 1999, p. 29)

As outlined in my story about Jay, suggesting that the agency controlling the funding was being paternalistic created discomfort and reopened the possibility of Jay being eligible for the funding. However, I also learned that using Foucault's ideas meant seeking to suspend judgment and looking for contingencies rather than causes (Kendall & Wickham, 1999). I felt that a methodology that would produce unsettling effects more deliberately and with greater clarity could be useful. Hence, I decided that I would do a discourse analysis using Foucault's concept of genealogy.

Reading about Foucault led me to works by Bruno Latour, and, subsequently, other Actor-Network-Theorists (as they are sometimes known). While these writers do not generally employ genealogy,⁸ it was their ideas about discourse and the active role of non-humans in our social world that I found myself drawn to.⁹ Keeping in mind the terrestrial origins of my problem, the material aspect of discourse (which I will discuss further below) seemed particularly relevant. While Foucault refers to the influence of the non-human in his studies, Latour and colleagues opened my eyes to the necessity of including non-human subjects in my research. My Foucauldian genealogy, therefore, has a bit of a "materialist" twist.¹⁰

Key Ideas Used in My Thesis

Before I get into the detail about the big ideas that inform my analysis, I would like to highlight two statements that Foucault made regarding what can be studied, and how non-human subjects contribute to discourse. Whenever I tell anyone that my thesis is about showers, the response is one of surprise and, perhaps, shock. Apparently, the idea of doing a PhD on showers seems rather odd. It would seem that showers are much too mundane to be worthy of academic pursuit, particularly at a PhD level. However, I feel quite justified in studying showers, and there are two important quotes from Foucault that I hold to in my justification. Foucault (1976/1980b) noted:

I believe that the manner in which the phenomena, the techniques and the procedures of power enter into play at the most basic levels must be analysed, that the way in which these procedures are displaced, extended and altered must certainly be demonstrated; but above all what must be shown is the manner in which they are invested and annexed by more global phenomena and the subtle fashion in which more general powers or economic interests are able to engage with these technologies that are at once both relatively autonomous of power and act as its infinitesimal elements. (p. 99)

⁸ They typically follow sociological and anthropological methods which bring them very close to a particular space in a particular time; however, I am going to be exploring my subject through history.

⁹ See Latour (1992) for an explanation of the need to include non-humans in social studies.

¹⁰ Foucault is, however, arguably materialist to begin with. For example, even when talking about seemingly abstract concepts he demands that the focus of study be material—"For a sequence of linguistic elements to be regarded and analysed as a statement, it must fulfil a fourth condition: it must have a material existence" (Foucault, 1969/2002, p. 112).

It was the “basic level”, invested and annexed by global phenomena or “general powers” and “economic interests”, that I became interested in. I wanted to explore how the infinitesimal element of the shower as a technology might be analysed to show the phenomena, techniques, and procedures of power. I hoped that this perspective might help me to understand how the problem of housing modification eligibility was connected to more global phenomena, and how the shower might be the “infinitesimal object” in which such general powers are invested.¹¹ In relation to showers, for example, the need for me to step over a 4-inch plastic tray into my shower (“micro”) reveals “macro” discourses such as local and international economic politics, natural resources engineering,¹² national building regulations, and so forth.

In addition to becoming interested in the “small”, I became interested in the material. Foucault (1975/1995) noted in his study of discipline and punishment:

Architecture... is no longer built simply to be seen (as with the ostentation of palaces), or to observe the external space (cf. the geometry of fortresses), but to permit an internal, articulated and detailed control – to render visible those who are inside it; in more general terms, an architecture that would operate to transform individuals: to act on those it shelters, to provide a hold on their conduct, to carry the effects of power right to them, to make it possible to know them, to alter them. Stones can make people docile and knowable... in its very materiality, a therapeutic operator. (p. 172)

From this perspective, the shower acts on the conduct of those showering. I hoped that this perspective would help me to learn about the influence of the shower itself. Not only is it the product of “global phenomena”, but its form acts as a “therapeutic operator”. The shower unit did not allow Jay to shower privately and autonomously; however, a modified shower would. The stones, or in this case plastic and metal, could transform Jay from someone who needed an assistant to shower (a Showeree), into someone who could shower when and as she wished (a Showerer). I wanted to understand how the shower itself operated to carry the effects of power right to the Showeree or Showerer themselves. Foucault’s concepts would help me understand these operations and effects of power, starting with the idea of discourse.

Discourse

While discourse might commonly be thought of as simply what is said or written,¹³ those using Foucauldian discourse analysis propose that discourse plays a more significant role than just being words. Discourses may be thought of as the glue that holds our shaky world together. This “glue” takes the form of transactions between

¹¹ Foucault (1975/1995) discussed such ideas in his study of the Birth of the Prison to show how “macro” strategies of penal discipline are targeted at the body and soul of an individual.

¹² See for example *American plastic: A cultural history* (Meikle, 1995).

¹³ See for example Cambridge University Press (2022), “discourse”.

“objects” and “subjects” which then creates that of which we can speak, think, and do. Therefore, discourse constructs the interaction or “relation” that we can talk about and enact. Foucault (1969/2002), explained that “when one describes the formation of the objects of a discourse, one tries to locate the relations that characterize a discursive practice” (p. 53).¹⁴ This view of discourse means that I am seeking to understand how subjects such as Disabled People, showers, and state funding for modifying showers have come to be formed and relate to each other.

Discourse creates a world that we can make sense of by governing the interactions between people; and between people, objects of knowledge, and material things. Foucault explained that the interactions or “relations” that discourses govern are formed within existing “laws of possibility” and “rules for existence”.¹⁵ These laws of possibility and rules for existence that may be hidden or obscured from us in our day-to-day activities can be revealed through analysis of discourse.¹⁶ Such analysis uncovers the contingencies that our accepted practices rest on, which then helps us understand why we do what we do and, more importantly, what this doing does (Foucault, Personal communication, cited in Dreyfus & Rabinow, 1983).

Discourse produces and defines subjects and objects, it differentiates and relates, creates and limits truth and possibilities. Discourses, therefore, connect us to ourselves, to others, to the worlds that we are part of. They can take the shape of statements that define us (such as “I am a healthy, hygienic, independent citizen”) and

¹⁴ Foucault (1969/2002) stated that the basic element of discourse, the “statement”, functions as connection: “There is no statement that does not presuppose others; there is no statement that is not surrounded by a field of coexistences, effects of series and succession, a distribution of functions and roles” (p. 112). Latour (1991/1993) talked of “the world of meaning and the world of being are one and the same world, that of translation, substitution, delegation, passing” (p. 129).

¹⁵ “A statement... is linked rather to a ‘referential’ that is made up not of ‘things’, ‘facts’, ‘realities’, or ‘beings’, but of laws of possibility, rules of existence for the objects that are named, designated, or described within it, and for the relations that are affirmed or denied in it. The referential of the statement forms the place, the condition, the field of emergence, the authority to differentiate between individuals or objects, states of things and relations that are brought into play by the statement itself; it defines the possibilities of appearance and delimitation of that which gives meaning to the sentence, a value as truth to the proposition” (Foucault, 1969/2002, p 103). Furthermore, Foucault (1980/2003e) noted that in his own studies of prisons “the target of analysis wasn’t ‘institutions’, ‘theories’, or ‘ideology’ but practices – with the aim of grasping the conditions that make these acceptable at a given moment” (pp. 247-248). Hook (2001) added “discourse is both that which constrains or enables, writing, speaking, thinking. What he [Foucault] terms ‘discursive practices’ work both in inhibiting and productive ways, implying a play of prescriptions that designate both exclusions and choices” (p. 3).

¹⁶ While analysis aims to reveal what is “hidden” Foucault (1969/2002) explained that this “hidden” does not mean revealing something other than what is materially evident: “The analysis of statements, then, is a historical analysis, but one that avoids all interpretation: it does not question things said as to what they are hiding, what they were ‘really’ saying, in spite of themselves, the unspoken element that they contain, the proliferation of thoughts, images, or fantasies that inhabit them; but, on the contrary, it questions them as to their mode of existence, what it means to them to have come into existence, to have left traces, and perhaps to remain there, awaiting the moment when they might be of use once more; what it means to them to have appeared when and where they did – they and no others” (p. 123).

our relationships (such as “the occupational therapist has to apply for shower modification funding”). Discourses also form and are formed by the world we manufacture. For example, a shower unit is produced by historically contingent discourses regarding the purpose and limits of the shower, the possibilities of the materials that comprise it, and the subject who is expected to use it. In Figure 2 below, this includes the 4-inch step that demands the Showerer stand and step up, and a showerhead controller that the Showerer must reach up to.

Figure 2

My shower unit with a 4-inch lip to step over



Note: Own work.

Discourses can be named as a collection of statements and objects (such as knowledge of what it is to be a healthy, hygienic citizen, who enforces the shower step rules and what a shower step does) that function to govern our ways of being and doing in the world.

Discursive Objects and Therapeutic Operators

An aspect of discourse that is particularly important in this thesis are “discursive objects”—objects that are formed through discourse.¹⁷ This is not to say that material objects do not exist outside of discourse; rather, that discourse governs the transactions between all objects that are caught in the discursive net. The laws of possibility and rules for existence for objects such as the shower (such as they can transport warm water to wash dirty skin or suddenly drop cold water to cool manic brains) are governed by discourse. The shower is one of the infinitesimal elements of discourse. These laws and rules for the shower emerge from a history, or “archive”, of what has been said and done and that continue to define the relations between things. This archive of possibilities, connections, and differentiations “systematically form the objects of which they speak” (Foucault, 1969/2002, p. 54). By studying the shower, I aim to reveal how it is (in its many forms) a discursive object formed by the order of discourse.

In addition to being formed by discourse, the shower is a “therapeutic operator”. Through its materiality, it contributes to the establishment and maintenance of its laws of possibility and rules for existence. It connects and disconnects through transactions with humans and other objects of the environment such as water, plastic, drains, and concrete. While discourse may create the laws and rules, discursive objects are also agents in the production of discourse. Foucault (1969/2002) explained that objects (or “things”) exist prior to (or anterior to) discourse and may be considered “prediscursive” (p. 52). This is not to say that analysis should seek to know the “prediscursive”; rather, that through transactions objects enter discourse, bringing with them possibilities that may not yet be named and defined within the discursive net (e.g., the effect of warm water on the body). While it is not possible to describe the pre-discursive, analysis can seek out and recognise the contributions of pre-discursive effects of non-human agents as they have entered into discourse.

Foucault has been argued to be a “materialist” (Olssen, 2002). The non-human aspect of discourse is important in Foucauldian discourse analysis, and particularly in studies of governmentalities. Foucault (1979/2007) defined the milieu that is the focus of biopolitics (a governmentality I discuss further below) as “the intersection between a multiplicity of living individuals working and coexisting with each other in a set of material elements that act on them and on which they act in turn” (p. 37).¹⁸ To

¹⁷ When Foucault (1969/2002) refers to “objects” he means anything that is named or that can be known. So “madness” could be an object; however, material things are also objects when they are named and are thus subject to the laws and rules of discourse.

¹⁸ Latour (1992) goes further than describing the material and social as simply that which interacts suggesting that the two create networks that can only function together: “[researchers]

understand the milieu in relation to showering, we must consider both discourses such as hygiene and what warm water does when it acts upon the skin (e.g., produces a pleasant sensation) to then shape the shower that we can speak of. While some forms of discourse analysis privilege “that which we speak of”, Hook (2001) cautioned Foucauldian analysts not to underestimate the effects of the “material”:

There is nonetheless a critical methodological efficacy in a cautious, pre-cursory exploration of the blurring between the textual and material, the ‘discursive’ and the ‘extra-discursive’... Being able to cautiously blur these lines will keep the analyst from under-estimating the discursive effects of the material, and the material effects of the discursive. (p. 30)

In this study I propose that discursive material objects and the therapeutic operations of such objects are particularly important as they may be distinguished from other discursive objects (such as ideas or subjectivities) by their durability. As Callon and Latour (1981) proposed, while the thoughts and activities of humans may be amenable to fairly rapid change, the materiality of manufactured objects and structures make historically accepted discourses durable. Rose and Miller (1992) explained that Latour’s notions of the actions of material forms in networks stabilise and extend the effects of the general powers in which Foucauldian scholars are interested. They reiterate the idea that such materialisations are produced by discourse and provide a hold on the conduct of individuals (i.e., perform therapeutic operations): “Architecture embodies certain relations between time, space, functions and persons – the separation of eating and sleeping, for example... not only materializing programmatic aspirations but structuring the lives of those caught up in particular architectural regimes” (Rose & Miller, 1992, p. 184). While discourse and discursive objects can be seen in the present day, it is their historical construction that is of interest in a genealogical study.

History

Traditional historical research seeks to map out factual accounts of periods in the past and to explain that which shaped the events of that time. In contrast, a genealogy seeks to understand how modern practices have come to be.¹⁹ Without this appreciation of the history of a problem at a decentralised micro and material level, the

are never faced with people on the one hand and things on the other, they are faced with programs of action, sections of which are endowed to parts of humans, while other sections are entrusted to parts of nonhumans” (p. 174). Foucault (1976/1980b) agreed that it is not the existence of material and social that is important; rather that the action that results from the interaction is central, suggesting that power, as a force of governance, is “neither given, nor exchanged, nor recovered, but rather exercised, and that it only exists in action” (p. 89) and “individuals... are the vehicles of power, not its points of application” (p. 98).

¹⁹ As noted above, referred to as a history of the present.

complexity of discourse remains hidden. While historians may see such research as biased by “presentism”, post-structural genealogical research has proven itself to be useful for uncovering the contingencies that taken for granted truths have been built on and opening the way for radical rethinking of future possibilities (Garland, 2014). Unlike traditional historical research, its strength is not in following prescriptive methods; rather, it is in challenging boundaries that pre-determine what can be or ought to be known, and how this knowledge should be created.²⁰ It is interested in decentralised, heterogenic collections of discourse, architecture, material objects, humans, practices, and subjectivities (see “Dispositif” below). It is innovative, contentious, interesting and often unusual research that does not propose linear progressions or a steady advancement in knowledge.

As noted in the Introduction chapter, although I am interested in current practices that exclude people from funding for a modified shower, I came to wonder how showering within one’s own home had come to be an essential everyday activity. “How had the shower come to take the shape that it did, necessitating the need for it to be modified; and how did the State come to be involved in any of it”? Using Foucauldian discourse analysis would help me to uncover the taken for granted truths that established the practice of showering, of building shower units that some people cannot access, and establishing funding from which some people were excluded. A tool that Foucault proposes can reveal this decentralised and contingent history is the “dispositif”.

Foucault’s “Dispositif”

A key concept of Foucault’s that guided my study of the history of the shower was the “dispositif”. Expanding on the idea that discourse is beyond linguistics, Foucault (1979/1980a) described the dispositif as a network of discourses, objects, laws and rules that has emerged as a strategic imperative to address an *urgent need*. The dispositif itself is the relations between these elements (connections and disconnections) that adjust over time (a “strategic elaboration”) as the effects of these relations emerge (Foucault, 1979/1980a):

What I’m trying to pick out with this term [dispositif] is, firstly, a thoroughly heterogenous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic prepositions – in short, the said as much as the unsaid. (Foucault, 1979/1980a, p. 194)

²⁰ Foucault’s ‘history of the present’ is a post-structuralist approach in which knowledge is understood to be unstable and contingent (Foucault, 1968/2003c). Writing of history is not seen as the ordering of a linear advancement; the present is, however, an effect of “historical conditions that allow us to think, speak and act as we do now” (Fadyl & Nicholls, 2013, p. 25).

Analysis of the *dispositif* reveals multifaceted, decentralised power relations, through which power (defined further below), its achievements and successes, its ruptures and contradictions, can be understood.

As a tool for application to present-day problems (such as the puzzling exclusion of Jay from funding), exploration of the archives associated with the *dispositif* can be particularly useful:

A history of the present always involves a critical distancing from the present, an analytical description of the *dispositif* within which the object of study is constructed and experienced in the present, and a specific problematization that views that object as puzzling in ways that can be made less puzzling by means of historical inquiry. (Garland, 2014, p. 379)

While the *dispositif* has numerous functions, analysis of these historical constructions and adjustments can reveal how the *dispositif* “can function as a means of justifying or masking a practice which itself remains silent” (Foucault, 1979/1980a, p. 194). In other words, revealing the hidden general powers that tell us why we do what we do, and keep from view what our doing does. Through my analysis I will reveal how the MOH funding for modifying showers is a feature of a *dispositif* that has been constructed and adjusted over time to justify and mask the puzzling and problematic way that the grim housing situation for disabled people in Aotearoa New Zealand has been maintained.

Power

Analysis of the *dispositif* can reveal the “general powers” that act through basic level technology such as the shower (Foucault, 1976/1980b). So, what is this “power”? Power can be thought of as the “governing” effect of discourse.²¹ Foucault (1975/1995) explained that:

To analyse the political investments of the body and the microphysics of power... one would be concerned with the ‘body politic’, as a set of material elements and techniques that serve as weapons, relays, communication routes and supports for the power and knowledge relations that invest human bodies and subjugate them by turning them into objects of knowledge. (p. 28)

While Foucault referred to weapons and subjugation, it is important to note that this concept of power is not limited to being an oppressive force. Rather, it is connective and serves to determine what we do. What we think and think to do rests on knowledge: shared understandings of what is possible, what is preferable, and what is out of the question. Power is not something held, it is something practiced through the collective action of taking up ways of speaking, thinking, and doing (Foucault, 1982).

²¹ Foucault (1975/1995) suggested that “power... is conceived not as a property, but as a strategy, that its effects of domination are attributed not to ‘appropriation’, but to dispositions, manoeuvres, tactics, techniques, functionings; that one should decipher in it a network of relations, constantly in tension, in activity, rather than a privilege that one might possess” (p. 26).

For example, occupational therapists are constructed as EMS assessors as part of the MOH housing modification process, and in that role, they take up a duty to adhere to the modification manual. This then supports and sustains the MOH practices that construct Disabled-People, their houses and the possibility of modifications.

Foucault (1969/2002) suggested that this accepted knowledge, or “the Truth”, relies in part on “authorities” who determine the limits and boundaries of its acceptance.²² Authorities can extend the reach of a discourse. This should not, however, lead the reader to the belief that power is held by a few sanctioned people, documents, or institutions (such as the MOH), or that discourses emerge from these few to be dispersed throughout society. The governing function of discourse and the power discourse conveys relies on the connections that are formed and maintained down to the most basic levels.²³

Authorities employ discourse to create subjects and govern the interactions between subjects and objects. Foucault (1969/2002) explained that grids of specification (systems in which objects are “divided, contrasted, related, regrouped, classified, derived from one another” [p. 46]) function to categorise/know and relate objects. It is through this arranging, rearranging, and dividing that the laws and rules that create possibilities or impossibilities are defined and enforced. While authorities are involved with the production and dissemination of discourses, their position of authority also relies on discourse. Discourses that establish and maintain an authority (i.e., help us to decide who should be listened to) change over time. For example, the authority of the king was once accepted as he was chosen by God. To disobey the king was to disobey God and thus risk eternal damnation. An example of an agreement that we have today with our elected leaders is that the individual should follow rules that are intended to protect us and others. Thus, good citizens follow building regulations that might otherwise seem to be an inconvenience; as such, people accept the knowledge that the rules are there to protect them and their property. Furthermore, technologies of training parents to bathe their children, requiring students to shower at school, connecting antisocial behaviour to poor hygiene, and the presence of humans and machines that monitor adherence and punish breaches, govern all towards stepping over the shower lip.

As noted above, this thesis is particularly interested in the power of the material, the therapeutic operations of walls, shower trays, water, and so forth that “operate to

²² Here I have used Foucault in that very way. As an authority on discourse analysis, I have drawn on his own writings to add support to my own attempts to explain and define the object of discourse.

²³ I very much enjoyed Latour’s (1986) “Powers of Association” article on this topic and think it is a useful discussion of how the world might be tied together.

transform individuals: to act on those it shelters, to provide a hold on their conduct, to carry the effects of power right to them, to make it possible to know them, to alter them” (Foucault, 1975/1995, p. 172). It is this function that makes the material political, contributing to the structures that produce the grim effects we see today in relation to housing disabled people. As Winner (1980) stated: “the issues that divide or unite people in society are settled not only in the institutions and practices of politics proper, but also, and less obviously, in tangible arrangements of steel and concrete, wires and transistors, nuts and bolts” (p. 128). As noted above, the materiality of such arrangements makes them durable, and also makes them difficult to resist.

Governmentalities

Although I am studying showers, a “basic level” technology, I am interested in how the shower is “invested and annexed by more global phenomena and the subtle fashion in which more general powers or economic interests are able to engage with these technologies” (Foucault, 1976/1980b, p. 99). Foucault referred to these macro-level influences as “Governmentalities” (Rose et al., 2006). While it might sound like Foucault is suggesting that such powers belong to the political parties that govern the country, this is not what he is suggesting with his use of this term. Rose (1996) proposed that in studying governmentalities

One needs to ask how, and in what ways, and to what extent the rationales, devices, and authorities for the government of conduct in the multitude of bedrooms, factories, shopping malls, children’s homes, kitchens, cinemas, operating theatres, classrooms and so forth have come linked up to a “political” apparatus? (p. 38)

A study of governmentalities focuses on the practical effects of general powers, the interactions between the day-to-day conduct of individuals and societal level powers. General powers infiltrate down to the most infinitesimal elements of society and can be revealed by analysing the most basic level of conduct, such as showering.

Just as the archive reveals the formation of the laws of possibility and rules for existence of discursive objects, history reveals how day-to-day conduct (i.e., what we do) is the practice of governmentalities. Foucault was interested in governmentalities and the discourses that function to both legitimise and limit the involvement of the state in the lives of the subjects (Rabinow & Rose, 2006). Rose and Miller (1992) suggested that the governmentalities legitimise and limit the connections between subjects, objects, and the political apparatus to connect the conduct of citizens to the aspirations of governments. These governmentalities may, therefore, be considered systems of thought and systems of action (or general powers) that are used to give effect to government. I talk about two such governmentalities that Foucault wrote (or spoke) about—biopower and neoliberalism—below.

Governmentalities: Biopower and Neoliberalism

Biopower

Foucault named one such governmentality biopower. This governmentality involves attending to the bios or biology of the population or populations as “species”.²⁴ Biological functions become objects of knowledge and enter discourse so that functions such as birth rate, mortality, and bodies in their transactions with production, or the health and wealth of the nation, can be governed (Foucault, 1979/2007).²⁵ Biopower involves putting security mechanisms in place to produce a way of living and includes “improving life by eliminating accidents, the random element, and deficiencies” (Foucault, 1976/1997, p. 248). As such, this is a governmentality that aims to normalise. There are two key biopower governmentalities employed to do this—anatomo-political discipline (in which “man-as-body” is the focus)²⁶ and biopolitics (in which “man-as species” is the target of government)²⁷ (Foucault, 1979/2007). In addition to these two forms of biopower that Foucault described, I introduce two additional forms of biopower that have been described by Foucauldian scholars and which I have found pertinent to my study. These are the Fordist disciplinary society and democratic power.

²⁴ “This year I would like to begin studying something that I have called, somewhat vaguely, bio-power. By this I mean a number of phenomena that seem to me to be quite significant, namely, the set of mechanisms through which the basic biological features of the human species became the object of a political strategy, of a general strategy of power, or, in other words, how, starting from the eighteenth century, modern western societies took on board the fundamental biological fact that human beings are a species. This is roughly what I have called bio power” (Foucault, 1979/2007, p. 16).

²⁵ “The population can only be the basis of the state’s wealth and power in this way on condition, of course, that it is framed by a regulatory apparatus (appareil) that prevents emigration, calls for immigrants, and promotes the birth rate, a regulatory apparatus that also defines useful and exportable products, fixes the objects to be produced, the means of their production, as well as wages, and which prevents idleness and vagrancy. In short, it requires an apparatus that will ensure that the population, which is seen as the source and the root, as it were, of the state’s power and wealth, will work properly, in the right place, and on the right objects” (Foucault, 1979/2007, p. 97).

²⁶ “Disciplinary normalization consists first of all in positing a model, an optimal model that is constructed in terms of a certain result, and the operation of disciplinary normalization consists in trying to get people, movements, and actions to conform to this model, the normal being precisely that which can conform to this norm, and the abnormal that which is incapable of conforming to the norm” (Foucault, 1979/2007, p. 85).

²⁷ “A plotting of the normal and the abnormal, of different curves of normality, and the operation of normalization consists in establishing an interplay between these different distributions of normality and [in] acting to bring the most unfavorable in line with the more favorable. So we have here something that starts from the normal and makes use of certain distributions considered to be, if you like, more normal than the others, or at any rate more favorable than the others. These distributions will serve as the norm” (Foucault, 1979/2007, p. 91).

Anatamo-politics

Anatamo-politics aims to govern what we do by disciplining the operations of the individual body. Foucault (1975/1995) explained:

The historical moment of the disciplines was the moment when an art of the human body was born... a policy of coercions that act upon the body, a calculated manipulation of its elements, its gestures, its behaviour. The human body was entering a machinery of power that explores it, breaks it down and rearranges it... A 'political anatomy'... defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus discipline produces subjected and practised bodies, 'docile' bodies. (pp. 137-138)²⁸

Anatamo-politics achieves this production of docile bodies through several techniques beginning with "an uninterrupted, constant coercion, supervising the processes of the activity" (Foucault, 1975/1995, p. 137). This constant supervision of a discipliner is enhanced by the creation of spaces in which the subjects can be brought together and made visible. Such spaces are characterised by "enclosure, the specification of a place heterogeneous to all others and closed in upon itself. It is the protected place of disciplinary monotony" (Foucault, 1975/1995, p. 141). The concentration of subjects into these collective, confined spaces further functions to "eliminate the effects of imprecise distributions, the uncontrolled disappearance of individuals, their diffuse circulation, their unusable and dangerous coagulation" (Foucault, 1975/1995, p. 143).

The disciplinary apparatus is formed to produce bodies (and body parts) that perform, and through that performance are themselves productive; "disciplinary power appears to have the function... of coercive link with the apparatus of production" (Foucault, 1975/1995, p. 153). Timetables, timed motion, correct position, exhaustive use, and body-object articulations are methods employed to control the activities of docile bodies and make them more productive (Foucault, 1975/1995). It is this connection to the "apparatus of production" (or a nation's more general economic interests) that links the practice of anatamo-politic discipline to biopower's purpose of improving the health and wealth of the nation (Foucault, 1979/2007).

As noted above, architecture, and indeed any object, can form part of the discourse that governs through discipline. Transactions between objects and bodies or body parts may operate to transform individuals, to make them "docile and knowable" (Foucault, 1975/1995, p. 172). Disciplinary practices, such as rehabilitation, employ discourse to define the laws of possibility and rules for existence for the bodies that are acted upon. These discourses produce and define subjects and subjectivities, while

²⁸ While the focus is on the individual body, Foucault goes on to explain that discipline is still a practice of biopower in that the individual is a factor of the multiplicity, rather than the "raw material" of a disciplining governmentality. Discipline exists to produce a result at the collective level.

bodies as material objects conversely contribute to the laws of possibility and rules for existence of the discipline to which they are subjected. Bodies, subjects, subjectivities, and a multitude of material and abstract objects become the infinitesimal elements of power; the conduct of the individual and societal level powers converge. Thus, I am interested both in how disciplinary powers might produce who we are and what we do, and how an object such as the shower might enter discourse as an anatomo-politic disciplinary technology to normalise and connect bodies to the apparatus of production.

The Fordist Disciplinary Society

Although not described by Foucault, Fraser (2003) identified a post-World War I shift in the government of populations as the emergence of the “disciplinary society” (p. 163), associated with a Fordist governmentality. Within this governmentality, individuals were organised in time and space “according to expertly designed logics of control” (Fraser, 2003, p. 162). Discipline extended out from enclosed spaces and detached from a disciplining “other” to be dispersed through society. Strategies for the subject to become their own discipliner were established so that they would become self-regulating:

As Foucault emphasized, advocates of social control sought to foster self-activating subjects capable of internal self-governance. Wagering that such subjects would be more rational, cooperative, and productive than those directly subordinated to external authority, Fordist reformers devised new organizational forms and management practices... the overall thrust was to “subjectify” individuals. (Fraser, 2003, p. 164)

Rather than contain people in disciplinary spaces, a Fordist governmentality started to operate discipline at a distance through a network of institutions spread throughout society (Fraser, 2003). Fraser argued that Fordism connected individuals to the apparatus of production through national economic policy, specifically mass production and commodity consumption. Importantly, it was a totalising governmentality in which gender norms, family forms, home and community life, age and body regimes, and even entertainment were connected to the disciplinary network.

Fraser (2003) explained that a major feature of the Fordist disciplinary society was the proliferation of social work, psychotherapy, and psychology services to enlist subjects as agents of discourse:²⁹

The overall thrust was to “subjectify” individuals, to encourage linguistification of their internal processes as a means of holding them responsible for those processes, thereby augmenting their capacities for self-policing. Effectively conscripting individuals as agents of social control while at the same time promoting their autonomy, Fordist discipline sought to replace external coercion with internal self-regulation. (p. 164)

²⁹ See Molke (2011) for a discussion of the normative and coercive functions of occupational therapy.

Rose (1993) described this shift during the early 1900s as an “advanced liberal” governmentality in which experts could govern the conduct of citizens “at arms length” (p. 285). As Rose pointed out “two, apparently illiberal, poles of ‘power over life’ that Foucault identifies—the disciplines of the body and the biopolitics of the population—thus, surprisingly, find their place within liberal mentalities of rule” (p. 289). Experts who made claims to the “correct” conduct of individuals in the name of health were a key feature of this emerging governmentality:

In the name of social and personal well-being, a complex apparatus of health and therapeutics has been assembled, concerned with the management of the individual and social body as a vital national resource, and the management of ‘problems of living’, made up of techniques of advice and guidance, medics, clinics, guides and counsellors. (Rose, 1993, p. 286)

While conceived of as discipline, in a society governed by Fordist and liberal mentalities, discipline takes a very different form to anatamo-politic discipline which sought to contain docile bodies in disciplinary spaces and subject them to disciplinary practices. Within the disciplinary society, experts influence the social body as a composition of individuals who, through various techniques, “freely” self-manage their own health. The idea of such freedom is highly relevant to my concern regarding showering, privacy, and autonomy.

Biopolitics

While anatamo-politics aims to govern the individual body and body parts, biopolitics focusses on the population: “Biopolitics deals with the population, with the population as a political problem, as a problem that is at once scientific and political, as a biological problem and as power’s problem” (Foucault, 1976/1997, p 245). Osborne (1996) explained that a biopolitical governmentality recognises that there are pre-discursive influences such as natural or unknown actions and reactions of citizens, the market, and other things. This governmentality aims to understand these influences and to govern through manipulation of the environment (or “milieu”), to manipulate the actions and reactions of populations. Foucault (1979/2007) added that in a biopolitical governmentality the health of the population and the milieu are inextricably connected, in that the population is:

A multiplicity of individuals who are and fundamentally and essentially only exist biologically bound to the materiality within which they live. What one tries to reach through this milieu, is precisely the conjunction of a series of events produced by these individuals, populations, and groups, and quasi natural events which occur around them. (p. 37)

Biopolitics aims to “Make Live” by governing subjects towards “health, well-being (that is, sufficient wealth, standard of living), security, protection against accidents” (Foucault, 1982, p. 784). It is government at the level of generalities; statistics seek to

understand influences on the health, well-being etc. of populations, and to produce more favourable subjects through governing the milieu:

The mechanisms introduced by biopolitics include forecasts, statistical estimates, and overall measures. And their purpose is not to modify any given phenomenon as such, or to modify a given individual insofar as he is an individual, but, essentially, to intervene at the level at which these general phenomena are determined, to intervene at the level of their generality. The mortality rate has to be modified or lowered; life expectancy has to be increased; the birth rate has to be stimulated. And most important of all, regulatory mechanisms must be established to establish an equilibrium, maintain an average, establish a sort of homeostasis, and compensate for variations within this general population and its aleatory field. In a word, security mechanisms have to be installed around the random element inherent in a population of living beings so as to optimize a state of life. (Foucault, 1976/1997, p. 246)

While a biopolitical governmentality may function to improve the health of the population ("Make Live"), "Biopolitical Racism" functions to exclude (or "Let Die") populations who are seen as a cost to the health and wealth of the nation.

Unfavourable "species" (such as "the physically disabled", "the Elderly", or "Useless Eaters") are identified in relation to distribution around the norm. Biopolitical racism (biological rather than ethnic) towards the "inferior species" permits the state to not only allow natural death but also to kill to ensure population health:

On the one hand, racism makes it possible to establish a relationship between my life and the death of the other that is not a military or warlike relationship of confrontation, but a biological-type relationship: "The more inferior species die out, the more abnormal individuals are eliminated, the fewer degenerates there will be in the species as a whole, and the more I – as species rather than individual – can live, the stronger I will be, the more vigorous I will be. I will be able to proliferate". (Foucault, 1976/1997, p. 255).

Biopolitical death may mean literal death; however, it may also mean exclusion from life:

When I say "killing," I obviously do not mean simply murder as such, but also every form of indirect murder: the fact of exposing someone to death, increasing the risk of death for some people, or, quite simply, political death, expulsion, rejection, and so on. (Foucault, 1976/1997, p. 256)

This idea of "exclusion from life" is particularly important in this thesis as I explore the discourses that have determine where and how disabled people should live.

Though Foucault used the term "Biopolitical Racism" to describe the relation between the population and any "inferior species", in this thesis I have decided to use the term "Biopolitical Disablism". I discuss the complexity of study in post-colonial Aotearoa New Zealand further below; however it is useful to mention here that problems associated with ethnicity could be diminished by using the term "racism" in the way Foucault intended. Today, concerns about "colour-blind discourse and the phenomena of racial silencing" (MacDonald & Reynolds, 2017, p. 57) means that consideration should be given to the ethnic distinction associated with the term

“racism”. Furthermore, those both Māori and disabled face additional exclusions from life (Ingham et al., 2022) that the single term “biopolitical racism” could minimise. As such, the term Disablism is recommended (Ingham et al., 2022).

While anatamo-politics recognises body-object articulations and the use of architecture to carry disciplining power to the body of the individual, biopolitics has an even greater focus on the transactions between subjects and objects in the milieu.³⁰ It is the milieu which may be manipulated to promote the health and wealth of the nation or, more accurately, particular species of human within the population. Objects such as the shower may act as a therapeutic operator through anatamo-politic disciplining power, while also serving a biopolitical function as part of the milieu that promotes life, or excludes from life.

Democratic Power

While Foucault did not discuss democratic power, there seems to be a consensus that it is a form of biopower in Western modernity as described by Foucault (Prozorov, 2019).³¹ I did not set out intending to include the idea of democratic power; however, my analysis of showers designed for groups of people to shower in led me to seek additional tools with which I could explain government of a population. I found Cruickshank’s (1996) analysis of Tocqueville’s (1835/1961) study of “Democracy in America” particularly useful in describing the material effects of this form of governmentality. I introduce the idea of democratic government in Essay 2 (where it was employed within a shower room designed for miners); however, it may be useful to explain some key features here.

Democratic power may be distinguished from anatamo-politics, the Fordist disciplinary society and biopolitics through the granting of freedom to individuals within a population. However, isolated individuals are relatively powerless, so to exert any effect individuals must act collectively, tying their self-interests to the interests of the population. Democratic power relies on the interests of the collective and the actions of the individual being visible, and as such collective “associations” (such as Unions) form. To ensure these associations act in the interest of society, individual citizens must have “‘enlightened self-interest’ or ‘interest rightly understood’” (Tocqueville, 1961 cited in Cruickshank, 1996, p. 242). Venues for these self-governing associations to

³⁰ For example, “sewers, drains, privies and the water supply were also ‘organic’, in that they coupled themselves directly and literally to the vital economy of the body... tying the body, city and economy together... the environment has ceased to designate an exterior; the hydraulic city has become a regulated milieu along with the body and the economy” (Osborne, 1996, p. 114).

³¹ Prozorov’s (2019) book attempts to explain the complex relationship between biopolitics and democracy which is not necessary for the purpose of applying the idea of democratic power in this study.

gather are established and these shared spaces create “comrades” (from French, originally “one who shares the same room” [Harper, n. d.a]) who can overcome the powerlessness that they would have as isolated individuals.

Foucauldian scholars link the idea of democracy to Foucault’s discussion of ethics of self,³² however my interest is more material and terrestrial. The idea of rights is associated with democratic power. Again, influenced by my analysis of the shower room for miners, I argue that the idea of rights ties the interests of an individual to the territory of a collective. Simultaneously, having gained the right to the territory of the collective provides the individual with the chance to tie the interests of the collective to their own. The idea of rights is particularly important to this study given my interest in showering, privacy, and autonomy.

Neoliberalism

I had initially thought that neoliberalism would be an important governmentality to consider in my study. However, the legislation that established government funding of housing modifications was established before neoliberal rule came to dominate in the 1980s (Wilson, 2018). My final Essay includes some detail regarding the mid-1990s, where I show that rather than connecting disabled people to the neoliberal project, they are abandoned. I discuss this idea further in my thesis, but here I introduce some points regarding neoliberalism that are relevant to these arguments. The disciplinary society employs experts to influence the “freedoms” of citizens, but within neoliberalism the state becomes involved in the production of markets that produce “individual-liberty” and a totalising “market society” (Wilson, 2018, p. 29).³³

Within a neoliberal governmentality the individual is connected to the market society through the acquisition of their own human capital:

The neo-liberals pose their problems and set out their new type of analysis much more from the angle of acquired human capital, that is to say, of the more or less voluntary formation of human capital in the course of individuals’ lives. (Foucault, 1979/2008a, p. 229)

Biopolitics focuses on humans as specific populations and associations, while neoliberalism looks to manage heterogenous, autonomous individuals. These

³² “The care for the self always aims at the good for others... This implies also a relation with others to the extent that care for self renders one competent to occupy a place in the city, in the community or in interindividual relationships... I think the assumption of all this morality was that one who cared for himself correctly found himself, by that very fact, in a measure to behave correctly in relationship to others and for others. A city in which everyone would be correctly concerned for self would be a city that would be doing well, and it would find therein the ethical principle of its stability” (Foucault, 1984/1991 cited in Olssen, 2007, pp. 208-209). Clearly Foucault was also connecting the individual to the collective and to “interests rightly understood” within democratic government.

³³ “The main and constant concern of governmental intervention... must be the conditions of existence of the market” (Foucault, 1979/2008c, p. 140).

individuals are human capital, and can act as “Entrepreneurs of the Self” to self-govern their participation in the market society:

The neo-liberal analysts look out at the world and do not see discrete and identifiable firms, producers, households, consumers, fathers, mothers, criminals, immigrants, natives, adults, children, or any other “fixed” category of human subjectivity. They see heterogeneous human capital, distinct in their specific attributes, abilities, natural endowments, skills. They see entrepreneurs of the self. They see *homini oeconomici*, responsive agents to the reality of costs and benefits attached to activities, each of which are productive of satisfaction. (Dilts, 2011, p. 138)

The market society is governed through “*artificially* arranged or contrived forms of the free, *entrepreneurial* and *competitive* conduct of economic-rational individuals” (Burchell, 1996, pp. 23-24; italics in original). Mechanisms appear “with the function of producing, breathing life into, and increasing freedom, of introducing additional freedom through additional control and intervention” (Foucault, 1979/2008b, p. 67). As Foucault (1979/2008c) explained: “The regulatory principle should not be so much the exchange of commodities as the mechanisms of competition... The *homo oeconomicus* sought after is not the man of exchange or man the consumer; he is the man of enterprise and production” (p. 147). Individuals act to maximise their capital in relation to others, seeking to access activities that will add to their human capital. This then produces the source of their own income that they can then deploy to satisfy their wants and needs. Such activities may include education; participation in the cultural, commercial, and political community; and, of particular interest to this thesis, the construction and possession of buildings and things.

While neoliberalism is seen to be the dominant governmentality today, biopower and neoliberalism are not mutually exclusive. Biopolitics, discipline, and liberalism and neoliberalism may all be utilised for the purpose of state security. In his biopolitics lectures, Foucault (1979/2008b) explained that freedom and risk associated with liberal governmentality and biopolitical security of the state are two sides of a coin which furthermore, are “completely bound up” (p. 66) with disciplinary techniques. Clearly, the relationships between these different forms of governmentality are complex; however, Mavelli (2017) proposed that rather than acting in opposition, biopolitics may be thought of as complementary to a neoliberal governmentality. Biopolitical governmentalities function by “governing neoliberal life, namely, ensuring the resilience of neoliberalism by securing neoliberal life through a series of countermovements/biopolitical interventions that transcend the mere construction of resilient subjects” (Mavelli, 2017, p. 500). As such, they may function “as a way of smoothing and governing the harshest effects of neoliberalism, and thus as a way of governing the resilience of neoliberalism by preserving neoliberal life” (Mavelli, 2017, p. 501). In this thesis, I discuss the harsh effects of liberal and neo-liberal

governmentalities, the biopolitical smoothing of these effects, and the subsequent inclusion and exclusion of disabled people from community life.

Summary

The philosophical ideas of Foucault and others are used throughout this thesis to reveal the discursive history that has produced the grim picture of housing disabled people. Although the problem is clear to those who experience inaccessible housing, it has yet to be analysed from a governmentality level. Applying a post-structural, critical history methodology should reveal the macro level ideas that produce and sustain showers that disabled people cannot access within their dwellings.

3. Methods

While a post-structural researcher ought to avoid following prescriptive research practices, it remains a common practice for researchers to:

- see some sort of problem
- gather some form of data related to that problem
- in some way analyse the data that are gathered
- communicate findings to create some other place or space from which the research started

This is indeed the practice I have followed.

See Some Sort of Problem

As discussed in the Introduction chapter, the problem that is the focus of this study is exclusion from government funded housing modifications. It is clear from the Donald Beasley Institute's (2020) report, "My Experiences, My Rights: A Monitoring Report on Disabled Person's Experience of Housing in Aotearoa New Zealand", and the reports that came before it, that there is a serious problem with housing for disabled people in Aotearoa New Zealand. Research has continued to identify that the current process for making homes accessible via housing modifications is not meeting the need. Furthermore, cost analysis suggests that housing modifications can reduce the cost of health care, although it is a more expensive approach than building accessible homes. What has not been done before is research that could reveal how the current system came to be the way that it is and make it possible for this dissatisfactory system to be maintained. Following their comprehensive review of housing choices for disabled New Zealanders, McDermot Miller (2005) recommended several areas for further research, including studies that should "be concerned with investigating institutional social and economic structures and the extent to which these structures contribute to the specific forms of exclusion experienced by disabled people" (Zarb, 2003, cited in McDermot Miller, 2005, p. 22). Understanding these structures and how they produce the grim picture that disabled people experience in relation to housing, could "be made less puzzling by means of historical inquiry" (Garland, 2014, p. 379).

While previous studies have considered housing modifications, or housing for disabled people in general, I decided to study the problem through analysis of showers. As noted in the Methodology chapter, Foucault proposed that general structures, such as those that continue to produce unmet needs for housing disabled people in Aotearoa New Zealand, can be revealed by analysing the most basic level technologies. Such analysis can show how the act of excluding Jay from a modified shower is invested with and annexed by more general powers. A Foucauldian study

takes the problem of housing disabled people beyond present-day discourses regarding costs and benefits, to tell the reader about how disabled people have come to be governed. This brings the problem back to the very basic level of 1) a shower that had been installed in someone's home that demanded a very specific type of body to be available to control it, 2) people who shared the idea that showering was an essential everyday activity, and 3) a State that was connected to the possibility of funding or denying funding to modify this person's shower. It is a problem where the material and the social transact through historically contingent discourses, providing a methodological perspective on the more general problem that has not been employed before.

Gather Some Form of Data Related to the Problem

Having identified the problem I wanted to research, at the time of my public PhD confirmation of candidature presentation, I proposed to explore data from the mid-1970s, when level access showers emerged in New Zealand. I started out gathering documents that contained references to manufactured (as opposed to rain) showers. I searched Aotearoa New Zealand public and university libraries (digital and paper), local city council archives (paper), government department archives (digital and paper), and the Aotearoa New Zealand digitalised newspaper repository (I detail these further below). Similarly, I read modern books that had included some research into showers (such as those listed in the Introduction) to determine what territory had already been covered and to identify additional sources that could help me with my study.

As my search expanded, I sought out experts to consult and spoke with them regarding their knowledge of historical practices in relation to shower modification in New Zealand. I hoped that these consultations would lead me to further sources. Such experts included: people who had lived in large group homes or rehabilitation facilities, people who had been recipients of housing modifications in their own homes; people who had produced publications for designing and building modified showers; disability advocates, community occupational therapists (current and retired), funding advisors, tradesmen, sales reps, government ministry employees, architects, and academics. Because I was seeking established discourses, rather than wanting to construct new subjects and data that had not been involved in the existing structure, I decided to consult rather than interview.³⁴ At this point, I was hoping to locate data (comprised of text, drawings, photographs, and materials) that governed the possibility of modified showers over the period I was interested in.

³⁴ See Fadyl and Nicholls (2013) for a detailed explanation of the rationale for exclusion of interview in a study of the history of the present.

As I started gathering data, I realised that it would be necessary to go much further back into the archive to reveal the structures that had made modified showers a thinkable thing. Rather than limit my study to discourses from the 1970s to today, I decided to seek out the birth of the modern shower. While I felt it was necessary to go deeper into the archive, a Foucauldian approach to history is not the pursuit of detailing the facts from a particular period to provide a comprehensive account of an occurrence. Foucault (1969/2002) advised that the search for origins is fruitless; however, he suggested that it is useful to map the “surfaces of emergence” of an object as this is the time when the object’s domain is staked out, making it “manifest, nameable and describable” (p. 46). As Foucault pointed out, a genealogical analysis is not a study of linear progressions, it is a search for what has been thinkable and doable to make the effects of the present day possible. He stated: “Genealogy is gray, meticulous, and patiently documentary. It operates on a field of entangled and confused parchments, on documents that have been scratched over and recopied many times” (Foucault, 1971/2003, p. 351). As such, scholars must cast their net wide and deep to study the genealogy of an object.

While my decision to divert from my original proposal could be seen as a planning failure, Foucault (1969/2002) argued that undertaking the type of research that he employed is commensurate with venturing out of familiar territory:

At the end of such an enterprise, one may not recover those unities that, out of methodological rigour, one initially held in suspense: one may be compelled to dissociate certain oeuvres, ignore influences and traditions... instead of providing a basis for what already exists, instead of going over with broad strokes the lines that have already been sketched, instead of finding reassurance in this return and final confirmation, instead of completing the blessed circle that announces, after innumerable stratagems and as many nights, that all is saved, one is forced to advance beyond familiar territory, far from the certainties to which one is accustomed, towards an as yet uncharted land and unforeseeable conclusion. (p. 42)

I gathered texts from as early as 1754 BC (translated), but the majority of texts dated from the early 1800s when manufactured showers emerged.

For some time I debated limiting my data to texts produced in Aotearoa New Zealand, as I wanted certainty that the texts related to the practice of determining eligibility for level access showers at a local level. I felt that there was a risk in including texts from overseas which, although interesting, may have had no direct influence on local practices. However, Foucault’s discussion of *raison d’Etat* highlights the interest of the state in the actions of other states in its practices of governing, and the marketisation of the “rest of the world” in Europe’s interests.³⁵ Therefore, I decided it

³⁵ Foucault (1979/2008b) stated in the “globalization of the market... the whole world is summoned around Europe to exchange its own and Europe’s products in the European market”

was necessary to include documents produced outside of Aotearoa New Zealand in my data.

This preference for research to advance beyond familiar territory means it can be challenging to know what to do to carry out a Foucauldian study, particularly as Foucault offered little description of his process, leaving others to chart their own course. As such, I found my own way to gather data which, thankfully, Brinkman (2014) has described. Brinkman explained that “abductive reasoning” is a form of data gathering that post-structural researchers may use when they do not want to be confined by traditional research methods. Brinkman wrote:

As an alternative to the inductive “collector” and the deductive “framer,” I shall introduce the image of the abductive tool-user, the bricoleur, the craftsperson, as the ideal qualitative researcher. Unlike induction and deduction—both of which address the relationship between data and theory— abduction is a form of reasoning that is concerned with the relationship between a *situation* and *inquiry*. It is neither data-driven nor theory-driven, but *breakdown-driven* (Alvesson & Kärreman, 2011). It occurs in situations of breakdown, surprise, bewilderment, or wonder. (p. 722; emphasis in original)

Abductive reasoning is used when researchers want to understand a situation and inquiry is the process of sense-making. It is a never-ending process in which methods are learned about in response to a breakdown in one’s understanding. When using this approach, inquiry is used to help regain balance when researchers are tripped up by that which they do not understand, and what they stumble across as they search for sense. This becomes the data that is given to us. Although this might sound too loose to be considered appropriate for a PhD, Brinkman (2014) contended:

This is what objectivity might signify in qualitative inquiry: Stumbling upon objects. This means that the most objective forms of qualitative research are often the ones with the loosest designs. The more one decides to “collect data” in a methodological way or “frame the data” within a preset theoretical framework, the less objectivity and “givenness” can be attained. (p. 724)

I discuss this process of encountering a breakdown and sense-making further in the following discussion of my analysis.

To stumble upon data, I searched for reference to showers (and other terms which I discuss further below) in paper and electronic records in libraries including: the Auckland Public Library and its collections, the National Library of New Zealand, Auckland University of Technology library (with inter-loans from libraries throughout Aotearoa New Zealand and Australia), Auckland University Library (particularly the Architecture Archive), the Ministry of Health Library, the Philson Library of the Auckland School of Medicine, Massey University, Victoria University of Wellington, Christchurch

(p. 55). As a colonial nation, not only had the colonisers brought with them European discourses, Aotearoa New Zealand is a participant in the global market which involves the exchange of material goods and agreed ways to maintain this exchange peacefully. As a consequence, the Aotearoa New Zealand shower may be considered an object that is formed in part from discourses beyond our borders.

Public Library, Palmerston North City Library, CCS Disability Action library, and the BRANZ library. I searched archive collections including the Auckland Council Archives, the Hutt City Council Archives, Archives New Zealand, St Stephen's (Tipene) Old Boys, Salmond Reed Architects, Standards New Zealand, archive.org, Papers Past,³⁶ Babel Hathi Trust,³⁷ New Zealand Legal Information Institute,³⁸ Illinois University,³⁹ Espacenet (patent archive),⁴⁰ the New Zealand Intellectual Property Office,⁴¹ and Google Patents.⁴² I submitted Official Information Requests to the Department of Internal Affairs, MOH, and Ministry of Social Development, and was given a large collection from the MOH. Google Books was a fruitful place to search, and I made use of Google Scholar and Google images. Through my consultation with experts I was given access to personal collections.⁴³ I also visited building sites where level access showers were being installed⁴⁴ to help me to understand the materials and processes involved in their modern-day construction. Drawing from these sources, I created a conference poster out of modern wet-area shower materials to share my proposed study while highlighting the materialist philosophy and experimenting with the materials myself (Appendix B). I also continued to practice as a community occupational therapist, assessing the need for and applying to the MOH for modified showers for people in my community.

As I stumbled across sources that mentioned showers, I would skim read to determine whether the source related to manufactured showers (as opposed to rain showers). All the sources I found (with the exception of a few personal collection resources) were digitalised and saved according to their publication date. A close reading followed, leading me to identify subjects, objects, and connections between them that I did not understand. This caused me to pursue further sources that would help me to understand the discursive constructs that I was finding. I ended up with over 2000 saved documents and I would return to them repeatedly as I wrote. In this way, data gathering occurred in conjunction with analysis (which I discuss further below).

³⁶ www.paperspast.co.nz

³⁷ <https://babel.hathitrust.org/cgi/mb?a=listis&c=71329709>

³⁸ <http://www.nzlii.org/>

³⁹ <https://digital.library.illinois.edu/collections/8ec7a20-a0a1-0131-4a3f-0050569601ca-3/tree>

⁴⁰ <https://worldwide.espacenet.com/>

⁴¹ <https://www.iponz.govt.nz/>

⁴² <https://patents.google.com/>

⁴³ Some of which I have been given permission to archive in a public library for future researchers.

⁴⁴ Indeed, as I write this thesis, the shower unit in my own home has been demolished and a new shower is being constructed.

In Some Way Analyse the Data that are Gathered

It would be fair to say that I did not have a particularly clear idea of how I was going to go about analysing my “data” when I set out on my studies. The most concrete plan I had was to “reach into Foucault’s lectures and writings, and secondary interpretations of Foucault’s readings as I proceed with data gathering” (Cox, 2015, p. 32). I gathered up documents and read them, making notes about points of interest (such as “waste: water washed away vs compostable”) in my journal. At the same time as I started collecting data, I was fortunate to participate in a “Summer Discussion Series on Post-Structural Inquiry using Foucault and/or Deleuze” with Joanna Fadyl and David Nicholls. My participation in this discussion series undoubtedly influenced my understanding of what might be data and introduced me to post-structural researchers such as Elizabeth St. Pierre (1997) who uses Laurel Richardson’s (1994) idea of “writing as a method of inquiry” (St. Pierre, 1997, p. 365).

When using writing as analysis, St. Pierre (1997) employed Deleuze and Guattari’s idea of “smooth mental spaces” that allows researchers to make sense of what they find in their “data”. She writes of taking walks, writing, talking, and gardening as providing these smooth spaces. In addition to the talking that I was involved in through the Summer Discussion Series, I was fortunate to be part of a monthly ‘Foucaultquim’⁴⁵ for several years of my study. My analysis employed all these spaces; although I found, as did St. Pierre, that trying to adhere to academic writing conventions stymied the smoothness of the space I needed to make sense of what I was learning. Following Joanna’s suggestion, I started describing my findings in ‘Essays’. For me, the Essay evoked memories of high school, where I had successfully written short critiques of novels, poems, and plays. Academic conventions were not so demanding, and there was a more creative space than science or maths would allow. As such, my analysis Essays were sometimes handwritten, sometimes typed, and sometimes included drawings and photographs. Essays were written, re-written, shared,⁴⁶ and sometimes abandoned. Eventually, they came to form the Essays that make up the Findings section of this thesis.

Writing is a process of analysis described by post-structural researchers. St Pierre (1997) wrote about the use of writing the “aside” as a method that assisted her

⁴⁵ Effectively a book club for fans of Foucault.

⁴⁶ In addition to sharing my writing with my supervisors, my friends, family, and associates were subjected to my Essays. I was particularly fortunate to have been writing during Aotearoa New Zealand’s COVID lockdowns where many people became much more interested in how we are governed. I used this as an opportunity to discuss my ideas regarding democracy, rights, and the government of health through social media. This gave me an opportunity to test out my ideas with people who challenged me and reflected back different perspectives on topics such as power. This helped me to clarify my understanding of these concepts.

with her analysis. I tended to use footnotes in my Essays as a method to assist me with my writing, some of which have been retained in the final version of this thesis. Much of these related to theory, as I found myself moving back and forth between philosophy and findings as I wrote. Mazzei (2014) provided a detailed account of her use of reading and writing for analysis which describes my own experience of relating theory and data. Drawing on Karen Barad's (2007) concept of diffraction, she named the method she used as "diffractive reading", where data and theory are read alongside each other: "Reading these texts diffractively means that I have tried to read these texts through, with, and in relation to each other to construct a process of thinking with the data and with the theory" (p. 744). While perhaps my description of reaching into Foucault's theory while gathering data might seem simplistic, Mazzei explained that reading "data" and "plugging" theory and data into an assemblage allows analysis that "takes a rhizomatic (rather than hierarchical and linear shape) form that leads in different directions and keeps analysis and knowledge production on the move" (p. 743). Put simply, this method is "reading-the-data-while-thinking-the-theory, of entering the assemblage, of making new connectives" (p. 743). One such assemblage that I created early in the process of this study was the construction of the poster I referred to above (Appendix B). Having signed up to do a poster presentation at a conference, it became apparent to me that I could not follow the tradition of making a poster out of paper. From reading Actor Network Theory articles, I could see that the paper was important, but that it did not have a place in the study of showers. This led me to wonder whether there were shower materials that I could use to form a poster? Thanks to having earlier stumbled upon my builder-husband, we were able to access what was needed to produce such a poster. It was a Bricolage, as, in some ways, is this thesis.⁴⁷

Augustine (2014) expanded on this idea of moving between data and theory through the process of writing. Drawing on Alvermann's earlier work, she explained:

Deleuzian concepts that I only marginally understood percolated into my writing and connected to participants' experiences, making "it possible for me to 'see' in the data" and through the writing "something other than what I went looking for in the first place" (Alvermann, 2000, p. 126 cited in Augustine, 2014, p. 749)⁴⁸

Augustine described the process as "a machining or putting together" data and theoretical concepts. As I read source material, I was initially looking for objects and subjects that connected to showers and showering. As I wrote, I searched for the rationalities that connected these subjects and objects to governmentalities. As I

⁴⁷ I discuss how I have communicated my findings below; however, I would like to note that I have continued to struggle with the idea of this thesis ending up on paper. I would much rather it was a shower curtain.

⁴⁸ This quote appeals to me, as I, too, experienced only marginally understanding Deleuzian concepts. Unfortunately, I found percolating on his ideas too dangerous for my purposes of actually completing a thesis!

identified objects and subjects that were connected, I was able to search for and stumble upon additional sources (e.g., search did not start with but came to include searches for “housewife” in sources, “something other than what I went looking for in the first place”).

During my analysis (both initial and subsequent), I captured statements (e.g., “essential everyday activity”) and images to copy into my journals or save in an electronic format. As my analysis continued with writing Essays and reading philosophy, I returned time and again to source material to search for more data to help make sense of what I was seeing. Through reading source material, I discovered that my process of analysis was both about answering my research question, and uncovering the questions that needed to be asked. Such questions (e.g., “how did the state become connected to the government of private dwellings?”), would lead me to seek further sources, often resulting in my writing bounding and rebounding back and forth through time periods.

Writing Essays might have helped create the smooth mental spaces needed to analyse what I was reading; however, it was not a smooth process. I wrote a number of small Essays about a variety of topics relating to the data, philosophy, and my experience of doing my research, but eventually I started writing what would become my first publication and Essay 1 in this thesis. Essays would start small and usually swell to become behemoths. As I continued to write, read, discuss, and think, they would be divided, named, renamed, combined, restructured, refocused, cut, and pasted into the final form that they appear in here. To keep track of the changes that had been made, and not to cut something that I then wished to reinstate, document names included the date they were worked on and saved. Essays were then renamed when I opened and edited them. I ended up with around 200 documents that were Essays, parts of Essays, and reworked versions of Essays.

My decision to focus my study on showers as discursive objects that are part of a dispositif helped to initially extend and then refine my analysis. For example, while much could be written about hydropathy, seeking connections to showers refined my analysis to the specific practice of dropping cold water on the heads of maniacs and the discourses that connected the objects and subjects together to enact this practice. A further strategy that I employed to reduce the enormity of what I was analysing in my Essays was to continue to search for literature related to that which I was writing about. In the introduction to my Findings section, I identify the books and articles that I found to sufficiently attend to aspects of the dispositif that I did not need to repeat. I refer back to these sources within my Essays so that those who wish to read about these topics may do so.

The final issue that I had to contend with in the way I analysed my data, was to find a place where my study could end. The trouble with a PhD is that it does have to end and there are limits to how much it can contain and how long it can take to write. Despite my initial plan to start with the 1970s, most of this thesis leads up to that time, with the final Essay including some sources from the 1990s and early 2000s. Through my work as a community occupational therapist, I know that some fascinating practices emerged in the 2000s;⁴⁹ however, I felt that I had done enough when I had answered my research question.

Communicate Findings

Just as data gathering and analysis leaked into each other, presenting my findings has been a philosophical problem for me. Finding order to my Essays was extremely challenging, as the threads of discourses that established, ordered, maintained, or disrupted the subject and/or object that was the focus of an Essay did not follow a neat story of evolution. As noted above, “genealogy is gray, meticulous, and patiently documentary. It operates on a field of entangled and confused parchments, on documents that have been scratched over and recopied many times” (Foucault, 1971/2003a, p. 351). As such, when an Essay should start or end was difficult to specify, and which one should follow another was unclear.⁵⁰ Should the order of the Essays be determined by how long ago the discourses that I discuss emerged, or should they be ordered by the date of the object I was analysing? At one point I tried to abandon the idea of a thesis and proposed a website where Essays could be dipped into and out of in no particular order.⁵¹ I drew pictures and diagrams in an attempt to create some order for a reader (Figure 3):

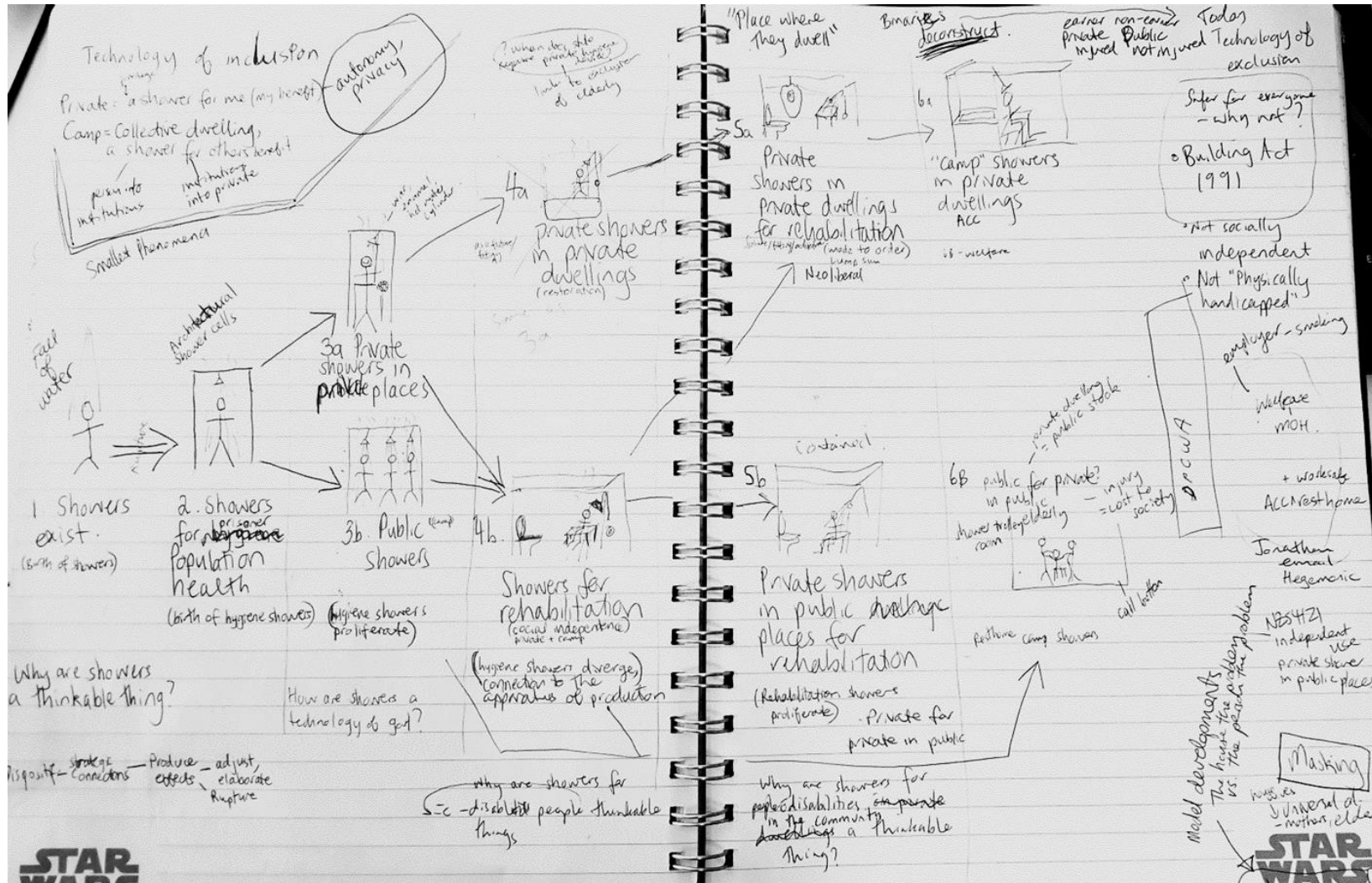
⁴⁹ For example, the since abandoned “Impact on Life” questionnaire that proposed to give disabled people a voice in the assessment process, while simultaneously using an algorithm to determine the availability of funding based on who had the greatest need and the greatest ability to benefit from a proposed housing modification.

⁵⁰ Perhaps this is a “problem” of post-structural research as beginning and ending was a problem that St. Pierre (1997) also encountered.

⁵¹ An idea I have not entirely abandoned.

Figure 3

Drawing to get Essays in an order



Note. Own work.

While the lack of order in my thesis might appear to be a fault, Foucault (1969/2002) argued:

We must renounce all those themes whose function is to ensure the infinite continuity of discourse... We must be ready to receive every moment of discourse in its sudden irruption; in that punctuality in which it appears, and in that temporal dispersion that enables it to be repeated, known, forgotten, transformed, utterly erased, and hidden, far from all view, in the dust of books. (p. 28)

Despite the struggle I had with creating some order in relation to my findings, eventually the Essays became more refined, and an order did emerge. The findings do, however, remain a bricolage, a collection of materials and ideas that have been crafted into something that is a thesis.

With regards to the collection of materials, where possible I have presented historical text as an image rather than writing it verbatim into my work. While it was not practical for me to cut up historic papers and paste them into my Essays, it seemed important to keep the sample from the source as close to its original form as possible. Presenting the text as close to the material construction that it was originally seemed to better align with my philosophy.

As Fadyl (2013) explained:

Foucault's ideas do not imply that discourse analysis can reveal truth (discourse contests the very idea of truth), but that discourse is a useful way of seeing things, one that can make available a type of critique that is focused on questioning the effects of the knowledges that make up our everyday. One difficulty with discourse when it comes to analysis is that by definition we speak, think and do within current discourse even as discourse analysts. The aim in examining discourse, therefore, is not to go outside of it but to make it more visible. (p. 15)

The purpose of these images is not to supply evidence to support the 'truth' of what I am saying; rather, to make the discursive constructs visible.⁵²

One of the issues that I encountered when crafting together the ideas and the materials was my desire to connect particular words that I used throughout the thesis to the discursive construction that I had described in my findings. I started to capitalise such words, for example, Essential Everyday Activity. However, the number of words that I wanted to capitalise grew and grew, producing sentences with so much reference to objects discussed elsewhere that it became disturbing to the reader. I explored the idea of using a glossary that could be used to check these internal references against; however, as the Essays started to have some order the need for such referencing seemed to reduce. I have, however, capitalised some words where it was particularly important that they not be read without connection to the discursive history discussed in this thesis. This includes words such as Independence, Rehabilitation, and Accessibility. Secondly, I have joined some words through the use of a hyphen, for example, Disabled-People and Wet-Area-Shower, to

⁵² These images are supported with Alt Text for those unable to see or read them.

maintain them as a discrete discursive assemblage. I hope the reader finds this strategy useful.

Ethical Considerations

I had initially proposed that my study would include sources from the 1970s through to 2015 and that I would seek access to clinical files for those who had sought housing modifications to reveal practices of exclusion beyond my experience with Jay. Ethical approval for this was granted. However, as discussed above, it became quickly apparent that it was necessary to look much further back than I had initially proposed, and eventually that I would not need to gather data from the modern day. As a result, I did not pursue this avenue. Consultation with the AUT Ethics committee confirmed that I did not need to gain ethical approval to speak with experts; however, I did provide an information sheet and obtained consent from those who shared their personal collections with me (Appendix C).

Foucauldian Discourse Analysis in Aotearoa New Zealand

While my study might be seen to have fewer ethical considerations than those that access private information about vulnerable people, the material aspect of my research led me to some quite different ethical deliberations. Today, in Aotearoa New Zealand,⁵³ undertaking research is, amongst many other activities, conducted in a space where knowledge and the right to knowledge is contested. Te Tiriti o Waitangi (1840) established a legal relationship between Māori, the British Crown, and, subsequently, the New Zealand Government. It is typical for research institutions in New Zealand to expect that researchers consider the relevance and impact of their research on Māori, and that their research be conducted in a way that (at the very least) does not further impinge on the rights that are laid out in Te Tiriti (e.g., Auckland University of Technology, 2020). Having studied Aotearoa New Zealand history in my final year at high school, and then studied te reo⁵⁴ for 4-years at Te Wānanga o Aotearoa (a Māori university), I took my responsibilities seriously. I initially proposed that I would consult with iwi⁵⁵ and hapū⁵⁶ as I set out on a study that could include

⁵³ I have chosen to use Aotearoa New Zealand at times and New Zealand at others. While I acknowledge that not all iwi refer to the islands colonised as “New Zealand” as Aotearoa, the term is the only one I have access to refer to New Zealand in te reo. At times I have just used “New Zealand” when the subject is a colonising entity, such as the New Zealand MOH.

⁵⁴ “Language, dialect, tongue, speech” (Moorefield, 2022a).

⁵⁵ “Extended kinship group, tribe, nation, people, nationality, race - often refers to a large group of people descended from a common ancestor and associated with a distinct territory” (Moorefield, 2022b).

⁵⁶ “Kinship group, clan, tribe, subtribe - section of a large kinship group and the primary political unit in traditional Māori society. It consisted of a number of whānau sharing descent from a common ancestor, usually being named after the ancestor, but sometimes from an important event in the group's history. A number of related hapū usually shared adjacent territories forming a looser tribal federation (iwi)” (Moorefield, 2022c).

seeking access to their personal collections. At this stage, I considered resources in public libraries as available to me without question. However, as my appreciation of the philosophy I was using grew, I took a very different path to that which I had initially proposed.

Traditional western research philosophies and practices, considered in the context of Te Tiriti, are a European peculiarity. They are shaped, often unknowingly, by the values, assumptions, technologies, and traditions of that particular place. For example, the idea that science may consist of an individual who has been educated at university and can use their senses (enhanced by machinery such as a microscope) to observe, measure, and document the material of the universe (and that such material is universal). The values and beliefs that underpin these ideas become questioned in a space where ownership of Indigenous knowledges, practices, and things remains contested (Waitangi Tribunal, 2011 – Wai 262). While some research methodologies accept their interpretive lens and recognise that this shapes the selection and use of data; the problem of ownership of knowledge, and the potentially oppressive effects of applying a foreign lens to Indigenous knowledge is less familiar. It is not just positivist research (which claims access to “truths”) that becomes questionable when one considers the use of Indigenous knowledges, practices, and things as research data; the application of any methodology generated outside of that which is Indigenous becomes the site of the possible perpetuation of colonisation.

As a non-Māori researcher, drawing on the concepts of a European philosopher, I find myself in the awkward position between discourses that aim to ensure research carried out in Aotearoa New Zealand is inclusive of the perspectives of the original inhabitants (thus preventing marginalisation), and those that argue one must not cause further harm to Indigenous knowledges by overlaying a European philosophy (and causing further oppression). If I avoid including discourses that have Māori origins, then I continue the long Eurocentric tradition that ignores Indigenous knowledges. If I include them, then I risk colonising those same discourses by attempting to analyse them through a European lens. As Hickey and Wilson (2017) explained, the very idea of disability is colonising and fails to appreciate the needs of whānau hauā from a Māori worldview.

In an attempt to find a position that allowed me to proceed with my research in this space, I turned to the writings of Kaupapa Māori researchers. These researchers are highly critical of the privileging of European philosophers (Dead White Males) in research practices (Pihama, 2001; Walker, 1996). For such researchers, Māori knowledges are considered a gift from the Māori gods that are “created by the use of whakapapa” (Pihama, 2001, p. 82). Māori knowledge is, therefore, a birth right that is part of the connection between the people, the natural and the supernatural worlds. These researchers aim to confront oppression by positioning Kaupapa Māori theory as the framework for understanding all things Māori, and challenge marginalisation by ensuring research is reproduced by Māori for Māori. “Kaupapa

Māori Theory is not for sale; it cannot be bought. Pakeha may attempt to co-opt our tikanga, to submerge te reo Māori within the Master Language, to appropriate our Theory itself... Our world, nor our World View, our Tikanga was never for sale. As Māori, we are not the commodity” (Walker, 1996, p. 118).

As noted above, in Kaupapa Māori theory, whakapapa is a fundamental concept. All things have traceable origins that describe where they have come from and that establish their connection to all other things.⁵⁷ It is this tracing back to Māori ancestors that some Kaupapa Māori researchers argue is an essential element in preventing the misappropriation of Māori knowledges. My genealogy is European. Indeed, the story of my family is that our first ancestor arrived in Aotearoa New Zealand as a deserter from the French navy (who were apparently hoping to claim Aotearoa New Zealand for themselves at the time).⁵⁸ A trail of immigrants followed on early ships from England, Ireland, and Spain (at times via Australia) throughout the mid to late 1800s and early 1900s. My whakapapa connects me to the knowledge of “Dead White Males” such as Michel Foucault. As I and my research methodology descend from European universities, I believe that were I to include data from Te Ao⁵⁹ Māori in my study, I would be further colonising that world.

By choosing to avoid misrepresentation of Māori knowledge, one could argue that I meant to deliberately exclude Māori, and discourses from Te Ao Māori that may have permeated practices involved in the funding of modified showers. Another argument might be that I intended to ignore that I conducted my research in Aotearoa New Zealand or that I forgot my obligations to conduct my research in a way that recognised and respected that I must not (at the very least) cause evil⁶⁰ to the Indigenous population. This was and is not my intention. It is the particular modern research tradition in Aotearoa New Zealand that calls on researchers to actively seek Māori representation throughout the research process (in an attempt to address the marginalisation that otherwise occurs)⁶¹ that I am concerned with. It is this seeking of representation, the inclusion of data from those representations and claiming that my study (at least in part) represents Māori perspectives is what I intend to avoid. It is the evil of taking matauranga⁶² Māori with the intent of using it for my own purposes, the harm caused by taking this knowledge and making it subservient to Foucauldian concepts, and my intent to be critical of all discourses that makes the deliberate practice of representation dangerous.

⁵⁷ Although it is recognised that an inability to know one’s whakapapa does not diminish its existence (Walker, 1996).

⁵⁸ Ko he waka taua o wiwi toku waka, ko ngāti wiwi toku iwi, ko Jersey toku motu, ko te British Isles toku moana, ko D’Authreau toku hapu, ko Lyttleton te kainga o toku tipuna.

⁵⁹ “World” (Moorefield, 2022a).

⁶⁰ “Nga kino” (Te Tiriti o Waitangi [Māori version], 1840, p. 2).

⁶¹ See the Health Research Council of New Zealand (2010) for example.

⁶² “Knowledge, wisdom, understanding, skill - sometimes used in the plural” (Moorefield, 2022a).

In my everyday practices (as an occupational therapist) I have obligations under Te Tiriti (1840). I must ensure that Māori are not marginalised and receive “nga tikanga katoa rite ki ana mea / the rights and privileges” (Ko te Tuatoru / Article the Third) of the British (and subsequently Aotearoa New Zealand immigrant) population. To this end I have sought and continue to seek an understanding of Te Ao Māori. However, in my position as a researcher, particularly as the title of a PhD confers a level of expertise, I am in a very different space. Rather than providing a service, I am seeking data. Rather than drawing on knowledge to inform my practice, I am creating and disseminating knowledge from a particular and privileged position. My thesis involves the application of Michel Foucault’s concepts, drawn from his own research of European history, to describe practices of government. While these practices were brought to Aotearoa New Zealand through the process of colonisation and, consequently, have an effect on Māori, the approach I took does not seek to understand the perspectives of Indigenous peoples; rather, to discover the effects of these practices. While I could (and originally intended to) search out knowledge from Te Ao Māori, my purpose would not have been to bring to light the truths contained in such knowledge, but to critically analyse the strategies of government evident in these discourses. To do this would risk misrepresentation of Indigenous knowledges by attempting to assimilate Te Ao Māori discourses into a Foucauldian analysis.

This Study and the Territory of Taonga

I would not like to think that my position represented a space in which non-Māori researchers in Aotearoa can simply exclude Māori perspectives from all forms of research. Whether one is Māori or not, and whether one is using Kaupapa Māori Theory or not, any research that aims to describe, define, or manipulate Māori taonga, or any other things that Māori connect to through whakapapa and kaitiakitanga, ought to be carried out in a manner that acknowledges the decision-making power and Māori control over all things Māori that was guaranteed in Te Tiriti (Broughton & McBreen, 2015). The question is then, do my studies enter the territory of Māori taonga or other things? In the following discussion I have attempted to ascertain whether my studies do encroach by searching Waitangi Tribunal claims related to the material included in this thesis.

My primary (but not only) data source is written texts. Te reo Māori is “an essential part of the culture and must be regarded as “a valued possession” (Waitangi Tribunal, 1986, WAI 11, s4.2.4). The Māori language was spoken (or sung), and stories were communicated through arts, but there was no written language prior to colonisation. As such “Kaupapa Māori Theory does not subsume itself within the European philosophical hegemonies that posit the supremacy of the written word over the spoken” (Walker, 1996, p. 119). Historical Māori texts do, however, exist and are themselves considered taonga: “Māori material in

archives and libraries are taonga because they hold matauranga about, and generated by, kaitiaki communities” (Waitangi Tribunal, 2011, Wai 262, s6.4.4[1]). Māori wish for such material to be made highly confidential “so as not to facilitate misappropriation and misuse” (s6.4.2[1]) and are of the view that current legislation regarding archives and libraries fails to address Te Tiriti obligations. However, access to, and protection of these taonga (for now) remains in the hands of the Crown. The risk for the misuse of information has been balanced against “one of the central tenets of open and democratic societies: freedom of access to information” (6.4.4[2]). As outlined above, it is my wish to avoid misappropriation and misuse of such taonga, given the issues outlined above regarding my methodology. As such, I did not source documents that were written in te reo or other materials that were produced or held by kaitiaki communities.

Most recently, the Wai 2575, #B23 Māori with Disabilities (Part Two) Report (Kiwai & Allport, 2019) identified issues with MOH funding for housing modifications:

This house, my husband and I had a freehold when we came here and we lived next door. We are in our 50s. We built this house for my granddaughter. To be able to do that we went into debt... We had no funding for this house. We did it on our own. I fought for everything, a [accessible] shower... I had to pay for the installing of it and that was dearer than the shower... There are so many things and yet for us here we strive for everything that we need for our children. (Whānau cited in Kiwai & Allport, 2019, p. 55)

The report acknowledges the historical structures that produced the disparities they identified:

This discussion of the historical context of disability services draws attention to the failure of state and voluntary agencies in the past to address the specific needs faced by Whānau Hauā, which has helped to explain current disparities, and which can be traced back to racial policies that underlay approaches to addressing Māori health and social issues. The colonial state’s commitment to policies of racial amalgamation, assimilation and integration meant that social policies, including policies towards Whānau Hauā, were based on the belief that ‘raising Māori up’ to accept Western ideas about health and wellness was the key to improving outcomes. (Kiwai & Allport, 2019, p. 72)

Issues were reported with the ways that the needs of Māori were assessed by providers, systems, and people who fail to understand what is important to Māori, insufficient support to navigate systems, and the failure of providers to recognise mana. The report found that the current system fails to uphold the sovereignty, autonomy, and equality that was guaranteed through te Tiriti, and concluded:

Certainly one of the key findings from this report would be the need for the development of a specific research agenda for Whānau Hauā and the disabilities sector, and it is hoped that this report will provide another platform for future discussions, and a platform to truly start listening to the many voices of all Māori whose lives have been affected by disabilities. (Kiwai & Allport, 2019, p. 76)

I hope that this thesis can go some way towards arguing for such an agenda as detailed in my Discussion chapter.

A second area my study enters, is the territory of buildings, in particular homes. Historic buildings are considered taonga (Mataatua wharehau for example) and traditional dwellings on Māori land are closely guarded through formal procedures that permitted or prevented visitors from entering: “To Māori, land is everything. Land provides our sense of identity, of belonging, of continuity. Whenua is our link to our tupuna and to the future generations” (Flavell, 2016, para. 4). Although many Māori today live in European style houses, this is associated with specific colonising strategies that aimed to disrupt Te Ao Māori (see Williams, 2001 and Wanhalla, 2006). With regards to ownership and governance of Māori land “statute law has tended to be less cognisant of tikanga Māori” (Te Puni Kokiri, 2016, p. 5).⁶³ Māori lands and the dwellings that rest on them are clearly taonga. While Māori have been included in this study as part of the population of Disabled-People, it is important to recognise that an additional history of colonisation has created further structures that create a particularly grim picture for Whānau Hauā.⁶⁴ I have not attempted to analyse these structures in relation to Whānau Hauā in particular. This is a vitally important area of research yet to be explored. For example, the Accessibility for New Zealanders Bill (2022) stipulates that “all persons performing a function or duty or exercising a power under this Act must act in a manner that gives effect to the principles of te Tiriti o Waitangi/the Treaty of Waitangi” (s6). Without knowledge regarding the additional effects of colonisation on housing Disabled-People, it will be difficult for those involved to appreciate the complexity of the structures that keep disabled Whānau Hauā from receiving the full benefits of citizenship.

While showers were a European invention, water is most certainly a Māori taonga (Waitangi Tribunal, Wai 2358, 2012). As outlined in the 2012 Waitangi Tribunal Claim (Wai 2358) freshwater claim, Māori ownership and control of water does not (at this point in history anyway) seek to be involved at the level of water coming out of a showerhead.⁶⁵ In contrast, bodies of water, which function as a resource for food, housing, clothing, healing, travel, enterprise, spiritual life and life force, identity, as the homes of spirits, territory guaranteed protection, relations through whakapapa, and places of occupation are a contested space (Wai 2358). As such, subjects such as the ownership and protection of

⁶³ For example, Te Ture Whenua Māori Bill (2016) which aimed to address the inconsistency between individualised interests in Māori land and Te Tiriti o Waitangi (Te Puni Kokiri, 2016), was recently presented to and rejected by Parliament (New Zealand Parliament, 2022).

⁶⁴ Previous research has involved consultation with Māori. McDermott Miller (2005) identified the issue of substandard housing as an issue that was compounded for Māori and the need for more research in this area. Saville Smith et al. (2007) identified barriers such as a lack of information, an expectation that people will ask for what they need, and a focus on the individual as particular barriers to housing modifications for Māori.

⁶⁵ “The claimants accept that nothing as a consequence of this claim can mean that anyone in New Zealand has their tap turned off. That’s unacceptable. It’s inconsistent with the partnership obligations under the Treaty. It’s inconsistent with the tikanga of sharing, which is also an essential part of Māori relationships with their water resources” (Waitangi Tribunal, 2012, s1.4.2).

waterways and ocean, and management of wastewater have attracted the attention of Māori researchers (i.e., Muru-Lanning, 2010, 2012 and Ahuriri-Driscoll et al., 2008). Furthermore, recently proposed legislation aims to give effect to Te Mana o te Wai (Water Services Entities Bill, 2022). Some research has attended to the history of Māori use of water for therapy (Nicholls et al., 2016; Stokes, 2000; Young, 1998). This relationship between water and healing in Māori, and the link between hygiene and showers that emerged in Europe, would be a subject of great interest. It is my hope that revealing European discourses that have shaped the way that water has been employed in the shower will create some further interest in this area of study and provide space for further analysis of this history from a decolonising perspective. This would further challenge what we take for granted and produce additional possibilities for doing things differently.

It appears that there are several areas in which my studies could enter into the territory of Māori taonga and other Māori things. While at times this seems to confer an obligation to include Te Ao Māori in my research, at other times to do so would seem to overstep. One resolution to this problem would be to establish a research partnership in which the issues that involve Te Ao Māori are represented through Kaupapa Māori research. However, the individualistic nature of the PhD means that while I have acknowledged the problem, I have not come to a resolution. I hope that by leaving this space open for further research, done by those better qualified to carry it out, it will continue to grow (i.e., the work by Hickey 2006, 2008, 2008, 2020a), and be seen as essential in giving effect to Te Tiriti o Waitangi.

Summary

Employing post-structural research methods, the abductive use of data and theory outlined in my methodology chapter, ensures a novel understanding of the problem of housing disabled people is revealed in this thesis. The idea of the *dispositif*, formed through historically contingent discourse, and the practice of stumbling upon data means that my findings attend to a range of distinct but related subjects and objects. In the following chapter, I introduce the structure of my Findings section, the *dispositif* that connects housing disabled people to the state, and give a brief overview of each Findings Essay.

4. Findings

The Structure of the Thesis

The findings of this thesis are presented in a series of Essays that I introduce in this chapter. Rather than following the tradition of two or three findings chapters that might attend to particular periods of time, the Essays are shaped by the idea of the *dispositif*. They show various forms of shower to be part of a decentralised network comprised of achievements and successes, ruptures and contradictions, and strategic responses in relation to an “urgent need” (which I describe below). Each Essay is focussed on a particular shower and elaborations of the shower, and the discourses that produced, and were produced by, these showers. The Appendices connected to the focus of the Essay follow immediately afterwards helping to connect them to the particulars of the times and places the Essay explores. This focus on particular materialisations of the shower means that unlike many other Foucauldian studies in which the study is focussed on knowledge relating to a single discursive object (i.e., gerontology [Foster, 2020], cardiac rehabilitation [Satija, 2020], occupational therapy clinical governance [Orton, 2021], or toilet training [Robinson, 2018]) I have ventured into particular places where showers emerged. The particulars of the emergence of this material object means that, at times, my sources are limited to those that pertain to that place (e.g., the Warm Springs Rehabilitation Facility in the USA). However, unlike other materialist methodologies (in which researchers may study just one “source”), this remains a study of genealogy. This means that how the objects and subjects relate in various ways at different points in time remains important, and sources that connect the discourses specifically to showers modified for Disabled-People in Aotearoa New Zealand are included where possible.

Each Essay aims to make visible the conditions in which various subjects and discursive objects were formed and from which government funded modified showers for Disabled-People became thinkable. In keeping with a genealogical analysis, the Essays do not follow a chronological order and do not attempt to present history as the development or evolution of showers. For example, Essay 4 concludes with discourses from the 1970s, while Essay 5 does not extend beyond 1940. Ultimately, however, the threads are drawn back to my question of “what are the discourses that have established, ordered, maintained, or disrupted the New Zealand government’s funding of showers modified for Disabled-People”? Subjects, objects and statements that are born in a particular place reappear, transform, or disappear from the *dispositif* are threaded through the Essays. As such, what may appear to be a loose thread is picked up and folded back into the discussion regarding the *dispositif*. To understand what connects these Essays, I next outline the urgent need that has come to justify the State’s involvement in housing Disabled-People.

The Dispositif: Unsound Physical and Mental Health as Depreciation to the Nation

As noted in the Introduction chapter, the Housing Modification Manual (MOH, 2014a) identifies showering as an “essential everyday activity” that might warrant housing modifications being funded, provided they are the “most cost-effective options” for “disability needs” (MOH, 2022). In this thesis, I argue that such modifications are part of a dispositif in which the state has tried to address an urgent need to minimise the loss of human capital that Disabled-People are proposed to create. This loss of human capital is connected to the health and wealth of the nation, justifying the involvement of the state in governing the places where Disabled-People live.

To give a very brief overview of the history of the government of where Disabled-People in Aotearoa New Zealand live, a liberal governmentality initially placed responsibility on the family to maintain anyone unable to work.⁶⁶ However, by the 1860s provincial councils were increasingly placing the elderly (and otherwise unemployed) in hospital wards, homes, and former asylums (Sullivan & Stace, 2020; Tennant, 1983). The Sick and Destitute Act of 1868 introduced a general tax to cover the state’s costs of accommodating people in hospitals and charitable homes. Towards the end of the 1800s “undesireables” (“those with mental health issues, intellectual impairment, disabled children, alcoholics, as well as elderly and homeless people” [Sullivan & Stace, 2020]) were increasingly confined within asylums or jails (Sullivan & Stace, 2020). By 1883, a review of New Zealand’s hospitals found that “they are made the home of aged, infirm, and chronic cases, corresponding very closely to the permanent pauper inhabitants of an English union workhouse” (Graham, 1883, p. ii).

At the beginning of the 1900s, concerns were raised regarding the cost to the nation of individuals who were not “of sound physical and mental health”. The idea that the physical and mental health of individuals formed a calculable benefit or cost to the population justified a public interest in identifying and limiting the burden such individuals placed on the health and the wealth of the nation:

⁶⁶ Destitute Persons Act (1846)

Every unit of sound physical and mental health in the community is a public asset, and it is plainly in the public interest that no step should be neglected which, if taken, may have a value in checking any tendency that may exist towards the depreciation of the physical capital of the country.

(“The Health and Development of Children”, 1906, p. 8)

The need to limit the cost of those units of unsound physical and mental health, prompted the emergence of a dispositif to respond to the need. Strategic responses included establishing large group facilities within which it was intended the inhabitants would reside for the rest of their lives. Another response was to temporarily accommodate Disabled-People in specially designed group facilities to transform them into independent, productive subjects. Eventually, these special designs entered private dwellings, so that independent Disabled-People could live in the community and make their own contribution to the physical capital of the country. However, for those who remained dependent, the possibility of choice and control over where they would live remained diminished. In this thesis, I argue that the large group facilities or confined, collective spaces are particularly dangerous. Furthermore, that the distinction between subjects who do or do not have choice and control over where they live, and when and how they shower, reveals government over the right to life.

Showerers and Showerees in Private or Confined, Collective Spaces

As discussed in the Introduction, Disabled-People continue to report concerns regarding limited choices and control, and difficulty getting their needs met in relation to their living situation (Donald Beasley Institute, 2020). Foucauldian scholars are encouraged to avoid a normative position such as stating that “autonomy is good”, and a loss of choice and control is bad. However, Olssen (2014) argued:

The concept of life, on which Foucault wrote on several occasions, generates immanent forces to survive and continue, and achieve well-being and introduces a normative force which can salvage a certain conception of objectivity and the good, and can thus function as a constructed and variable ground for a politics of hope and a politics of the future... Although some may argue that this is so obvious as to not need stating, the recognition that life itself is defined by its immanent quest to survive and continue, without presupposing any vital force or entelechy, enables a greater awareness of why we act in certain ways, and why we make the judgements we do. (p. 47)

In this study, this idea of the quest to survive and continue relates back to Foucault’s concept of biopolitical death and exclusion from life, described in Chapter Two. Permanent

exclusion from society via placement in permanent homes thus becomes a problem in terms of the quest for life itself. As such, the idea of spaces that are confined (i.e., separated) and collective (for a specific population or ‘species’ from a biopolitical disablism perspective) can be seen as dangerous, and are of particular interest to me in this study.

Related to this is my idea of distinguishing Showerers from Showerees. As Foucault (1982) discussed in “The Subject and Power”, the subject might be a speaking subject, with consciousness and identity. Conversely, a subject might be subjugated or objectivised through various strategies such as being categorised and separated. Thus, discourse can construct humans as objects within the environment of other subjects. For example, the Long-Stay-Geriatric-Patient-Wheelchair-Shower pictured in Essay 8 may be a discursive object that is designed for the Showerer (a workspace for the nurse), while the Showeree (the patient) is constructed as an object to be subjected to the shower within that environment. While this does not mean that I seek to privilege the speaking subject over objects (human or non-human), there is an important distinction in terms of who speaks, and who or what acts and can thus pursue the quest to survive and continue.

Introduction to the Essays

There are eight findings Essays, including one ‘background’ Essay and two ‘introductory’ Essays. The first three Essays are distinguished from the rest in that they provide the context in which showers became a thinkable thing, but do not focus on the modification of showers for Disabled-People. Of course, to be modified, the shower had to have an unmodified form; the background and introductory Essays analyse these forms of shower that emerged for various subjects and that produced discourses, subjects, and discursive objects that contributed to the dispositif in which showers modified for Disabled-People could materialise. Each Essay is introduced with a decorative image of a shower or shower facility which is later discussed as a figure in the Essay. These images illustrate the material shifts in shower design that are the focus of each Essay.

In Essay 1, Dr Blair’s early 1700s “Fall-of-Water” and Dr Morison’s early 1800s “Douche Bath” illustrate the birth of the Hydropathic shower. In the mid-late 1800s, Hygiene showers emerge in confined, collective spaces,⁶⁷ such as Dr Delabost’s late 1800s warm water “Ablution-system”. Such showers established the idea of the shower as an efficient method for washing upright bodies en masse.

⁶⁷ Osborne (1996) explained how public health was spatialised in the 18th century by an interest in a series of “collective – but confined – spaces”, such as army camps and ships. Osborne explained that this interest later extended to the “open space” of the town, and then the hydraulic city to which the liberal space of private dwellings could connect.

In Essays 2 and 3, I introduce two approaches to shower design that are important when considering who and what is being governed in the dispositif and the governmentalities that are employed to do so. These approaches are the “Collective” shower, designed to contain more than one person; and the “Private” shower, which is for one person. In Essay 2, I briefly analyse showers within the English “public baths”, followed by a more detailed analysis of Bresgen’s late 1800s Prussian “Army-Division-Shower-Bath-Facility” and New Zealand’s early 1900s “Changing-Rooms-&-Baths-for-Miners”. These showers were designed to reduce the incidence of disease within particular populations and illustrate very different governmentalities that could be employed to induce populations within confined collective spaces to shower. Finally, I introduce the “New-Zealand-Field-Hygiene-Section-Shower-Unit” from the 1940s, where collective showers for populations intersect with discourses associated with the private domestic shower being established at that time.

In Essay 3, I analyse the emergence of the private shower. While the idea of private showering was circulating as part of a hydropathy discourse from the early 1800s, a complex arrangement of technologies was needed for private hygiene showers within private dwellings to proliferate. Concerns with population health produced the “hydraulic city” (Osborne, 1996), an application of liberal governmentality that limited the involvement of the state in private dwellings. This meant that very different strategies to those employed in collective showers were needed. In this Essay I investigate the discourses, discursive objects, and governmentalities that induced individuals to participate in showering as an essential everyday activity within their own home. Modifications of the shower over the bath, such as Gerhard’s “Rain-Bath-Compartment” for use in private dwellings, are analysed. The economical shower compartment established the design of the shower as a space in which private citizens who could stand and step over a shower lip could invest in their human capital through showering as an essential everyday activity.

Essays 4 and 5 are the first two Essays that analyse showers designed for Disabled-People. These are showers that formed in confined, collective spaces (the Large-Permanent-Home and the Rehabilitation Facility respectively). The Large-Permanent-Home for Disabled-People emerged in the 1920s to permanently exclude those thought to have defective genes from society. I argue that a discourse of Eugenics served to reduce the cost of disability through eliminating the population and establishing their permanent exclusion from community life. Resistance to Eugenics and the problem of the cost of the Large-Permanent-Home meant they were falling out of favour by the late 1950s. In Aotearoa New Zealand, a 1979 review of in-patient accommodation of “psychopaedic” services problematised the collective shower space of established large permanent homes. This resulted in the Hospital Design and Evaluation Unit (HDEU) “Shower Room”. This room remained a collective space within which patients could be showered; however, a degree of

privacy between patients was introduced. While the collective shower of the Large-Permanent-Home had been problematised, the modification of the shower shows how facilities were converted into a new form of permanent home that could remain acceptable.

In contrast to Essay 4's Large-Permanent-Home, Essay 5's Rehabilitation Facility was designed as a space of transformation. While it was also a confined, collective space, it was a place that aimed to maintain the connections between Disabled-People and the "outside". The facility would produce subjects who could be returned to society rather than remain permanently excluded. The idea of Rehabilitation emerged as a "New Education" to connect Disabled-People to the apparatus of production through efficient movement and body-objects articulations (such as wheelchair users). Rehabilitation produced Independent Physically-Disabled-People who could perform everyday essential activities without human assistance within the disciplining space of the Rehabilitation Facility. I argue that these facilities were designed as the agents and instruments of care, promoting the elimination of dependence. In Essay 5, I analyse the architectural bathroom arrangement for "A Polio who Prefers a Shower" that emerged from Warm Springs during the 1930s. Within Warm Springs, a private hygiene shower designed for a Disabled-Person to use became a thinkable thing.

In Essay 6, the idea of the Rehabilitation shower and transformation of Disabled-People into subjects who could contribute to the physical capital of the nation continues. In this Essay I explore the governmentalities that established associations between Physically-Disabled-People and work, eventually connecting showers designed for their use within private dwellings. To contribute to the apparatus of production, Disabled-People needed to leave the Rehabilitation Facility. However, juxtaposed against the accessibility of Warm Springs, the attitudinal and architectural prejudice of the outside world became visible. The idea of reciprocal duty towards army veterans produced the 1947 Paraplegic Veteran's Bathroom Unit. This was part of a "prosthetic home", designed to be installed in a private dwelling outside of the Rehabilitation Facility. However, I propose that a liberal governmentality continued to limit the involvement of the state in private property. Discourses emerged to produce Disabled-People who had the capital to participate in the property market. The idea of individual determination to overcome handicap emerged. Education facilities, such as the University of Illinois, became an important site for Physically-Disabled-People to invest in their own human capital. Gadgets, such as Jerry Chapin's 1950 "Ingenious Portable Shower", and minor adjustments to established bathroom facilities produced the possibility of Physically-Disabled-People living "independently" in the community, providing opportunities to invest in their own human capital. Connected to work and thus the property market, the possibility of the made-to-order private dwelling emerged. In 1968, Gutman and Gutman suggest a "stall shower with shower wheelchair" which

promised Physically-Disabled-People the possibility of private showers in private dwellings, free from “architectural barriers”.

In Aotearoa New Zealand, in the late 1960s, the idea of reciprocal duty was extended beyond army veterans to include all people injured via accident. The idea of injury to any member of the population creating a loss to the capital of the nation established a connection between rehabilitation and compensation, and injured workers, the elderly, the young, and housewives. In Essay 7, I discuss these connections with a particular focus on the housewife as a subject who was indirectly involved in contributing to the physical capital of the nation. I show that from the mid-1900s a discourse of “designing for the disabled” emerged to produce Disabled-Housewives who were able to maintain the functions of the Family-Home. While the established order continued to promote the interests of the worker, Aotearoa New Zealand’s accident compensation legislation made it possible for injured housewives to access government funded housing modifications. In 1980, the Accident Compensation Commission funded a Family Unit and Single Unit for use by paraplegics. The showers within these units were designed for the injured paraplegic-worker; however, the compensation funding meant it was possible for the units to be inhabited by housewives. Indeed, they were both inhabited by housewives and, although the showers were not designed for their use, a pamphlet promoting the units illustrated the functions of the independent Disabled-Housewife as she maintained the state funded disability design Family-Home.

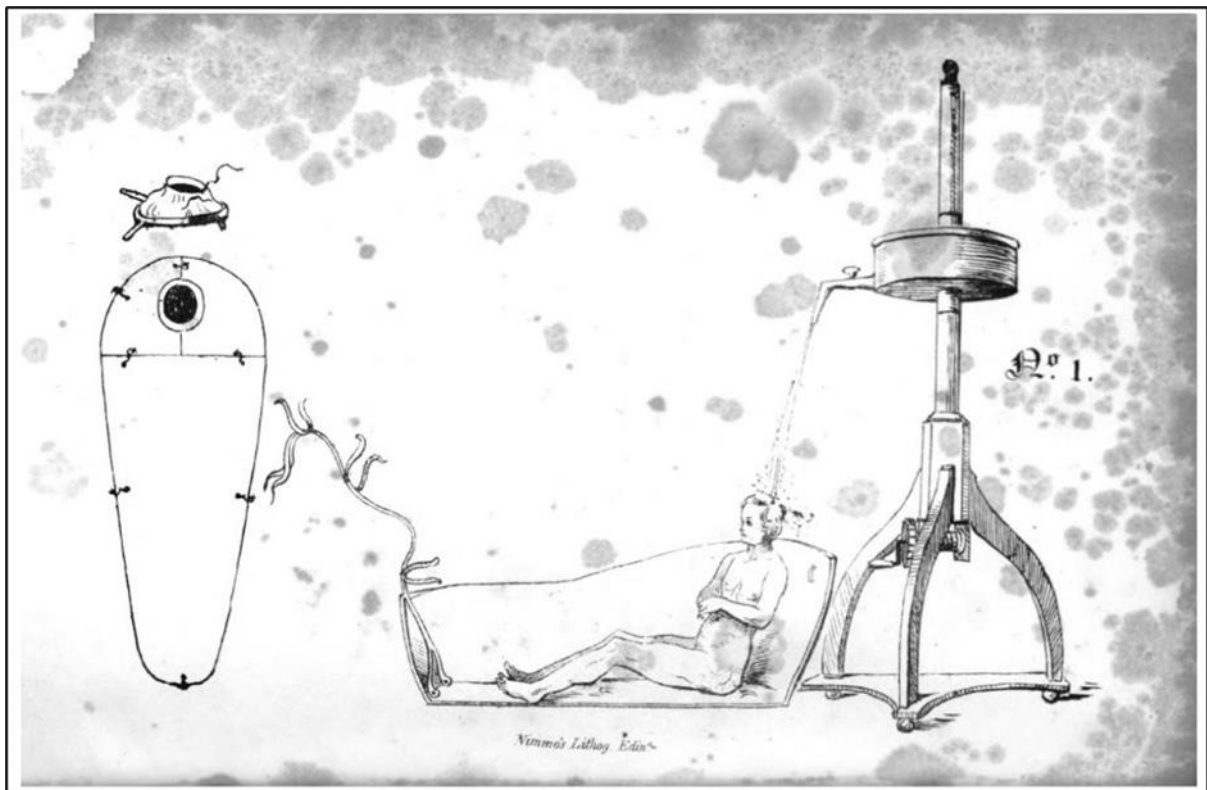
In Essay 8, I return to the idea of the permanent home and the shower for the Disabled-Person and an attendant, this time within the private dwelling. In 1975, the Disabled Persons Community Welfare Act extended government funding for housing modifications to people who were disabled but not via injury. The Elderly, governed by practices that removed them from Family-Homes and installed them in dwellings designed for their use (Pensioner Flats, Old People’s Homes etc), were unlikely to be eligible for such funding. Pensioner-Flat shower units promoted independent living for Little Old Ladies; however, the Elderly who depended on wheelchairs were destined to be moved into geriatric hospitals. Within these hospitals, the Wheelchair-Shower was the ideal workspace for the nurse, and something that the patients would get used to. The idea of the Wet-Area-Shower (a form of Wheelchair Shower), designed by Graham Booth in the mid-1980s to be installed into Family-Homes, was promoted as being universally usable. This shower allowed Disabled-People who were dependent on assistance within the shower to remain living in a Family-Home in the community. The funding for such showers was designed to be a partial investment by the state in the accommodation of Disabled-People; however, it was attached to the permanency of the dwelling and unpaid carers. Although initially the funding bonded Disabled-People to their home for 5-years, from the mid-1990s the funding was redesigned

Findings

as a one-off grant, establishing new specially designed permanent homes for Disabled-People. In Essay 8, I argue that funding for housing modifications shifts the risk of housing Disabled-People in the community onto Disabled-People and their families, and excludes Disabled-People from neoliberal life.

Having provided an overview of the dispositif and each of the Essays, I now discuss the birth of the hydropathic shower and the discourses that led to the manufacture of an object that would pour water onto people's heads.

Essay 1 The Birth of Hydropathic Showers



A. Morison's Douche for treating mania (1828)

Introduction

This Essay is the first publication produced from my studies with minor amendments. The article is an analysis of the birth of the shower and forms a background for my study (Cox et al., 2019). While my research question relates to the government funding of showers modified for Disabled-People it was important to understand the genealogy of the shower as a discursive object. As the article was published in a history journal, rather than a journal of Foucauldian studies, this Essay has less of a discussion of governmentalities than the rest of the thesis.

Although this is a background Essay, the findings remain important to understand the dispositif in which showers emerged, and the strategic elaborations that formed in the 1800s to address two quite different urgent needs. The idea of the shower initially came from observations of the favourable effects of cold water on mad or maniacal men and women in the late 1700s. Manufactured showers appeared across Europe to cure mania in response to an urgent need to reduce the cost of containing “incurable lunatics” in asylums and prisons. These Cold-Water-Shock-Showers, designed to harness the therapeutic operations of cold water, were connected to a discourse of mania being caused by a hot brain. The showers employed cold and fear to act upon the body and will of the patient, producing docile subjects. Those transformed by the Fall-of-Water were able to be returned to society. In the mid-1800s corporal punishments, and thus the Cold-Water-Shock-Shower, fell out of favour. However, emerging ideas about the connection between the skin, water, and disease saw the shower transformed into the warm water hygiene device that is familiar to many people today.

Showers: From a Violent Treatment to an Agent of Cleansing

Introduction

Showers are a familiar part of the bathroom landscape in which people around the world clean and preen their bodies (Euromonitor International, 2014). However, the manufactured shower first emerged from within the walls of the early 1800s asylum with a purpose quite different to that of washing. For over 150 years prior to the development of showering to get clean, Physicians contrived devices that could pour cold water on the heads of “maniacal” men and women to cool “hot brains” and break “impetuous Wills”. This paper uses Foucault’s genealogical approach to history to explore the arrangements that made the shower a thinkable object.

In this article, we outline a period of radical change in the medical discourses regarding insanity and the treatment of the insane during the 1800s. We propose that these shifts can be seen in the design and application of the shower, in addition to its naming. This article begins with unpleasant but effective Hydropathic devices for the insane such as the

“Fall-of-Water” (Smith, 1723), followed by manufactured devices such as the “douche” (Pinel, 1807) or “shower bath” (Stock, 1805).⁶⁸ Towards the end of the 19th century, the use of the shower as a treatment for insanity fell out of favour. However, the shower was transformed into an “ablution-system” (Delabost, 1875) and re-emerged as a pleasant and economical device for washing the skins of the population.

The Birth of the Shower

The happy consequences of the cold shower,
the psychological effect of the unpleasant surprise
which interrupted the course of ideas
and changed the nature of sentiments.
(Foucault, 1964/2001, p. 253)

While the use of water to treat mental illness can be traced back to antiquity, accounts suggest that modern medical science appropriated water to cure insanity quite by accident in the mid-1600s:

This invention, supposedly dating from the middle of the seventeenth century was the fortunate result of chance: a heavily chained madman was being transported on an open wagon; he managed, however, to free himself from his chains and jumped into a lake, tried to swim, fainted; when he was rescued, everyone thought he was dead, but he quickly recovered his spirits, which were abruptly restored to their natural order, and he “lived a long time without experiencing any further attack of madness.” This anecdote supposedly enlightened Van Helmont, who began to plunge the insane indiscriminately into the sea or into fresh water; “the only care that must be taken, is to plunge the sufferers into the water suddenly and unawares, and to keep them there for a long time. One need have no fear for their lives”. (Menuret, n.d., cited in Foucault, 1964/2001, pp. 167-168)

After a century of plunging patients into water, Van Helmont’s methods were considered “exceedingly reprehensible to a well-informed Physician of the present day” (Davis, 1806, p. xlvii). However, it was neither the water treatment nor the lack of regard for bringing someone close to death that the Physician of the early 1800s considered reprehensible. Rather, it was Van Helmont’s lack of discrimination about who and what should be treated with water that was considered primitive.

The late 1700s would see a growing interest in the potential for medicine to cure the insane. It was argued that medical treatment was needed, not only to save the individual, but for the benefit of the nation. In England, for example, the House of Commons was advised that there were:

Many thousands, perhaps some tens of thousands, of our fellow beings, languishing in the hopeless confinement as incurable Lunatics, who, under a better system of

⁶⁸ The focus of this paper is on insanity as it was in this context that shower apparatuses were designed. Hydropathy, however, developed for the cure of many diseases. As early as 1732, cases of both insanity and paralysis were being treated with the “Cataract” or “Fall-of-Water” from sources such as a mill (Floyer, 1732).

treatment, might have been useful, safe, and happy members of society... incurable Lunatics, cost the State about six hundred pounds each upon average, besides the loss of a subject; while the cost of cure, in those that recover, average about forty pounds only. (Bakewell, 1815, pp. 7-8).

The “well-informed” Physician aimed to establish authority over the diseases that caused insanity, naming their limits and possibilities.⁶⁹ These Physicians used a science of “minute and accurate observation” (Pinel, 1808, p. 1) that aimed to pinpoint the nature and expression of the disease and document the effects of prescribed treatments. Various apparatus that harnessed therapeutic forces emerged during this time to aid in curing those diagnosed as insane. The shower was one such apparatus.

Showers for Cooling the Hot Brain

The mind cannot act
with precision on a disordered brain.
(Rowley, 1793, p. 10)

The qualities that defined mania in the 1700s were a violent heat that boiled the blood and dried out the brain (Foucault, 1964/2001). Thus, cooling the brain seemed an obvious solution. Dr Blair was an early proponent:

Dr Blair, who in a Letter to Dr Baynard, declares, That he cured a Man raving mad, who being bound in a Cart, stript of his Clothes, and blindfolded, that the Surprise might be the greater; he on a sudden had a great Fall-of-Water let down on him from the height of twenty foot, under which he continued so long as his strength would permit: and after his Return home, he fell into a Sleep, and slept twenty-nine Hours, and awaked in as quiet a State of Mind as ever, as so had continued to the time of writing that letter, which was twelve Months... a hot Brain being the Cause, perhaps, of several disorders in the Understanding, and is in great part found to be true, in the ridiculous behaviour of some drunken men, which, when their Heads are become cool, abhor what they before did do or say [emphasis in original]. (Smith, 1723, pp. 44-45)

Such observations reflect an agreement amongst Physicians of an abnormally hot brain being the cause of a mad mind, and the brain being susceptible to the beneficial effects of shock and prolonged pouring of cold water on the head. While the description of the hot brain would shift over the following century, the principles of the “Fall-of-Water” would remain largely unchanged.

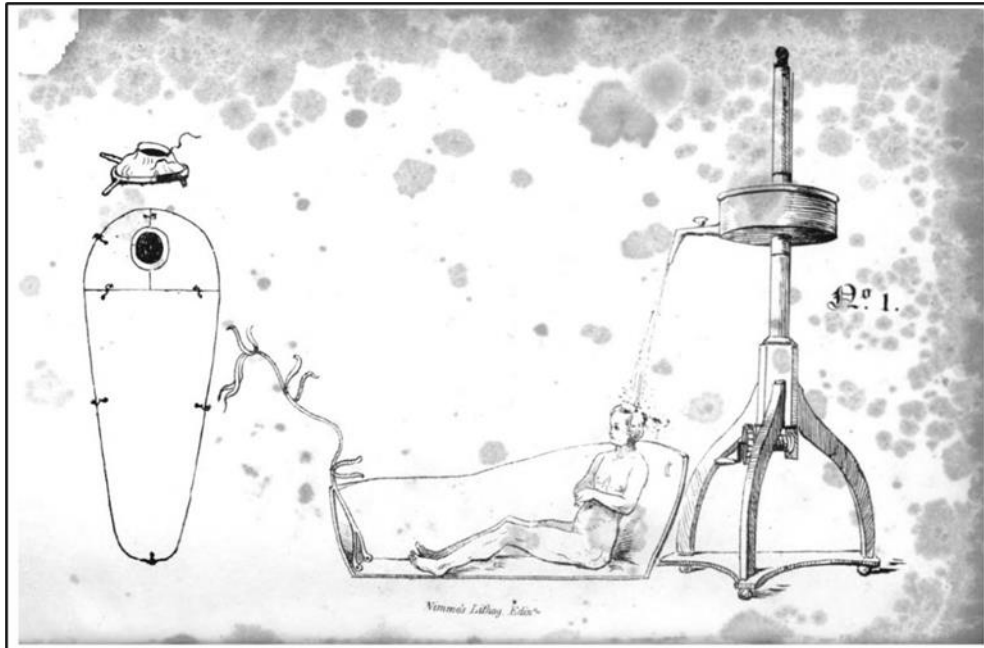
⁶⁹ Foucault (1969/2002) explained how governing occurs through classification as in such systems objects (concepts) are “divided, contrasted, related, regrouped, classified, derived from one another” (p. 46). Through arranging, rearranging, and (dis) arranging, possibilities or impossibilities are defined and enforced.

Towards the end of the 1700s, Physicians pinpointed the blood vessels in the brains of the insane as the specific site of disorder.⁷⁰ The brains of lunatics having been opened up and examined had shown signs of inflamed and distended vessels (Haslam, 1798; Rowley, 1793). The movement of blood within the brain had been hypothesised to be subject to the passions and focus of the mind; “Madness is commonly caused by a gradual, slow, and continued determination of the blood to the brain from pathemata animi,⁷¹ or meditation on one subject, until the fluids of the brain become, and continue, vitiated” (Rowley, 1793, p. 13). The “hot brain” came to be described as “inflamed” and congestion within its blood vessels or nerves viewed as either caused by or causing the chaotic mind. The science of Hydropathy observed that cold water could counteract inflammation of the joints, ears, eyes, navel, mouth, throat, skin, intestine, abdomen, and tissue; could mend bones and other wounds; reduce the heat associated with fevers; cure headaches and toothache; and prevent congestion of the blood (Claridge, 1842; Forbes, 1848; Stock, 1805). Physicians hypothesised that cold water’s natural qualities of constricting blood vessels would redirect blood away from the brain and towards the internal organs (Hartshorne, 1847) to reduce the unseen inflammation and congestion.

Therapeutic practices to reduce inflammation and congestion included bleedings, blistering, purges, and application of cold through baths and showers (Morison, 1828). With the location of madness marked out as being within the vessels of the brain, the practice of plunging the whole body into water came to be seen as primitive and uninformed. Knowledgeable Physicians now sought to design treatments that could target the particular site of disorder (see Figure 4).

⁷⁰ Dissections of mad persons showed “The veins of the dura and pia mater, cerebrum and cerebellum, are greatly distended with dark-coloured blood” (Rowley, 1793, p. 5). Rowley (1793) inferred (from the “antecedent appearance in mad persons” [p. 8]) that passions or meditations forced blood to the brain which, after a prolonged period, caused weakening of the vein walls. The increase in blood was proposed to create heat and irritation and leave contaminants in the brain, commonly resulting in inflammation (Rowley, 1793)

⁷¹ Passions of the mind (Hooper, 1831).

Figure 4*Morison's 1828 Douche Bath*

Note. From *Cases of mental disease with practical observations on the medical treatment* (p. 167), by A. Morison, 1828, Longman & Co and S. Highley. In the public domain.

The different parts of an apparatus for giving the Douche, consisting of a bucket, from which a stream of water is made to fall on the head of the patient from different heights, regulated by a rope and pulley, — by the cock inserted into the lower part of the bucket, the size of the stream is regulated; in this Plate is likewise exhibited a perpendicular section of a warm bath, with the position of the patient in it,— the form of spring-straps to fasten him, if necessary,— the cover of the bath, with space for the patient's neck, and a wax-cloth tippet to carry off the cold water. (Morison, 1828, pp. 163-164)

In Morison's Fall-of-Water (which, reflecting its European origins,⁷² he named a "douche") the patient's body and head are arranged according to the Physician's prescription; the body is stripped, tied down, sealed and immersed in water. The head separated off by a collar, endures the Fall-of-Water. The Physician uses the device to harness the natural forces of water, cold, and gravity to reach into and reorder the brains of the patient.⁷³ The apparatus

⁷² Morison's design was a replication of a shower designed for Italian asylums (Gualandi, 1823). Morison's particular design had the advantage of being relatively portable; thus, could be employed outside of the asylum walls. Given Morison's interest in providing services to the wealthy in domestic settings (Scull, 2011), his showers may have been the earliest to enter into private dwellings.

⁷³ Foucault (1963/2003b) outlines in "The Birth of the Clinic" how the medical gaze associated with this period established a world in which disease was attached to a particular part of the body. The physician could bracket off the person to see and know the species of disease that he was confronted with. The disease and body communicate through qualities, such as heat, and the physician could read the unspoken signs of these qualities as they acted on body to see the disease. As such, the brains of diseased maniacs, combined with a history of their symptoms, could signal the nature of mania and inform the physician of the actions needed to combat it.

and body are thus employed by the Physician to carry out his prescription with measured precision.

Showers for the Obstinate Will

The douche of cold water... directed upon the head,
as well to diminish vascular activation in the brain
as to repress violence, to overcome obstinacy,
and to rouse the patient when indolence or stupor prevails.
(Morison, 1828, pp. 44-45)

Alongside the effect on the brain, the cold shower was argued to exert therapeutic benefit on the more ethereal aspects of insanity.⁷⁴ In the 1700s and early 1800s, there was a close connection between the passions, the will, one's spirit, and madness. Excitement or anger could take control of the mad mind—taking hold of attention and imagination, “the distraction of the mind is the result of our blind surrender to our desires, our incapacity to control or to moderate our passions” (Sauvage, as cited in Foucault, 1964/2001, p. 85). Passions, “assume a kind of additional power which ultimately renders it irresistible even to the most concerted efforts of the will” (Foucault, 1964/2001, p. 85). An unbridled will could fail to moderate the passions, which could then take control of the mind; thus, having taken hold, overpower any potential taming influence of the will.

Cold water showers designed to shock were thought to exert an influence on the will. Passion was thought to subdue passion; “Fear being a passion that diminishes excitement, may therefore be opposed to the excess of it... In most cases it has appeared to me necessary to employ a very constant impression of fear” (Cullen, 1784, pp. 153-154). Pinel's moral treatment proposed in 1794 that “one of the major principles of the psychologic management of the insane is to break their will in a skilfully timed manner without causing wounds or imposing hard labour” (Pinel, as cited in Weiner, 1992, p. 732) which sounds somewhat innocuous. However, he continued; “Rather, a formidable show of terror should convince them that they are not free to pursue their impetuous wilfulness and that their only choice is to submit” (Pinel, as cited in Weiner, 1992, p. 732). Fear, like cold, was thought to transmit a beneficial effect on the disordered brain.⁷⁵ Fear was aroused in the patient by the

⁷⁴ Water and the soul was already established Christian baptism discourses at this time (e.g., Bradford, 1708; Jowitt, 1837; Oliver, 1806). The method of application was debated; however, there was a general consensus that Baptism required water of some form to bind one's soul to God. Unlike hydropathy for insanity, early baptism discourses were connected to cleanliness; “Then will I sprinkle clear water upon you, and ye shall be clean from all your filthiness, and from all your idols will I cleanse you – A new heart also will I give you, and a new spirit will I put within you” (Ezek. xxxvi 25, 26 cited in Chapman, 1806, p. 59). Washing in general was also connected to Christianity as it “prepared the mind for Divine Illuminations” (Floyer, 1732, pp. 68-69).

⁷⁵ Profession of fear of and obedience to Christ and God was also associated to Christian discourses regarding baptism, with water functioning as a seal of this promise (Chapman, 1806; Church, 1805).

shower in two ways. First, the shower started unexpectedly; second, the shower would continue for as long as the patient could endure, thus creating in them the fear of death. The animal heat and passion of the mad was seen as power and strength rather than weakness; hence, the mad could go without the basic needs of man (i.e., food and warmth), could demonstrate uncommon muscular strength, and be considered in good health (Crichton, 1789; Pinel, 1808). The Cold-Water-Shock-Shower was, therefore, prescribed for an extended time, and made to fall with force to break down the unusually strong will of the insane. Once the passions were subdued, the weak or wild will could submit to the will of the Physician, allowing a cure to be realised.

Dr Patrick Blair (1725) gave an early example in his description of his Fall-of-Water from an abandoned 35-foot-high water tower, under which he placed a Bath tub [Trigger Warning: Describes torture]:

A married woman... became mad, neglected every thing, would not own her husband nor any of the family... I ordered to her to be blindfolded. She was lifted by up force, plac'd in and fixt to the Chair in the bathing Tub. All this put her in an unexpressable terrour especially when the water was let down. I kept her under the fall 30 minutes, stopping the pipe now and then and enquiring whether she would take to her husband butt she still obstinately deny'd till at last being much fatigu'd with the pressure of the water she promised she would do what I desired on which I desisted, let her go to bed... A week after I gave her another Tryal but adding a smaller pipe so that when the one let the water fall on top of her head the other squirted it in her face or any other part of her head neck or breast I thought proper. Being still very strong I gave her 60 minutes this time when she still kept so obstinate that she would not promise to take her husband until her spirits being allmost dissipated she promised to Love him as before... I gave her the 3d Tryal of the fall and continued her 90 minutes under it... I threatned her with the fourth Tryal, took her out of bed, had her stript, blindfolded and ready to be put in the Chair, when she being terrify'd with what she was to undergo she kneeld submissively that I would spare her and she would become and Loving obedient and dutifull Wife for ever thereafter. I granted her request provided she would go to bed that night with her husband, which she did with great cheerfulness... it appear'd that in 90 minutes there was 15 Ton of water let fall upon her. (Blair as cited in Ingram, 1998, pp. 74-75)

In this example the Fall-of-Water was used to produce fear, weakening the will of the patient, making her more liable to submit to the will of the Physician, and subsequently to the will of her estranged husband. The removal of clothing, binding to the chair and blindfolding, along with the Fall-of-Water, are all carried out with the intent of instilling terror, fatigue, and dissipated spirits. The Physician threatened further Falls-of-Water for increasing lengths of time until the patient's will was broken and she became the submissive, obedient, and dutiful wife he would have her be. Blair's treatment precedes the discovery of the brain as the locus of insanity. Although the treatment was directed towards the body, the target was her head, neck or breast as the Physician "thought proper". He employs large quantities of water that can provide the time and pressure needed to wear down her strength and her will (effectively

dissolving her resolve). Blair's shower aimed to tame the patient and ensure that she return to her duties, to maintain the social order.

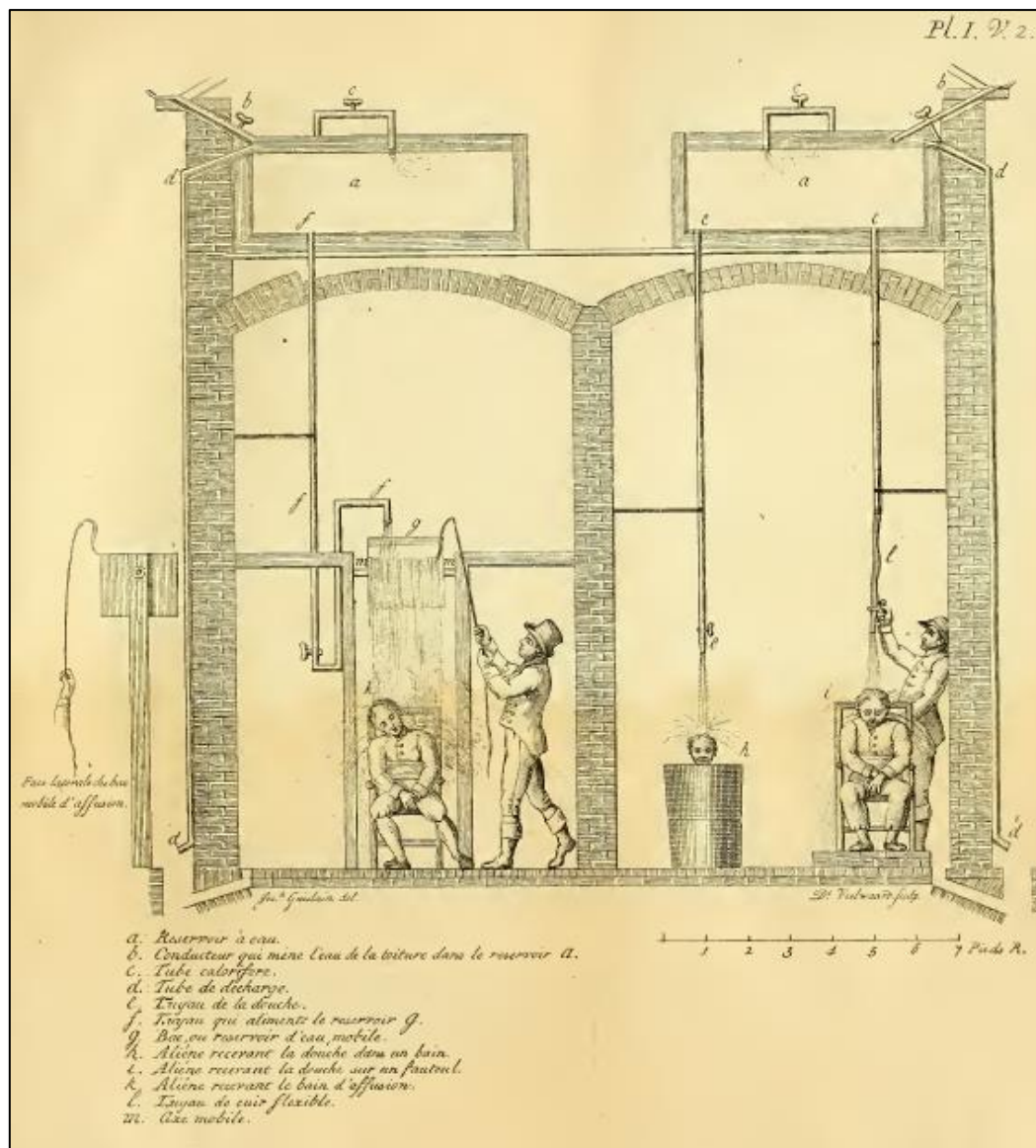
A century after Dr Blair's patient agreed to be an obedient wife, Physicians continued to employ the force and duration of the Cold-Water-Shock-Showers to treat their patients. For example, Dr Benjamin Rush (1835), in his "Diseases of the Mind," advised complete government over mania patients. As such, strapping the patient to a chair (the "tranquillizer chair"), applying the shower bath for 15-20 minutes and finally threatening the patient with death were considered effective strategies for resistant cases. While Blair had relied on an existing supply of water, later advocates of the shower, such as Rush, were designing buildings to suit their purposes. In the early 1800s, throughout Europe and North America Physicians were writing on the use of architecture in the treatment of the insane (e.g., Conolly, 1847; Gualandi, 1823; Guislain, 1826). They sought to design buildings and landscapes in which therapeutic practices could be built into the walls, windows, vents, gardens, bathrooms, and treatment rooms of the building.⁷⁶ Under the direction of Dr Rush, the Pennsylvania insane hospital wing included a novel (and seemingly one off) design for administering Shower-Baths:

In a wing of the hospital, particularly appropriated to the reception of insane patients, a space, about three feet square, was left in the flooring of the galleries communicating with the cells on each story. This space was occupied by a strong wooden lattice, or grating, divided into spaces of about an inch square. As these lattices were placed in an exactly perpendicular direction, one over the other, it was easy for the medical attendant to subject the patient to any degree of impression required, by directing the water to be thrown from a height of one, two or three stories. (Stock, 1805, p. 152).

The Physician could thus increase the force of the water (or "degree of impression") on the patient by prescribing greater heights for the water to be thrown from, but simultaneously decrease it by disrupting the flow with the lattice. The building was thus employed by the Physician to improve the ease with which treatment could be prescribed and administered.

While Rush's building aided Physicians in their control over the Fall-of-Water, it is unclear how the supply of water (and thus the important aspect of duration) was addressed. This issue is resolved in Guislain's (1826) design which enlists the roof of the building into the prescription of the cold shock shower. The roof of the building gathers and stores the water, and the height that the water falls from is set in stone (see Figure 5).

⁷⁶ As Foucault (1975/1995) noted "Stones can make people docile and knowable... in its very materiality, a therapeutic operator" (p. 172).

Figure 5*Guislain's 1826 Asylum Shower Designs*

Note. From *Traite sur l'alienation mentale et sur les hospices des alienes* (p. 38), by J. Guislain, 1826, J. Van derhey and H. Gartman. In the public domain.

In Guislain's shower, wood, leather, copper, and bricks partake in the prescription of the shower. In 1826, patients remained bound to a chair and the Attendant was positioned out of sight so that the patient would be surprised by the shower's start and end. Various objects allowed the Physician to prescribe the amount of force and duration of the treatment. The barrel provided the option of submersion in water, which could be warm or cold. The affusion shower bath (Figure 5 on the left) could be used if a more violent application was sought. Water poured in and drained away through the construction of the building,

solidifying the place of the Cold-Water-Shock-Shower in the manufactured treatment of the insane.

The Fall-of-Water, Douche, and Shower-Bath of the 1700s and early 1800s were born at a time when medical-science had connected insanity, the Will, and the spirits to the body. It was thought possible that a mechanical device could harness natural forces to counteract the effects of the disease, and to diminish the patient's will and spirit. The promise of returning the insane to being healthy, productive members of society justified building fearful devices into the walls that housed them or bringing such devices into their homes.

The Death of the Cold-Water-Shock-Shower

The shower was the habitual punishment
of the ordinary police tribunal
that sat permanently at the asylum.
(Foucault, 1964/2001, p. 266)

The problem of wilful disobedience was of concern not only to Physicians. Alongside the significant shifts in management of the insane, the mid-1800s were a time of major penal reform. Although attempts were made to separate the insane from criminals through the construction of asylums and large state prisons, the distinction between insanity and criminality remained blurred. As Foucault (1975/1995) pointed out, from 1832:

Every crime and even every offence now carries with it, as a legitimate suspicion, but also as a right that may be claimed, the hypothesis of insanity, in any case of anomaly. And the sentence... bears within it an assessment of normality and a technical prescription for a possible normalisation. (pp. 20-21)

Therapeutic devices such as the cold shower were used in prisons to treat both the "obstreperous lunatic" and those not insane (e.g., 1835). In the early 1800s, penologists were taking an interest in the corrective methods of medicine, as across Europe "punitive practices had become more reticent. One no longer touched the body, or at least as little as possible, and then only to reach something other than the body itself" (Foucault, 1975/1995, p. 11). The use of the body for productivity was connected to a disruption in relationship between punishment and inflicting wounds. Prior to this, "the human body, has neither the utility nor the commercial value that are conferred on them in an economy of an industrial type" (Foucault, 1975/1995, p. 54). As most corporal punishments were falling out of favour, alternative punishments were sought to affect the mind, ideas, and conscience of the criminal. Alongside solitude,⁷⁷ technologies such as the shower provided both Physicians

⁷⁷ The importance of controlling the ideas of maniacs and criminals would see much of Europe and the USA embrace solitude as a means of correction. The theory was that "being excluded from all

and prison administrators with a way to inflict “unpleasantness” on the body without leaving the marks of the whip.⁷⁸

However, unlike the heat associated with inflammation of the brain and its vessels, the impetuous will was not so easily connected to a particular part of the body. While Physicians argued that the soul, will, and nerves were somehow connected; “human knowledge has not yet discovered, nor perhaps never may discover, what the soul is, how it operates on the body by means of the nerves, or how the nerves operate on the soul, and convey our will or sensations” (Rowley, 1793, p. 14). This lack of connection between the mind and the body brought practices that targeted the body to influence the will into question. Although the Cold-Water-Shock-Shower was acceptable within the original moral treatment, a new form of moral treatment emerged in the mid-1800s that no longer accepted bodies being subjugated to induce fear.

Showers as Barbaric Form of Torture

Aligning crime and punishment with abnormality and treatment meant that practices that used violent physical force had been able to be carried out with apparently benign intent. While Pinel (1806) advocated for the use of fear, this did not mean that the Physician should be seen as a tyrant. Pinel suggested that “to render the effects of fear solid and durable, its influence ought to be associated with that of a profound regard... coercion must always appear to be the result of necessity, reluctantly resorted to” (p. 67). With the shower employed as an intermediary, the Physician could act with a measure of kindness while the cold water inflicted calculated brutality;

We profit from the circumstance of the bath [shower-bath], remind him of the transgression, or of the omission of an important duty, and with the aid of a faucet suddenly release a shower of cold water upon his head, which often disconcerts that madman or drives out a predominant idea by a strong and unexpected impression; if the idea persists, the shower is repeated, but care is taken to avoid the hard tone and the shocking terms that would cause rebellion: On the contrary, the madman is made to understand that it is for his sake and reluctantly that we resort to such violent measures; sometimes we add a joke, taking care not to go too far with it. (Pinel, 1806, as cited in Foucault, 1964/2001, p. 267)

Under the control of the Physician, it was argued that the power of the shower could be regulated, and the Physician himself could moderate the suffering. However, the shower

human society... will operate potently on the minds and manners of the people of every class; it will have its force in stopping their career, and drawing them back from paths of perdition” (Hanway, 1776, p. 109). Pinel (1806) concurred: “maniacs are seldom or never cured as long as they are kept at home, subject to the influence of family intercourse... [those] whose insulation is on that account most complete, are soonest and most easily cured” (p. 212). The introduction of the cell within asylums and prisons to enact this isolation would later influence the shower unit design for hygiene that many people are familiar with today.

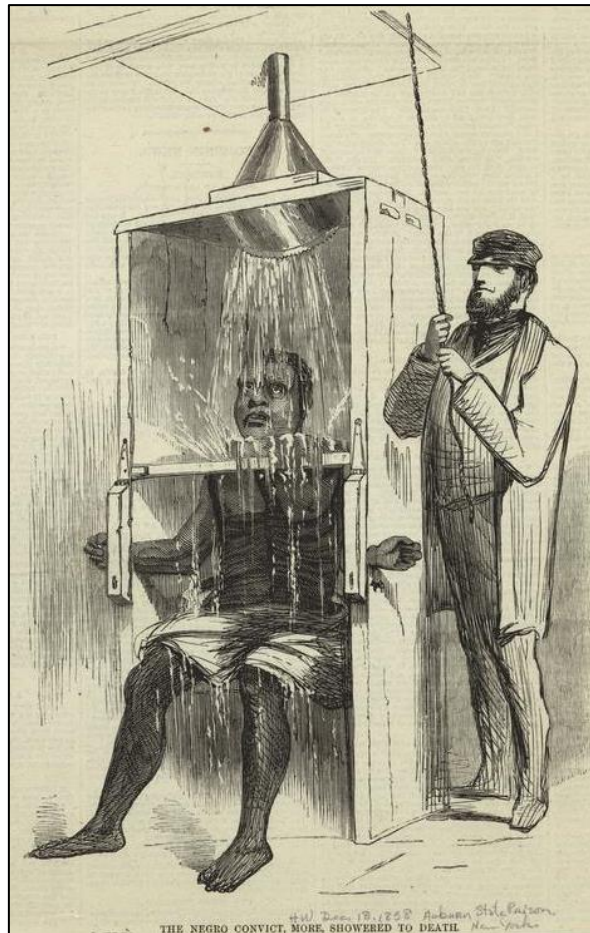
⁷⁸ In prisons, the shower-bath was used as an alternative to other corporal punishments when solitary confinement and a diet of bread and water had failed (The Prison Association of New York, 1845).

itself was not benign. While some Physicians argued that the benefit of the shower was in its potentially harmful effects,⁷⁹ shower-related deaths saw those that employed the Cold-Water-Shock-Shower charged with being outdated and ignorant. The problem of the ignorant Physician had been a concern of the state since ancient times and legislation regulating practitioners had been passed throughout the centuries prior to the misuse of the cold shower (Barrett, 1905). By the time the 1858 Medical Act gave the medical council of the UK support to control the education of Physicians and to prosecute those deemed ignorant (Glover & Davidson, 1858), the legitimacy of Hydropathy was being questioned. In defence of the practice, statements by gentlemen lecturers, the “most eminent among the present heads of the profession of medicine” and works of “stupendous labor and research” were used to argue that Hydropathy “undoubtedly includes powerful therapeutic (healing) agents” (Johnson, 1854, p. xxi). Nonetheless, Johnson (1854) declared that:

Indiscriminate... douchings for almost unlimited periods of time may be tolerable perhaps by the phlegmatic German. But a country like England... is not likely to furnish very numerous constitutions which would bear, either with advantage or safety, the daily hammering of so powerful an engine as the douche. (p. 81)

Newspaper articles published a short time later reported deaths of the inmates of an asylum and prison. The shower was deemed “frightening” (“The Lake Wakatip Mail”, 1866, p. 2), and a “fearful” example of the mismanagement of publicly funded institutions (Harper’s Weekly, 1858, p. 808). The death of a prisoner during a Shower-Bath punishment was used to illustrate the horror and the shower subsequently fell out of favour (see Figure 6).

⁷⁹ “That hydropathy can kill – and that it may kill – in the hands of the ignorant practitioner – is perfectly true. It would not be worth two straws if it could not. For that which, when abused, can do no harm, cannot be capable of much good when properly used” (Shew, 1844, p. 34).

Figure 6*Torture and homicide in an American state prison*

Note. From "Torture and homicide in an American state prison", 1858, *Harper's Weekly: A Journal of Civilisation*, 2(103), p. 808. In the public domain.

Just as plunging had been connected to the uninformed Physician, showers were to become a feature of the unintelligent: "The efficiency of punishment depends exactly upon its tendency to increase or diminish the self-respect of its victim... Hence the growing abhorrence among intelligent philanthropists for the use of *the cat*, the shower bath, the ball and chain..." (The Prison Association of New York, 1845, p. 245). Practices that would wear down or diminish the spirit of the prisoner or the patient were looked upon in disdain: "Cruelty... drownings... were resorted to... to quench the spirit, to frighten men into their senses, to subdue and train, to overcome and tame the passions... we shall say little more of what is worthy of being called the *Immoral Treatment*" (Browne, 1864, p. 4). By the mid-1800s, the inducement of fear had turned from being a therapeutic tool to a destructive aspect of the Cold-Water-Shock-Shower: "the shower bath, as a means of repression or punishment would probably be destructive, by the feelings of fear or dislike which it would inspire, of all the benefits likely to be derived from their use as therapeutic agents"

(Worthington, 1851, p. 210). Shower-Baths were occasionally used, but the purpose now was to produce “tranquillity” (Winslow, 1855).⁸⁰ The functions of the Cold-Water-Shock-Shower, its ability to induce fear and to wear down the will and spirit were no longer thought of as therapeutic, meaning that practices such as Blair’s were relegated to the immoral.

The Cold-Water-Shock-Shower went from being a saviour of the state to a foe. It was abandoned in Britain, Europe and parts of the Americas by all but a few asylums (Granville, 1877; Wines, 1873). In prisons, the Shower-Bath was deemed “a relic of barbarism, a connecting link between the outrages of the inquisition and the inhumanities of the slave-pen, a process of gradual strangulation by drowning, whose existence is a blot upon the fair escutcheon of our state” (Wines & Dwight, 1867, p. 166). In 1872, at the International Penitentiary Congress, the Shower-Bath was reported to be forbidden (“amongst other modes of torture” [Wines, 1873, p. 26]) in most prisons, but still practiced in some (Wines, 1873). Despite these criticisms, showers not only endured, but their use spread and they became an “essential” part of daily living.

Showers Reborn in an Economy of Cleanliness

For the 150 years that the Fall-of-Water was used to treat and punish, the use of cold water distinguished them from something that could be used to wash a person’s body. Although the possibility of using a shower to wash someone was apparent to those who used them, there was no reason to when warm baths were available.⁸¹ While the 1872 International Penitentiary Congress signalled the end of showers as a form of punishment, an interest in prison hygiene expressed at this same event transformed showers from devices that touched the brains, will, and ideas of lunatics and prisoners, into devices that acted upon their skin.

In society at large, the benefits of bathing were being debated during the 1800s and regular bathing was generally avoided (Bichart, 1824; Webster, 1861). At the same time, enforced cleanliness was argued to be a necessary part of the system of governing patients

⁸⁰ The cold shower to manage the mind was not completely abandoned. To this day Dialectical Behaviour Therapy self-help strategies include taking a cold shower (e.g., Rathus & Miller, 2015; Van Dijk, 2012). Cold showers are also promoted as an “alerting activity” that may reduce the use of restraint and seclusion (Gay, 2012), to treat depression (Shevchuk, 2007) and anxiety (Bongiorno, 2014).

⁸¹ A prison cell keeper reported: “We use both ducking and shower-bath... directed for special purposes, by the doctor... the water falls through a sieve, in a large streak – comes very heavy – and we are directed to give it so many minutes – sometimes 2, and sometimes as much as 15 or 16 minutes – according to the doctor’s directions. Once I gave it a half hour, and thought the man was better by it. The quantity is increased as repeated. I never knew it to do harm to any body. We did it as medical treatment principally. It will calm the most obstreperous lunatic. I am careful in administrating the cold shower-bath to follow the directions of the physician... Of my own mere suggestion, I have done it to others not insane- to the assistance with their own consent – not in winter – but in summer... I have never done it merely to wash a patient – we have warm baths to wash them in which we apply daily” (McElwee, 1835, pp. 50-51).

and prisoners. Both the insane and the criminal were thought to have particular need for washing: for insane patients, frequent washing was necessary so that “the peculiar odour of the insane, so often described, does not permeate every ward” (Conolly, 1847, p. 40).⁸² In prisons at that time, for the large majority of individuals, hygiene was said to be an almost unknown virtue, or in any case, a disagreeable practice (Delabost, 1888).

However, just as cold water could reach in to modify the inflamed brain and wear down the spirit, warm water and the resulting cleanliness could also permeate into the body and exert an influence on the mental and moral status and self-worth of the bather. Warm baths could soothe, refresh, and allay excitement (Worthington, 1851). Washing the body had long been connected to “mental and moral faculties” and was employed to improve health and self-respect:

The moral influence of a habit of personal cleanliness is neither slight nor unimportant... the bath is not so absolutely necessary in cool as in hot weather; yet it is, at all times, refreshing, invigorating and healthful. Many of the employments in prisons are of such a nature that the frequent use of the bath is demanded as well to insure self-respect as to promote health for who so degraded as not to feel a deeper degradation from personal uncleanness?... cool water will produce a feeling of refreshment; but water, moderately warm, with soap and the brush, or even a rough towel, really restores. (The Prison Association of New York, 1845, pp. 245-246)

It was, however, a shift in focus to Skin as the locus of disease that saw it become the primary target of washing.

The mid 1800s issued the “modern period of dermatology”, and saw connections established between the skin and a multitude of diseases (McCaw, 1944). Mania could be identified in the skin;

In those cases of maniacal excitement... functions of the skin... are greatly perverted, the surface of the body and the extremities being in most cases cool, and either moist or excessively dry and harsh, and presenting to the eye an earthy or dusky appearance. (Worthington, 1851, pp. 208-209)

Physicians argued that skin benefited from the application of water to remove impurities,⁸³ and skin washing became an important part of managing personal health.⁸⁴

⁸² Indeed, dirty habits and a “total disregard for cleanliness and decency” (Bucknill & Tuke, 1858, p. 225) were considered early signs of insanity in the 1800s, and remain a feature of diagnosis today (Morrison, 2014).

⁸³ One theory was that the pores of the skin functioned as tubes that aided in respiration and purification of the blood. Water “frees the mouths of the breathing pores from all obstruction” (Johnson, 1858, p. 357). The skin also “does possess and exercise the power of extruding from the system, through its pores, poisonous matters which have found their way into the blood” (Johnson, 1858, p. xxxi) which can then be scrubbed off with soap and water. The 1853 Hydropathic Encyclopedia for example, recommend regular cool or cold showers as a way of addressing “deficient external circulation, capillary obstruction, and internal congestion or engorgement” (Trall, 1853, p. 377).

⁸⁴ Gerhard (1895a) noted “It would be superfluous on my part to attempt to dwell, by way of introduction, upon the necessity of absolute cleanliness in institutions where large numbers of patients, ill in body or mind, or both, are cared for. The requirement of cleanliness is not confined to

Personal cleanliness is also afforded by each patient having a warm bath once a week. Where these regulations prevail, the Skin of insane patients loses its most repulsive and unwholesome aspect; general health is promoted, and with health, comfort, and cheerfulness. (Conolly, 1847, p. 40)

While washing was argued to benefit the health and well-being of the insane and prisoners, this institutional interest in their health and well-being was, in its connection to labour, viewed as a therapeutic tool within asylums (Conolly, 1847; Delabost, 1888; Pinel, 1808; Rush, 1835).⁸⁵ Healthy skin would enable asylum inmates to work, while work would also improve the health of their skin. Worthington (1851) suggested that perspiration from labour “seems the grand means appointed by nature to insure the healthy action of the skin” (p. 201). The inability of the insane to work was thought to account for the “altered condition of the cutaneous surface” (p. 201) and, thus, the large number of the incurable insane that suffered fatal chronic disease. Hygiene, health, and work were thus connected.⁸⁶

While good health was used to advocate for washing, the link between productivity and health had the added benefit of contributing to the economy of the institution. The good health of the inmates or prisoners allowed them to work, thus diminishing the cost of incarceration (Conolly, 1847; Delabost, 1888; Pinel, 1808; Wines, 1873). Prisoners were compelled to be clean, healthy, and productive; and a “want of cleanliness” was considered a punishable offence within a number of prisons. Despite the link to productivity giving reason for regular bathing, bathing was often not attended to in asylums (Conolly, 1847) and many prisoners bathed infrequently, as little as four times a year (Wines & Dwight, 1867).

Dr Merry Delabost, a French prison Physician, is credited with conceiving the idea of showers for washing.⁸⁷ Following the 1872 International Penitentiary Congress, the French government asked prison doctors what could be done to improve the cleanliness and hygiene of prisoners (Delabost, 1875). Delabost had been attempting, without success, to have cold showers installed for the purpose of hydrotherapy at the Rouen prison.⁸⁸ He proposed that the use of warm water, poured over the heads and bodies of prisoners, would

the buildings... to a higher degree, to bodily cleanliness. Therefore, no provision is of more importance for institutions than that of proper bathing facilities” (p. 23).

⁸⁵ The imperative to work was argued to foster obedience and orderliness (thus reducing the indolence that caused mental illness), and to distract and tire out patients (Windholz, 1995).

⁸⁶ As Foucault (1964/2001) pointed out in “Madness and Civilisation”, the idea of health and work being connected had a place in governing the insane for a long time prior to the development of showers.

⁸⁷ However, Peppe (1930) and Gerhard (1908) suggested that Dr Duval introduced showers for hygiene in the barracks of Marseilles in 1857 and that showers appeared in many barracks and penal institutes in France and Germany from this time. It is unclear, however, whether these showers were being used for washing or some other hydropathic purpose. Dr Alexander Bresgen published a pamphlet in Germany in 1871 on the use of rain baths used with the Prussian Army, and advocated for their use in all public institutions (see Essay 2). Delabost (1875) claimed that he had not known warm water showers to be used for washing prior to his experiments.

⁸⁸ Delabost (1875) noted that the reason for his failure was that cold showers were no longer a sanctioned therapy.

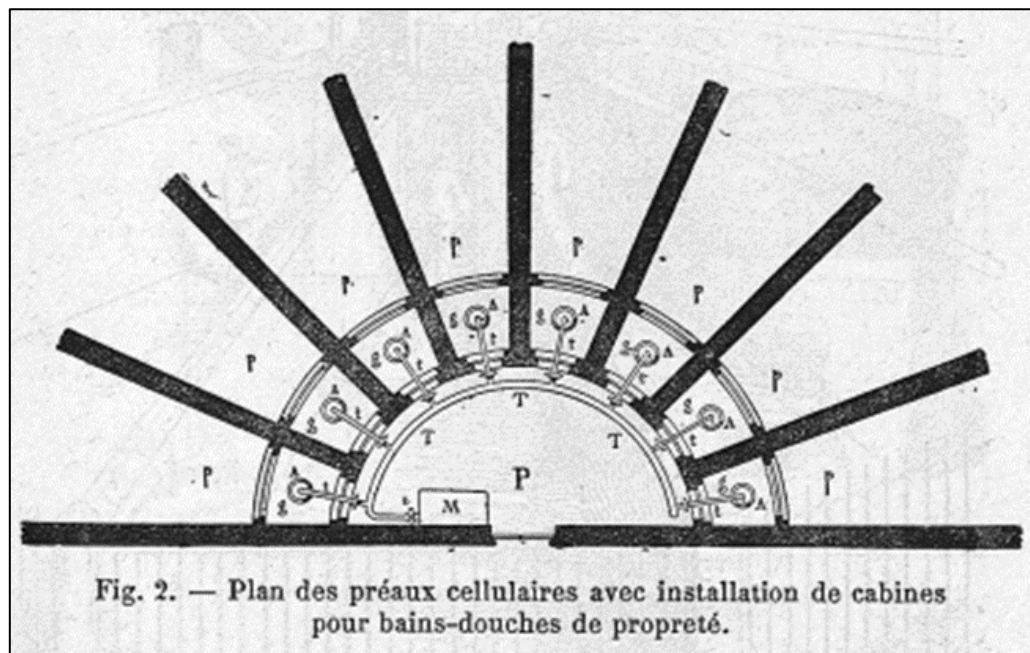
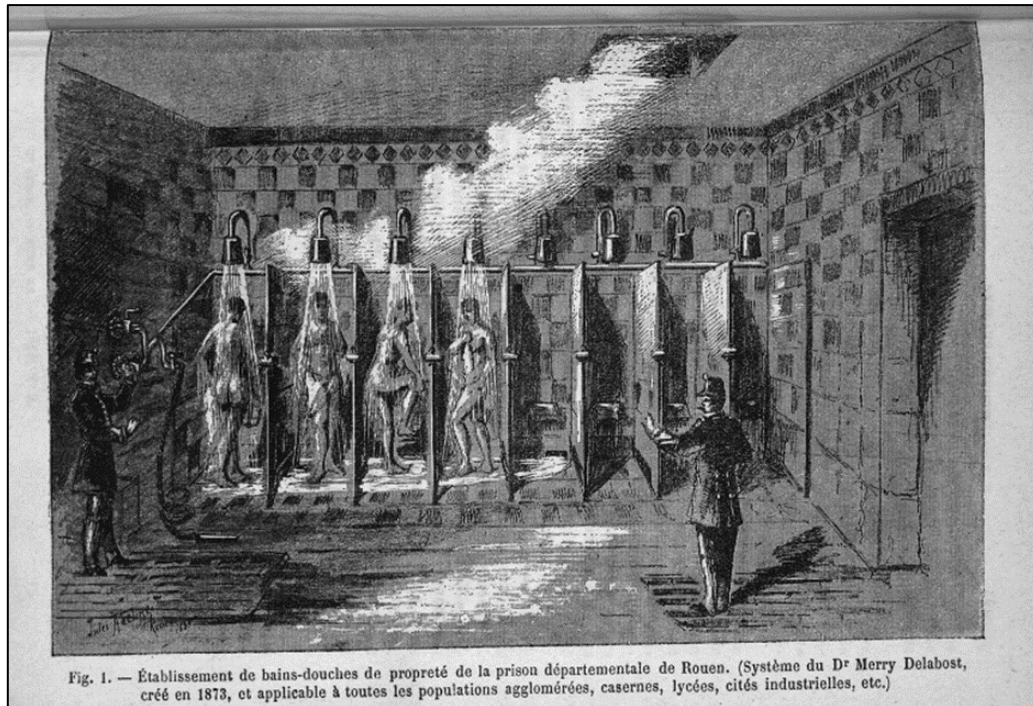
be an efficient and effective way to promote hygiene.⁸⁹ The shower was reported to engage the prisoners to scrub (with the assistance of soap), thus detaching impurities that the water (running over the surface of the body) would then take away (Delabost, 1875). He employed a cellular design (see Figure 7), which prisons had been using for some time to separate prisoners and improve the ease and efficiency of surveillance. It was argued that Guard surveillance was necessary during washing as most prisoners, through laziness, not caring, or existing uncleanliness, neglected to scrub sufficiently to be clean (Delabost, 1875, p. 114). The shower was proposed to have several advantages in this respect; the Guards had an unobscured view of the body, and, through an Attendant turning on and off the water, washing large numbers of bodies could be performed in less than 5-minutes (a population of 900-1200 could be showered within 2-days), using only 25 litres of water per person. Furthermore, the shower was reported to be very agreeable.

⁸⁹ Cost was considered in terms of construction of the showers, the guards' time, the cost of heating the water, and the amount of water used (Delabost, 1875). The army added the economy of space into their calculations of the benefit of the shower (Colonel Mengin-Lecreulx, as cited in Delabost, 1888).

Essay 1 The Birth of Hydropathic Showers

Figure 7

Delabost's 1888 Prison Shower Designs



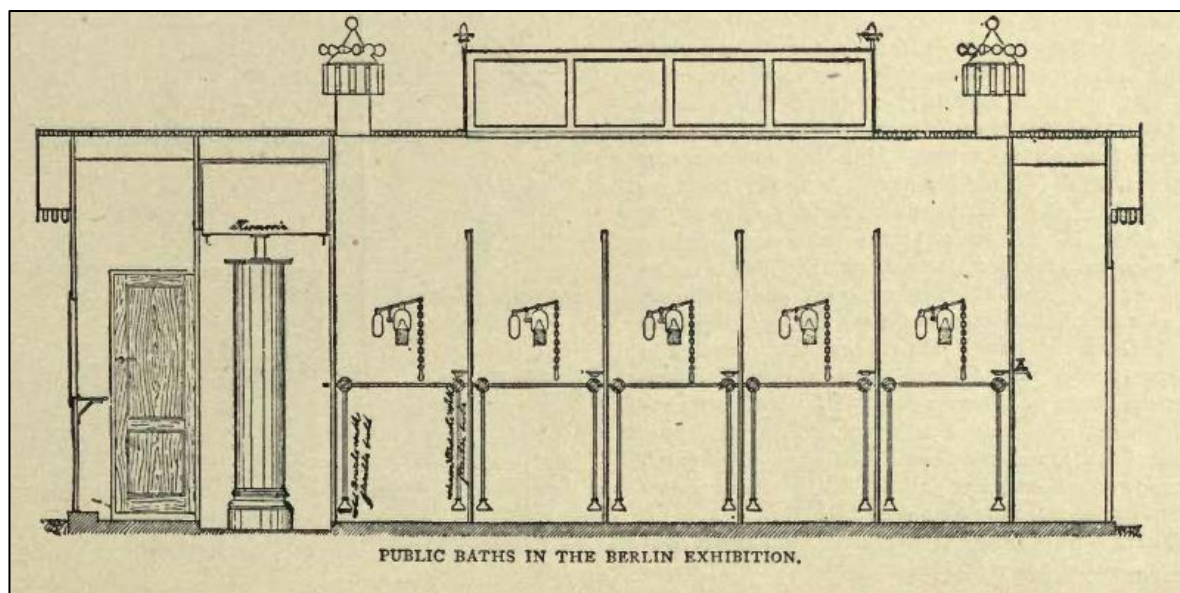
Note. From "Hygiène pénitentiaire: Bains-douches de propreté. - Leur application dans les prisons cellulaires," by M. Delabost, 1888, *Annales d'hygiène publique et de médecine légale*, 3(20), p. 233 & p. 227. In the public domain.

In Delabost's Ablution-system, the skins of the prison population were washed to ensure health and productivity. The shower functioned to wash away impurities with the greatest economy of time, water, heating, and surveillance.

Delabost's efforts to improve the health of the prison population through hygiene measures drew on broader societal discourses regarding public health and productivity. Towards the middle of the century, strategies to encourage personal hygiene habits were employed as part of public health reforms.⁹⁰ The "hygiene shower" was a shower for the masses and less than a decade after Delabost's invention, Dr Lassar promoted a shower block ("the people's baths")⁹¹ as an economical way of supplying public bathing to the poorer classes (American Plumbing Practice, 1897)—see Figure 8.

Figure 8

Showers for the Poorer Class at the 1883 Hygiene Exhibition



Note. From "Plumbing of swimming and rain baths", by *American Plumbing Practice*, 1896, p. 197. In the public domain.

By the end of the 19th century, Hygiene Showers had proliferated and become a common feature of public baths across Europe (Wright & Weaver, 1897); army barracks (Billings, 1875; Delabost, 1888); in schools, factories, and on ships (Gerhard, 1894); and athletics clubs and schools (American Plumbing Practice, 1896). Showers were also available in the British colonies ("Wyndham-street Hot, Cold, and Shower Baths", 1892), which is discussed further in Essay 2.

⁹⁰ See Crook (2016) "Governing Systems: Modernity and the Making of Public Health in England, 1830-1910" for a detailed analysis of these strategies.

⁹¹ The design was by David Grove in 1878 for army barracks (American Plumbing Practice, 1896). By 1889 he had also patented a portable shower bath for families, the public, the army, and factories (Grove, 1890). Delabost (1875) had also envisaged his showers being used by factory workers and armies.

The Hygiene Shower, as an object of economy rather than Hydropathy, became the domain of the Engineer rather than the Psychiatrists, with showers installed in asylums according to engineering plans and specifications (Gerhard, 1895a). Indeed, Gerhard (1895a) argued that baths were now the enemy of the asylum and should be abandoned as they were costly to maintain, time consuming to use, dirty, harmful, wasteful of water, and dangerous (in terms of spreading disease, scalding, being used for suicide). At this time, showers of various designs appeared for washing the insane, including the “needle bath”, “hand sprays”, and “rain baths” (Gerhard, 1895a). The Rain-Bath, in which the shower head with a fine, economical spray (Gerhard, 1895b), was angled on the incline, as is familiar today, was said to be the desirable option, as it could avoid “the shower striking the head of the bather, which to many persons is quite disagreeable” (Gerhard, 1894, p. 67). The shower, once designed to be unpleasant and target the head, could be used without the head getting wet at all, so to avoid any unpleasantness (see Figure 9)! Furthermore, the Rain-Bath would avoid the need for an Attendant to assist with showering, and would avoid the undesirable impression that patients might be showered against their will (Gerhard, 1895a). Such showers were vastly transformed from the fall of cold water that Dr Blair had employed to cure a wayward wife. The sudden shock, the fear and unpleasantness, and the cooling effects on the maniacal brain were all exchanged for agreeable, efficient application of warm water and soap, for the purpose of clean skin and health.

Figure 9

Bathroom of the Utica Psychiatric Centre, 1895



Note: From “The rain-bath - a novel form of bath and new method of bathing insane patients”, by W. P. Gerhard, 1895, *American Journal of Insanity*, LII(1), p. 34. In the public domain.

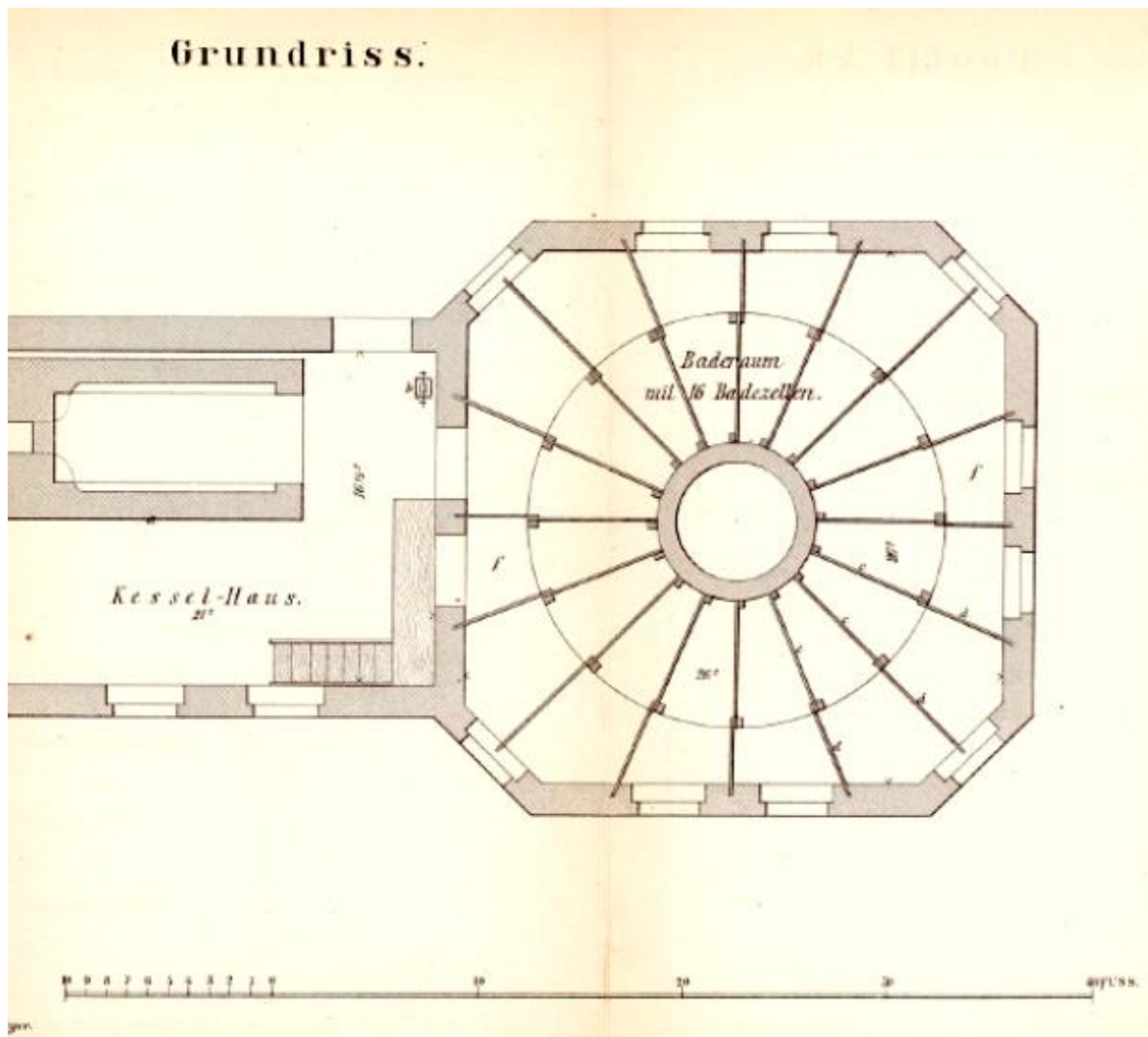
Conclusion

Shifts in knowledge through the 1800s made the shower thinkable—firstly as a device to aid in the treatment of the insane, and later to wash the skins of the masses. The well-informed Physician's understanding of the brains, minds, and will of the insane led to the manufacture of an object that would induce therapeutic cold, shock, and fear. The ideas that governed the practices of the Physicians and the lives of their patients materialised in the various shower designs; and, in their materiality, the ideas were made durable and could proliferate. However, when the Cold-Water-Shock-Shower fell out of favour, the shower was reborn. Connections were formed between skin, health, and productivity, and the failed hydropathic shower was transformed into an effective and efficient machine for bringing hygiene to the masses. The dosage of 1.5-hours was reduced to 5-minutes, 15 tons of water reduced to 25 litres. The shower now served the good of the nation by washing away the impurities of the masses with the minimum of expense. The shower went from being a device intended to inflict unpleasantness to one that was very agreeable. So agreeable in fact, that the following century would see populations calling for showers to be provided for them, and the mass production of shower units that people could purchase for their own homes.

Summary: The Birth of Showers

Showers were born in the 1700s from the observed pre-discursive effects of cold water on the mad or maniacal brain. Physicians produced various form of Cold-Water-Shock-Shower to govern the direction, force, and duration of the water onto the body to discipline the source of disorder such as the inflamed vessels of the brain and the impetuous will. Docile bodies were restrained as the Showerer subjected them to his cold Fall-of-Water or Douche Bath to normalise them and reduce the cost of their disorder on the health and wealth of the nation. Such was the apparent success of the treatment Fall-of-Water that showers came to be built into the asylum and the architecture became part of the therapeutic operations. Although the treatment appeared to have its intended effect, a shift in the dispositif towards a disdain for corporal violence and an emerging discourse regarding skin, hygiene, and population health transformed the shower into a pleasant, warm water washing Ablution-System. Born in confined, collective spaces for discipline, showers came to be characterised by their cell form, being efficient and economical, and allowing the upright body to be observed by an attendant. In some spaces (such as the asylum), open shower rooms materialised; however, the cell system remained and proliferated, becoming established as a technology of public health.

Essay 2 Hygiene Showers in Confined, Collective Spaces



A. Bresgen's Shower-Bath-Facility "Brause - Bade - Anstalt" (1871)

In 1871 Bresgen designed a Shower-Bath-Facility to wash the skins of an Army Division. This was a collective hygiene shower in the confined space of the army camp. As noted in Essay 1, the 1800s “modern period of dermatology” established a connection between the skin and reducing disease through washing. This Essay is the first of two introductory Essays in which I analyse the dispositif in which these hygiene showers emerged. Although the focus of this thesis is on showers modified for Disabled-People, they are part of a broader dispositif in which the idea of showering was established. In this introductory Essay, I discuss the birth of the Hygiene-Shower in confined, collective spaces. As noted above, the idea of Private versus Confined, Collective spaces is central to this thesis, revealing who is governed as Showerer (a speaking subject, with consciousness and identity) or as Showeree (subjugated or objectivised). I explore the discourses that made Hygiene-Showers for populations a thinkable thing, producing and being produced by various subjects and objects, and the associated governmentalities.

Hygiene Showers: Governing the Cleanliness of the Working Class

While there is some evidence that showering was practiced in ancient Rome (Gerhard, 1908), it was not until the 12th century that the modern idea of bathing to wash the body emerged in Europe (Ward, 2019). During the 17th century, concerns about the spread of disease via miasma suggested that offensive body smells could be a threat and bathing was promoted for population health. Water cure spas opened through Europe in the 1700s.⁹² However, it was not until the early 19th century that daily bathing was suggested (Ward, 2019). At this time, the skin was thought to be part of the respiration system. As such, washing to unclog pores helped with respiration and purification of the blood (Ward, 2019). As technologies became established to measure the influence of clean water on the incidence of disease, showers designed to wash particular populations emerged.

A pivotal moment in the government of public hygiene was the cholera epidemic of 1832, that spread through Europe and America. A biopolitical governmentality emerged at this time to address the urgent need to reduce the incidence of disease. Osbourne (1996) explained that from the 1830s “public health and sanitary science... were conceived as measures of security, forms of government that saved on interventions and costs in other sectors of the social order... Disease was a wastage” (p. 104). Measuring the spread and morbidity rates of disease through statistics emerged in western nations as a biopolitical

⁹² While there have been some studies of Indigenous knowledges regarding water, hygiene and health, a review of academic literature found “very few studies were found looking at the relationship between indigenous traditional beliefs and hygiene practices or household health care” (Jiménez et al., 2014, p. 285). As mentioned in my discussion of ethics, the use of steam (“vapour baths”) and bathing in natural hot springs had, however, been practised by Māori in pre-colonial times (Nicholls et al., 2016; Stokes, 2000; Young, 1998).

technology to understand the influences of the milieu on death rates. *The Cholera Gazette* (1833) illustrated how regions gathered statistics and, although there was still debate at the time about whether cholera was contagious, populations with access to clean water and the facilities for personal and house cleaning were found to fare more favourably than those who did not.⁹³

At the time of the cholera epidemic, Physicians were primarily focused on treating the symptoms of disease as it presented in their patients; however, the cold shower-bath was suggested as a hydropathic practice for strengthening one's constitution to prevent susceptibility to cholera:

The cold bath, or shower bath, and moderate exercise in the open air, are advantageous in strengthening the constitution, and in lessening the liability to the epidemic influence. The tepid bath in persons of debilitated habits would be better than the cold.

(M'Naughton, 1833, p. 138)

While the cold shower-bath might strengthen, it was a discourse of cleanliness that led to the widespread establishment of shower-baths for the public. The first public freshwater bath and washhouse was built in Liverpool in 1842 following the efforts of Kitty Wilkinson (who was reported to have reduced the spread of cholera by providing laundry services to the sick) and included Shower-Baths (Baly, 1852; Scally, 2004; Ward, 2019). These public baths aimed to provide a collective space in which working class families could wash “without the annoyances and discomforts (felt by the working man especially) of washing at home” (Baly, 1852, p. 4). Providing showers within public baths created a milieu in which it was possible for the working classes to be transformed into a more favourable population, cleaner in body and spirit, fit for connection to the apparatus of production:

THE main object of the General Committee was the promotion of the health and cleanliness of the working classes, and, as a necessary consequence, the improvement of their social condition and the raising of their moral tone; thereby rendering them more accessible to and better fitted to receive religious and secular training.

(Baly, 1852, p. 4)

While the promoters of Public Baths may have intended the shower to normalise the population, the effects were limited to those who chose to use the facilities.

According to Ward (2019), the Baths were somewhat of a success in England: “In its [the Liverpool baths] first year it provided 11,000 baths and in its second over 16,000 – impressive growth but still a small number for a city of more than 250,000” (p. 51).

⁹³ See Koch and Denike (2009) for an interesting analysis of John Snow's famous investigation of cholera in the 1850s and the view of Snow's contemporaries that his work was “unconvincing” (p. 1246).

Importantly, local or state government funding of such facilities “established the principle that the state shared **some** [emphasis added] responsibility for the cleanliness of British bodies” (Ward, 2019, p. 52). By creating a regulated milieu, or the “Hydraulic City” as Osborne (1996) has named it,⁹⁴ Shower-Baths could operate on the skins of the working class and Great Britain became seen as “a beacon of sanitary enlightenment” (Ward, 2019, p. 53). However, the act of bathing in public baths relied on the working-class population choosing to bathe. By the end of the 17th century, studies found that the percentage of the population that regularly bathed remained low in Britain and America, so it would seem there was little inducing the working class into the shower at that time.

Looking now to Aotearoa New Zealand, a discourse of washing the skins of the working class also had limited impact on the provision of public facilities in the early to mid-1800s, although the Municipal Corporations Act 1867 did include the possibility of council controlled public baths and washhouses.⁹⁵ However, in response to the arrival of smallpox, the influence of the state in relation to cleanliness was extended through the 1872 Public Health Act. This Act required town councils to take responsibility for the regulation of water supplies. By the late 1800s, showers were being established by private entrepreneurs and made available for those who could afford them (such as the 1885 Te Aroha hot springs⁹⁶ and the 1892 “Wyndham-street Hot, Cold, and Shower Baths”⁹⁷). Despite the possibility of shower-baths in Public Baths producing a clean working class, they had limited influence in Britain, America, and Aotearoa New Zealand during the 1800s. At the dawning of the 20th century, few people bathed regularly due to issues of cost and convenience, and in some cases a lack of desire to wash (Ward, 2019). However, this did not mean that collective bathing facilities faded into obscurity. In the rest of this Essay, I discuss the emergence of showering for hygiene in Army Camps and Miners Facilities. These showers were designed to reduce the incidence of disease within particular populations, but they employed very different governmentalities to induce subjects to wash.

The Army-Division-Shower-Bath-Facility: Disciplining Soldiers

While the working population was being induced to wash through the provisions of a milieu in which showers were available, disciplining individuals in collective, confined spaces was being employed to create nations of Showerers in the mid to late 1800s. Osborne (1996) explained that medical government in the late 18th century “was concerned with

⁹⁴ Discussed further in Essay 3.

⁹⁵ A few public baths did materialise such as the Dunedin Public Baths (“Baths”, 1864) and freshwater baths and showers available to the public in Lyttelton in 1885 (“Lyttelton Baths”, 1885).

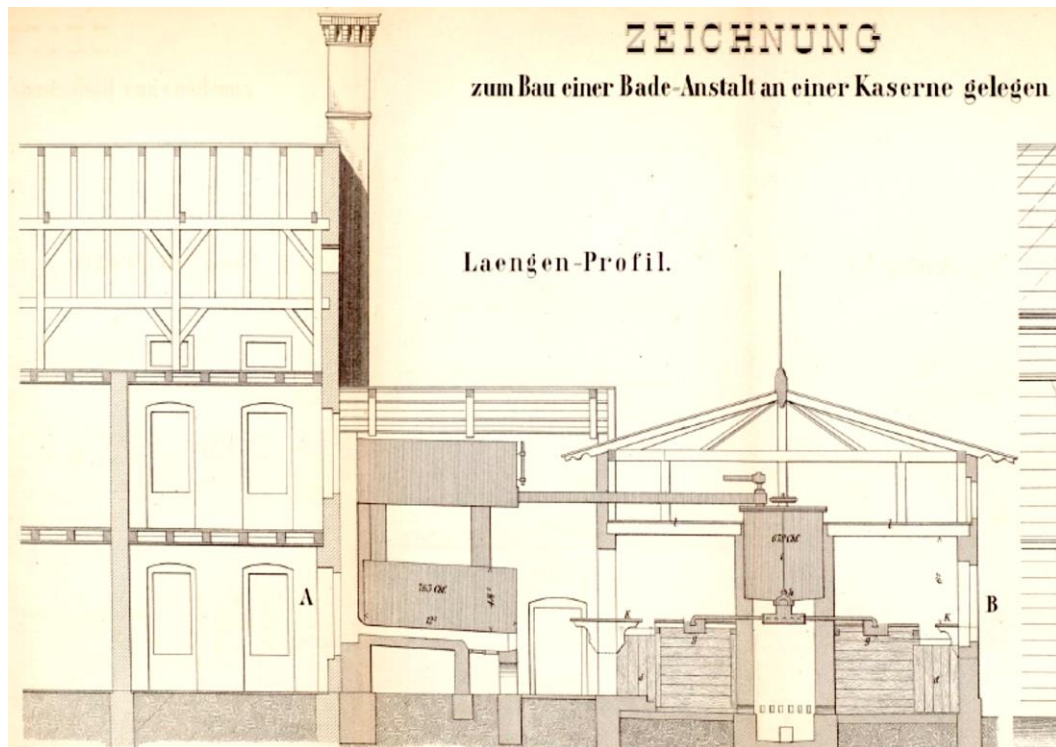
⁹⁶ The tickets for the pools were “a mere trifle” (“A trip to the Te Aroha Hot Springs”, 1885, p. 1).

⁹⁷ These were 1 shilling for a hot or cold shower or bath. The equivalent of approximately NZ\$10 today.

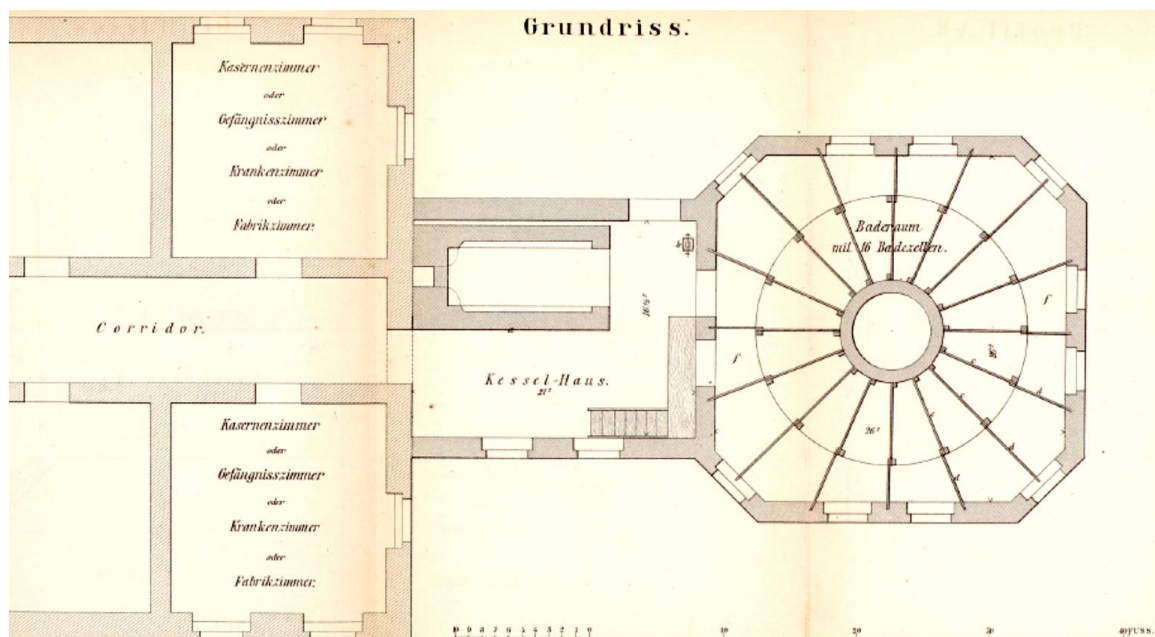
disease as it affected public space, not in the sense of spaces open to the public but concerning that series of closed spaces that were constructed in the interests of the public... hospitals, prisons, naval vessels, military camps” (p. 108). In particular, “the health of sailors and soldiers was a major concern... medicine of collective – but confined – spaces... concerned not with the provision of urban infrastructure but with the establishments of right conduct and discipline” (p. 109). Anatomic-political discipline was key to producing individual citizens who also took *some* responsibility for the cleanliness of their bodies.

In 1871 (translated), Alexander Bresgen, Royal Prussian Medical Officer, proposed that the improvements in the health of the troops he had observed when they had access to rivers to swim in was due to the cleaning effect the water had on the skin. As mentioned above, Bresgen also believed that the skin functioned to assist the lungs by discharging vapours and other substances from the blood. Cold and humidity were thought to suppress these functions, causing lung diseases. The nervous system, metabolic processes of the body, and life itself, relied on warmth and the skin played a vital function in detecting harmful changes in temperature. He proposed that soldiers tended to neglect skincare due to their low levels of education. Bresgen argued that frequent warm baths were beneficial for health, both to prevent and treat disease, with Spray-Baths (“Tropfbäder”) being more effective due to their ability to penetrate more deeply. He proposed that frequent washing was economical both in terms of the savings to be made through the health of the troops, reduced use of soap, and improved longevity of bedsheets and uniforms. Washing was also proposed to improve morale, the mental and physical capacity of Soldiers, and shortened training periods.

The method that Bresgen (1871) developed for washing the skins of Soldiers was a circular shower system (see Figures 10 & 11).

Figure 10*Bresgen's 1871 Shower-Bath-Facility Profile*

Note: From *Der Einfluss und die Bedeutung der diätetischen Hautpflege auf den Gesundheitszustand und die Leistungsfähigkeit der Friedensarmee* (p. 52), by A. Bresgen, 1871, Mayer. In the public domain.

Figure 11*Bresgen's 1871 Shower-Bath-Facility Plan*

Note: From *Der Einfluss und die Bedeutung der diätetischen Hautpflege auf den Gesundheitszustand und die Leistungsfähigkeit der Friedensarmee* (p. 55), by A. Bresgen, 1871, Mayer. In the public domain.

Bresgen's Shower-Bath-Facility⁹⁸ accommodated an entire Division (16 Soldiers), with the water "basin" holding enough water for five Divisions. This allowed 80 Soldiers to be washed and dressed in 30-40 minutes. The circular design allowed routine inspections of the whole body by the Physician, the only possible way, he claimed, to accurately diagnose a range of skin diseases such as scabies and syphilis. Ordinarily, Bresgen (1871) argued, the time taken to inspect the troops for these conditions and the violation of privacy had made such inspections impossible.⁹⁹ Bresgen proposed that the Shower-Bath-Facility, combined with a series of military commands, would allow the doctor to examine the body of each individual Soldier, a task made easier following the removal of dirt from the skin. Through the shower the skin of the Soldier thus becomes a discursive object upon which the Physician can act.

Division showering was scheduled once a week (to coincide with the laundry). Each Division would be marched to the shower cells, enter a cell, and follow the command "sliding doors closed, undress!", followed by "Enter!", then to the shower Attendant ("Wärter") "Taps on!" After three minutes the Attendant turned the taps off. The Attendant was required to check with the troop's doctor what temperature the water ought to be and to monitor the warmth. Every 4-weeks a medical examination should take place adding the command "Sliding doors back!" following which the doctor did his inspection of each Soldier's skin. Once they had been inspected, they may close the door to get dressed, and then the final command "Sliding doors back, dismissed!" was given. In addition to the shower acting on the skin, Bresgen (1871) proposed that the Soldier, as a creature of habit, would become a transformed subject through the therapeutic operations of his Shower-Bath-Facility. He proposed that the showered Soldier would continue with the duty to wash his skin when he returned home, providing great benefits to the entire nation. Furthermore, the Soldier was likely to induce and encourage his family and friends to wash. This would result in decreases in disease and death, improved efficiency and strength of the labour force, and increased wealth for the individual and the nation.

In the mid- to late-1800s, disciplining showers emerged almost simultaneously in Army Barracks in Prussia and in Prisons in France (as discussed in Essay 1), as a technology of anatomo-political discipline. As Foucault (1975/1995) explained, discipline produces docile bodies that can then be used in the interests of the nation. The collective and confined space of the Army-Division-Shower-Bath-Facility was a protected space in which each individual, constituting part of the collective, becomes knowable, and may be

⁹⁸ "Brause - Bade - Anstalt".

⁹⁹ Interestingly Bresgen had noted that medical inspections could be a violation of privacy if they were not done in his shower facility. He connects his shower design with privacy, and while he is not explicit as to how his design produces medical inspections that are private, it is perhaps preventing the Soldiers from seeing each other through the cellular design that eliminates the violation.

ordered, processed, measured, improved. Inside the shower, the bodies and habits of the Soldiers could be transformed into more healthy and productive members of the population. The skin became constituted as a discursive object that could transmit disease, health, moral and mental and physical productivity to the body through its connection to warm water. The design of these showers, and the effect of water sloughing away dirt from the skin, produced a Soldier with his skin exposed. Confined to a cell his nakedness was hidden from his peers but visible to the medical gaze. Although the Soldier is a Showerer (subjected to the shower), in the Shower-Bath-Facility the repeated practice of showering using military drill aims to reconstitute the Soldier into an educated Showerer. As such, once they leave the disciplinary space, they might continue to shower and facilitate the production of other Showerers to further benefit the Health and Wealth of the Nation.¹⁰⁰

Returning now to Aotearoa New Zealand, although showers in Army camps would appear in the 1900s (as discussed later in this Essay) it does not appear that hygiene showers for populations materialised in the 1800s. However, the German practice of discipline had an indirect influence on the appearance of showers in Aotearoa New Zealand via “manual instruction” in schools. In the early 1900s, the New Zealand government’s admiration for the German education system saw public schools being funded for Manual Instruction.¹⁰¹ At that time, the threat of German and American tradesmen being more skilled than the English warranted the introduction of discipline via state-funded training (Grace, 1900, p. 702). Manual instruction¹⁰² in the form of “physical education” justified the provision of a pool for the purposes of swimming training, including changing rooms with showers, at Mt Eden’s public school in 1906 (“Mt. Eden School Swimming Baths”, 1906). In the next part of this Essay, I discuss a Confined, Collective shower that did materialise in New Zealand but was connected to a different population—Miners; and that employed very different methods to induce the population to shower.

Changing-Rooms-&-Baths-for-Miners: The Democratic Shower

In 1908 the New Zealand Workers Compensation Act was passed. This Act required employers to compensate workers who were disabled from disease or injury resulting from their employment. However, as a result of the Act, mining companies sought to limit their liabilities and demanded that all Miners be subjected to medical examination and fired if

¹⁰⁰ Bresgen had also proposed that his shower-bath-facility for Barracks would be suitable for Factories, Prisons, Orphanages, and Alms-houses.

¹⁰¹ “There is nothing that has brought Germany more to the front than the technical education that they have had for so many years past. It has been a source of trouble to us at Home that our people have not received the large amount of technical education that is given to the people in Germany, which has been the means of pushing that nation so far ahead in manufactures” (Willis, 1900, p. 472).

¹⁰² Originally limited to manipulation of objects (Manual and Technical Instruction Act, 1900).

found not to be healthy. This led to the threat of strike action later that year (“Miners’ Complaint”, 1908, p. 2),¹⁰³ and, in 1911, a Royal Commission was established to “inquire into and report on the conditions relating to the health and safety of the miners of New Zealand” (Cochrane et al., 1912). The Report from the Royal Commission of Mines recommended the provision of showers “Changing Rooms & Baths for Miners” at larger mines to prevent “Miner’s Disease” (Cochrane et al., 1912).¹⁰⁴ In the following discussion, I analyse the discourses that connected Miners to showers and consider the therapeutic operations of the Changing-Rooms-&-Baths-for-Miners that the Commission suggested.

In the early 1900s mining was associated with a pulmonary disease named pneumoconiosis (Workers’ Compensation Act 1908) or Miner’s Phthisis (with subcategories of “fibrosis, tuberculosis of the lungs [or ‘consumption’], and tuberculosis of the lungs superimposed upon fibrosis” [Cochrane et al., 1912, p. 29]). As part of their inquiry, the Commission consulted Physicians who concluded that Fibrosis was caused by silica dust, while tuberculosis was caused by a bacterium passed from person to person via “sputum” and most likely contracted outside of work. Various actions to reduce disease were proposed by the Commission which included sprays to reduce dust in the mines, prevention of “indiscriminate spitting”, disinfection of workplaces and the use of “bath and changing houses” (Cochrane et al., 1912, p. 31). Physicians interviewed by the Commission were uncertain about the factors that were the cause of the disease in some Miners, but over exertion resulting in a “loss of vitality” (Cochrane et al., 1912, p. 36) was thought to be a factor, as was walking home in cold and wet clothing. The provision of baths and changing facilities was proposed to mitigate this risk.

While Physicians advocated for bathing facilities, there was some dispute as to whether Miners would make use of them. The Commission reported that in mines where baths were available, a lack of privacy and cleanliness had meant they were avoided. However, one mine-manager interviewed believed the Miners did not want to shower, and stated “you would have to tie them down to get them under the water” (McEwan, cited in Cochrane, 1912, p. 150). The Commission interviewed Miners, most of whom indicated that they would use showers. They found a consensus that a ratio of between one shower to four or one to eight Miners would be sufficient and help reduce costs, and there was a general

¹⁰³ This strike action was from Reefton Mines, the site widely regarded as bringing a start to industrialised union action in Aotearoa New Zealand with the “Blackball strike” earlier that same year. Strike action also resulted in meatworks factories being required to provide showers to workers (“600 Hands Idle at Westfield”, 1938) although national legislation did not require factories to have washing facilities until the Factories Act (1946). Interestingly showers were connected to strike action 35-years later when miners’ protested about a contagious foot disease they were contracting in the showers (“Again on Strike”, 1943). While showers were installed to prevent disease and as a response to strikes, it is ironic that they were, only a relatively short time later, the cause of both.

¹⁰⁴ The Mining Act 1898 and Coal-mines Act 1891 already had provision for facilities for changing and drying clothes.

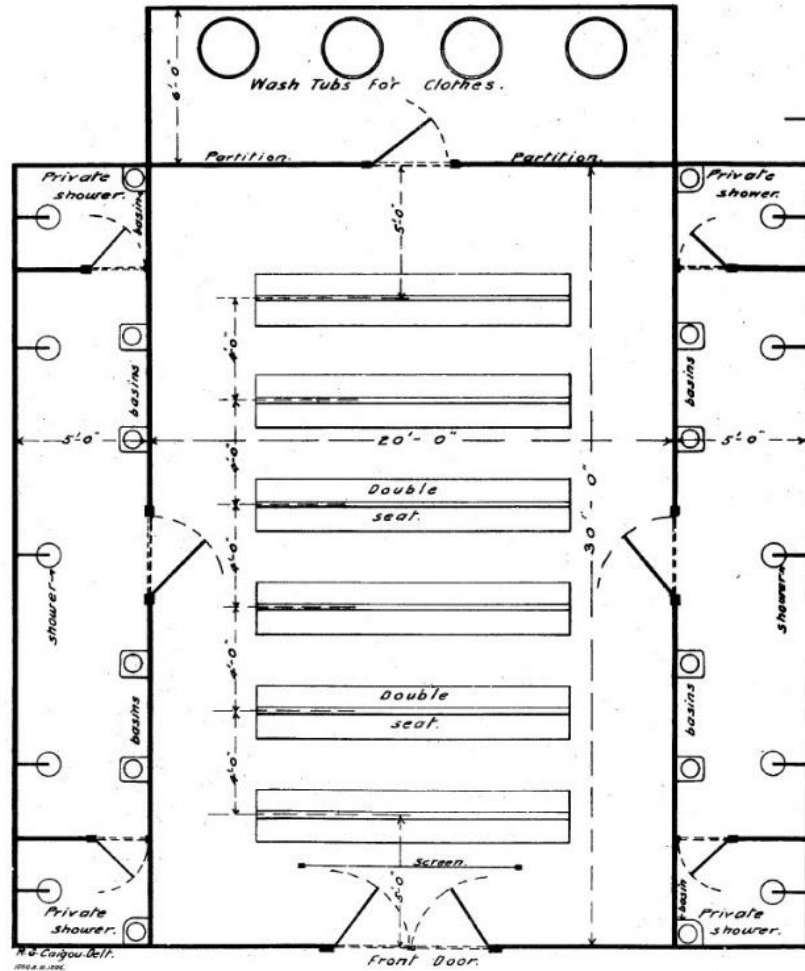
agreement that not every Miner would choose to wash. While some were not concerned about whether they were provided with a shower or a bath, a discourse of showers being more economical to build, cleaner, and possibly preferred by Miners¹⁰⁵ resulted in showers being suggested. Showers within workplaces, such as factories, had been established in Europe and the USA by this time (Gerhard, 1894; 1908). Their design included shower rooms very similar to Delabost's prison Ablution-System, where the Showerers were separated from each other within the shower, but visible from the outside (see Appendix I). Figure 12 shows the Royal Commission of Mines (1912) "Suggested Design for Changing Room & Baths for Miners". While the name would suggest that baths were recommended, the design was actually for a shower block with laundry facilities:

¹⁰⁵ Although it was suggested a ballot be taken on which was preferred.

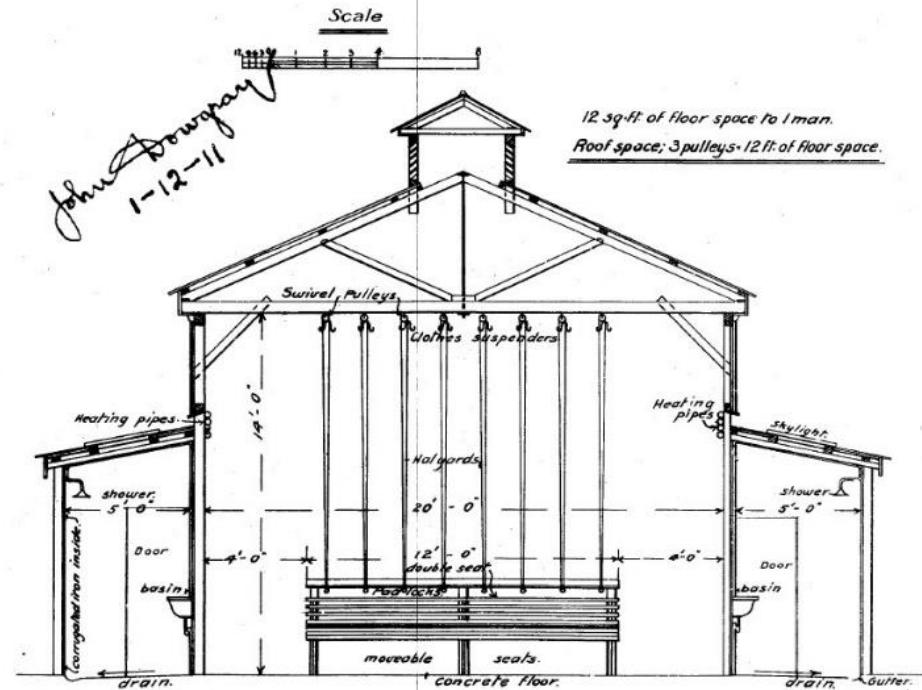
Essay 2 Hygiene Showers in Confined, Collective Spaces

Figure 12

1912 New Zealand Royal Commission on Mines Changing Rooms & Baths for Miners



SUGGESTED DESIGN
— FOR —
CHANGING ROOM & BATHS FOR MINERS.
(CAPACITY,
50 MEN ON ONE SHIFT.)
— TO ACCOMPANY THE REPORT OF THE ROYAL COMMISSION ON MINES N.Z. 1911. —



Note: From "New Zealand Royal Commission on Mines (report on the)," by N. D. Cochrane, 1912, Appendix to the Journals of the House of Representatives, S1(c-4), Appendix. In the public domain.

The suggested design provided showers at a ratio of 5:1 (10 showers for a shift of 50 men), with four of the 10 showers labelled “private”. Moveable double seats in an open collective space were included, presumably to assist with dressing and undressing. A screen blocked the view into this space from the entrance. A wall and door separated the showers from the changing area, with an additional wall and door within the shower space to separate the “private” shower. Wash tubs for clothes and a pulley system with padlocks were suggested for suspending clothes for drying. The floor was concrete with drains and gutters removing water. Heating pipes ran along the wall and down to the shower heads, and the shower walls were lined with waterproof roofing material (corrugated iron).

The Changing-Room-&-Baths-for-Miners was very different to Bresgen’s Army-Division-Shower-Bath-Facility in which all of the Showerees were separated from each other. The Miners showers and changing rooms were a collective space. Although private showers were available, they were designed in a way that required the private Showeree to pass through the collective shower space. Although an unwillingness to be naked in front of one’s colleagues was seen to be abnormal (“some men have a decided objection to stripping in front of others through some affliction” [Glover, ‘Miner and Workmen’s Inspector’, cited in Cochrane et al., 1912, p. 132]), Miners had indicated that a lack of privacy had dissuaded them from use of bathing facilities in the past, and desired privacy when bathing:

11. As to bath-houses and change-houses?—I think each mine should be provided with bath-houses.

12. And each man with a separate bath?—Yes, a stall closed off. I do not see why a miner should bath before a crowd; they do not allow it in any other place.

(Chapelhow, ‘Miner and Secretary of the Denniston Coal Miners Union’, cited in Cochrane et al., 1912, p. 122)

Private showers were preferred and possible, so what could be the purpose of the collective spaces? The Commission did not explain its rationale for the collective shower room, and the inquiry does not describe any findings that would advocate for the production of a collective showering space. Perhaps the design was connected to a discourse of financial prudence (showers were argued to be cheaper than baths [Reed, cited in Cochrane et al., 1912])? Maybe the cost of 10 doors had been considered against the cost of six? I argue that while economics was a consideration, these shared spaces were the therapeutic operations of a democratic governmentality aiming to induce Miners to shower, and to do so efficiently.

Compared to the Soldiers of the Prussian Army, Miners were not compelled to shower through military drill. Indeed, as noted above, concerns had been raised that the provision of such facilities was a wasted expense to the company as the Miners

would not use them. The legislation that resulted from the Royal Commission of Mines report (1912) ensured that although the installation of changing and bathing facilities was at the company's expense, they were only required to install them if a sufficient percentage of Miners voted for their installation and they then put them to use (Coal Mines Amendment Act, 1914). While the Miners generally desired showers, the collective relied on the individual's interests aligning with showering, since they would only be supplied if individual Miners voted for and used them. In contrast to Bresgen's 1871 Army-Division-Shower-Bath-Facility, in which the body as an object to be made visible to the Physician's inspection but hidden from other Soldiers, in the collective spaces of the Changing-Rooms-&-Baths-for-Miners the Miners are visible to each other. Such design could induce the Miners to shower, making visible those who were and who were not showering, ensuring that the interests of the collective were known, as were the individuals whose interests were not aligned with the collective.¹⁰⁶

In contrast to the concern that Miners would not use the shower, the Commission also investigated the concern that Miners who did use them may occupy the showers for an unnecessary length of time. This was argued to be a further waste of resources and would mean there would be insufficient water to provide showers to all. One of the Miners suggested that an awareness of their fellow miners waiting to shower would mitigate this potential risk:

90. You stated that one bath would be sufficient for six men ?—Yes.
 91. How long would you consider it would take one man to have a shower-bath ?—It all depends on the man himself.
 92. But, as a rule ? Men do not monopolize a bath when they know others are waiting ?—They are very kind to one another in that respect.

(Warne, Mine Manager, cited in Cochrane et al., 1912, p. 202)

There is no attendant to turn the taps off; rather, the Miners must be induced to keep their showers short. The collective space makes the Showerer and those who are waiting to shower visible to each other. Recognition of the interests of others ensures that individual Miners keep their showers short, compromising their self-interests so as to not make their fellow man wait. Drawing on Cruickshank's (1996) analysis of democratic government, I propose that collective, confined spaces, such as the Changing-Rooms-&-Baths-for-Miners, are an important feature of the dispositif in which showers were established, ordered, and maintained.

Cruickshank (1996) proposed that self-government has been arranged in a particular way since the birth of mass democratic forms of government in the 1830s.

¹⁰⁶ Gerhard (1908), who I discuss further in Essay 3, was explicit about this effect of visibility on the discipline of Showerers. His design for "Rain Baths" in schools omitted subdivisions that his Rain Bath Compartment for adults had, stating "I also hold that the educational effect of having the children undress together in one large dressing room should not be entirely lost sight of, for as already intimated this fosters habits of neatness as regards the under-garments. For the older girls it may be desirable... to provide simple curtains for greater privacy" (p. 167).

Although democracy may grant freedom to citizens, as isolated individuals they are relatively powerless. To exercise self-government citizens must act collectively, thus “persuading citizens to tie their self-interest and their fate to society voluntarily was the key to stability without the use of force” (Cruickshank, 1996, p. 243). Artificially created associations (such as Miners Unions, Miners sharing a mining shift, or even the 10 Miners who could use the Changing-Rooms-&-Baths-for-Miners at once) are “useful for cementing the individual citizen’s desires and goals to a vision of what is good for society. With no apparent coercion or centralized State action, voluntary associations ensured a united citizenry and a stable society” (Cruickshank, 1996, p. 244). To achieve this, “venues constructed for citizens to take care of organising and governing themselves” (Cruickshank, 1996, p. 244) became necessary. In such collective, confined spaces (such as the Changing-Rooms-&-Baths-for-Miners), individuals may feel their dependence on each other. This produces an awareness that small acts of self-denial (taking a shower even if one does not want to or cutting one’s shower short) are tied to desires of the collective. With each Miner’s interests tied to the interests of the collective, showering is under the surveillance of the group and does not need to be enforced by the state or the mining company. The collective space creates the comradeship¹⁰⁷ that democratic government relies on, and collective showering became the established way of things (Figure 13).

¹⁰⁷ Comradery is by definition the sharing of a room “Comrade, Comradery: ‘one who shares the same room,’ hence ‘a close companion,’ from French camarade (16c.)” (camaraderie | Etymology, origin and meaning of camaraderie by etymonline).

Figure 13*Coalminers showering in the bathhouse at the Surprise Mine in Reefton*

Note: From *Coalminers showering in the bathhouse at the Surprise Mine in Reefton*, By C. Ward, n.d. (<https://westcoast.recollect.co.nz/nodes/view/11840>). Copyright 2021 Claire Ward. Reprinted with permission

The Changing-Rooms-&-Baths-for-Miners produced and was produced by subjects who are part of a collective. While Cruickshank (1996) does not discuss the idea of rights, there is an interesting connection between the idea of rights and democratic government that is revealed by the connection between Miners and showers. By the time of Cochrane et al.'s (1912) Royal Commission of Mines report, Mining Unions had established the idea of collective action to uphold "Worker's Rights" to smooth the harsh effects of liberal capitalism. Originally a "Miners Right" was the document that granted an individual permission to mine and was connected to eligibility to vote in state elections ("The Grey River Argus", 1880). While initially every Miner was required to have a Right, these "Rights" could be held collectively ("Ohinemuri. Pegging Out and Area of Claims", 1875). Companies could buy Rights off of individuals and pay wages to the Miners ("Important Mining Case", 1894; "Mining Intelligence", 1865). Disputes over such wages resulted in the formation of Miners' Unions (Reefton, 1879) and, eventually, the idea of "Workers' Rights" as collective resistance to capitalist control emerged (Granity Miners Protest, 1912). Thus, ideas of individual interests being tied to collective interests in the form of rights, and democratic practices such as voting for the shower, were connected. I return to this idea of rights as a claim to territory in the following Essays.

In summary, the Miners' shower is an example of an early 1900s shower in Aotearoa New Zealand. Originating as biopolitical government of the milieu, The Workers Act (1908) functioned to minimise the harsh effects of mining on the health of Miners. A medical discourse suggested that the shower could reduce the impact of cold, wet clothing as one cause of disease, although provision of shower facilities would create a cost for mining companies. Born at a time of Miners strikes, a democratic shower facility emerged to be voted for by the Miners and maintained through their collective use of it. The design somewhat recognised the desires of the individual Miner through the provision of some "private" showers. However, the layout ensured that Showerees were visible to each other, allowing those who were showering for the good of the collective to be visible. Rather than being induced to shower through anatomo-political discipline of the Military Drill and surveillance of the Physician, a democratic governmentality produced a shower that could carry the effects of this power to the miners, tying the interests of the individual to that of that collective. The Changing-Rooms-&-Baths-for-Miners were designed to induce Miners to shower in a collective, confined space, with the aim of reducing the incidence of a specific work-related disease within a specific population.

New-Zealand-Field-Hygiene-Section-Shower-Unit

Bresgen (1871) had proposed that his system could be used in a variety of situations and had hoped that showering would proliferate. Showers were available in Aotearoa New Zealand army barracks from at least 1900 (Seddon, 1905a), and the idea of bathing or showering for "bodily cleanliness" had become so well established that nations were required to provide showers for their prisoners of war:

CHAPTER 3. *Sanitary Service in Camps*

ARTICLE 13

Belligerents shall be bound to take all sanitary measures necessary to assure the cleanliness and healthfulness of camps and to prevent epidemics.

Prisoners of war shall have at their disposal, day and night, installations conforming to sanitary rules and constantly maintained in a state of cleanliness.

Furthermore, and without prejudice to baths and showers with which the camp shall be as well provided as possible, prisoners shall be furnished a sufficient quantity of water for the care of their own bodily cleanliness.

(Geneva Convention Relative to the Treatment of Prisoners of War, 1929)¹⁰⁸

¹⁰⁸ In Nazi Germany, such provisions meant that the shower rooms converted to gas chambers appeared as familiar, innocuous hygiene spaces in prisoner camps, rather than the efficient murder device that was hidden within. I return to this subject in my Discussion chapter.

By the beginning of World War II, showers were a basic element of the Aotearoa New Zealand Army Camp. Newspaper articles from the late 1930s promoted showers as a feature of camp life that brought pleasure to army personnel in training camps and on the field. Rather than being an aspect of military drill, showering was conceived as a “luxury” (see Figure 14):

But it was not yet time to rest. Palliasses had to be filled and beds made up for the night; then the bliss of a shower. There was no more popular spot in the camp than the huge shower rooms, where men could strip and revel in the luxury of unlimited hot and cold water.

(“In New Home”, 1939)

Figure 14

Soldiers enjoying “the bliss of a shower”, 1939



Note: From “A hot shower and a shave,” 1939, *Auckland Star*, LXX(237), p. 7. CC BY-NC-SA 3.0 New Zealand licence.

Here the shower is a collective space, similar to the Changing-Room-&-Bath-for-Miners in that it is a space for comradery. Soldiers were seemingly freed from the medical discourse of order and surveillance that originally connected them to showers. This was a space to “revel” rather than to wash away disease. Although citizens may have been joining the army as a duty to the nation, a discourse constituting the shower as a reward emerged. Out in the field, away from the authority of the Physician, entrepreneurial individuals used natural water supplies and whatever materials were available so that troops could enjoy the “luxury” of a shower-bath’s “hydropathic pleasures” (Figure 15):

Figure 15*Showers for the Troops on the Palestine Front, 1935*

A WAR-TIME "LUXURY."—Necessity is the mother of invention, and a New Zealand engineer rigged up this shower bath in the desert on the Palestine front. By the pumping of water from the stream to the corrugated iron contraption on cross stays, and by a liberal perforation of the iron, hydropathic pleasures could be enjoyed by the troops.

—Entered by Mrs. M. Gibson.

Note: From "A war time luxury," 1935, by M. Gibson, *Auckland Star*, LXVI(181), p. 10. CC BY-NC-SA 3.0 New Zealand licence.

Showering was not, however, simply a luxury. By this time it was seen as an essential part of the war effort, reducing disease and necessitating the creation of showers that could be taken with the Army while the troops were on the move. The New Zealand Army invented an Experimental Squadron Portable Shower Bath which could be packed down and shipped out ("Experimental - Squadron portable shower bath", 1932). In 1942 a shower unit was a documented spoil of war for one New Zealand Field Hygiene Section fighting in Libya:

In Tobruk 4 (N.Z.) Fd. Hyg. Sec. salvaged, repaired and put into use a captured Italian mobile shower unit, thus equipping itself with a complete disinfestation plant.

(Crew, 1957, p. 233)

This shower would be claimed and renamed the New-Zealand-Field-Hygiene-Section-Shower-Unit (see Figure 16).

Figure 16

The Shower Unit of the 4th NZ Field Hygiene Section on the Cassino Front, Italy, World War II

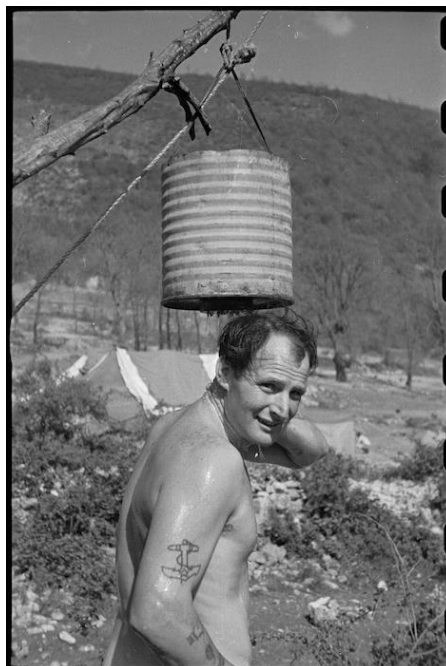


Note: From "General view of the shower unit attached to 4 NZ Field Hygiene Section on the Cassino Front, Italy, World War II," by G. Kaye, Ca. 1944. Alexander Turnbull Library. CC BY-NC-SA 3.0. New Zealand licence.

Entrepreneurial soldiers even produced their own showers out of whatever materials were available (see Figure 17).

Figure 17

A crudely constructed shower at 6 NZ Field Ambulance in Italy, World War II



Note: From “J R A Chote makes use of a crudely constructed shower at 6 NZ Field Ambulance in Italy, World War II,” by G. R. Bull, Ca. 1944. Alexander Turnbull Library. CC BY-NC-SA 3.0. New Zealand licence.

Showers maintained their hygiene function as a “complete disinfestation plant” for diseases connected to the skin such as typhus, skin conditions, and venereal diseases (Crew, 1957). However, a discourse of showers as a luxury, sought after, created or captured by the entrepreneurial Soldier, suggests a very different governmentality to anatomo-politic discipline. The shower is an asset, material capital that one can use to invest in the cleanliness of one’s skin. By the start of World War II cleanliness had become more than a technology used by Physician. It was as an aesthetic asset,¹⁰⁹ personal capital that the Soldiers themselves sought out (I discuss this idea in detail in Essay 3). Employing a “beauty shop” metaphor, the shower could wash away the “wear” of fighting on the front. The shower as a feature of the “revival tent” is proposed to transform the Troops from battered, dirty, and battle-weary into revived men who had been given a “treat” while on the front line of battle.

¹⁰⁹ see Essay 3 for analysis of this discourse.

ARMY "BEAUTY SHOPS" FRONT-LINE TROOPS SHOWERS & NEW CLOTHES

(11 a.m.) NEW YORK, Jan. 11.

Newly-developed "beauty shops" on the Fifth Army front in Italy are lifting the troops' morale in a big way, says the Associated Press' correspondent.

Going right up as the front line moves forward, these "beauty shops," which have been dubbed "revival tents" by the soldiers, receive the fighting men who have been relieved temporarily from the front line. The men go into the "revival tents" battered and mud spattered and, in less than an hour later, emerge after having had a shower and shave, wearing clean underclothing and new uniforms. The battle-weary troops are hardly recognisable as they leave the "beauty shops." The soldiers regard the new underwear and the uniforms as a real present, but the best treat of all is a hot shower, which is the last thing they expected to find near the front line.

("Army "Beauty Shops", 1944, p. 3)

While hygiene-showers were established to reduce the incidence of disease, the pre-discursive effect of the shower on the will that was associated with a hydropathic discourse (see Essay 1) remained. However, rather than breaking the will, the warm hygiene shower was associated with "improving moral" and revitalising the will. Warm water and clean skin were seen to have a normalising effect. With the previous battle on the front line washed away, the Soldier was renewed and ready to fight again. The discourse that connected World War II Soldiers to Luxury-Showers is interesting as it employs a governmentality whereby Soldiers are constructed as free, rational subjects, who have a self-interest in showering. Being clean revives them, it is a treat, a luxury that they seek out to improve their human capital. However, the State also has a biopolitical interest in the hygiene function of the shower to maintain the health and productivity of its Soldiers. In terms of design, the Soldiers' showers appear similar to the Changing-Rooms-&-Baths-for-Miners in that the Showerers are visible to each other. This suggests a desire for the Showerer to be showering with the interests of the collective in mind. Provision of showers would, therefore, seem to also employ a

democratic governmentality. While government of the milieu in the highly disciplined army context alongside a democratic governmentality might seem problematic, in fact this interplay is a feature of modern government:

Government, Foucault suggests, is a 'contact point' where techniques of domination... and techniques of the self 'interact', where 'technologies of domination of individuals over one another have recourse to processes by which the individual acts upon himself and, conversely, ... where techniques of the self are integrated into structures of coercion'. (Burchell, 1996, p. 268)

The Soldier's showers were one such contact point, a space in which the individual Soldier acts upon himself to maintain his own interests and the hygiene of the army, with an element of coercion due to the visibility of each individual Showerer to the group. However, it is apparent that the luxury-shower is part of a wider dispositif, connected to beauty and human capital. While visibility to other Soldiers supplied some inducement to shower, as I discuss in the next Essay, the idea of bodily cleanliness as capital had become established.

Summary: Hygiene Showers in Confined, Collective Spaces

Within a dispositif aiming to address the urgent need of the cost of disease, showering for hygiene became a thinkable thing as a medical discourse connected health to washing the skin. The therapeutic operations of clean water were connected to a reduced incidence of disease, and in response, public Shower-Baths for the Working Class emerged in Europe and the USA. These shower-baths were a feature of the Hydraulic City, a milieu in which the health and productivity of a population could be improved through the movement of clean water. Although these public facilities established the idea that the government could take some responsibility for providing showers for citizens, they did not transform the working class as it was hoped. While provision of a milieu may not have established showering, within the disciplinary space of the Army Camp, the urgent need to address the cost of disease, and the availability of the docile Soldier, meant the Army-Division-Shower-Bath-Facility could be employed to shower the barrack's population. This shower was designed for a docile subject, who could be marched to his cell, and his skin, made visible on the clean upright body, surveilled by the Physician. Like Delabost's Ablution-system (discussed in Essay 1), Showerees were hidden from each other but made visible to the Physician. The Soldiers were disciplined by the shower to become disease free and, as such, a more favourable Soldier. It was hoped that the shower would transform the Soldier into a Showerer and that they would return home to transform the rest of the population through their influence.

As a strategy for reducing the harshest effects of liberal capitalism, the Changing-Rooms-&-Baths-for-Miners shower functioned to minimise disease caused by mining. Born out of a democratic governmentality, Miners were not marched to the shower; however, they were compelled to shower for the good of the collective. This distinction can be seen in the design of the shower, whereby the Miners are visible to each other. In contrast to the Army-Division-Shower-Bath-Facility, the Miners have a degree of control over the shower, they are Showerers. However, they can only shower if their personal interests and the collective interests align to obtain and retain the resource. Just as a miner's individual mining right could be tied to collective interests through the formation of a mining company, the individual miner's right to health could be tied to the collective action of showering.

By the start of World War II, the idea of showers as an efficient technology to reduce the cost of disease was established and the New Zealand government invested in the provision of showers for Soldiers at home and on the field. While the showers were employed to reduce disease and transform the battle-weary Soldier into a subject ready to face the frontline, a discourse of showers as pleasurable, even a luxury, was employed. While the showers remained a feature of state government of the milieu, they were also produced by entrepreneurial Soldiers who desired to shower. In the next introductory Essay, I analyse the birth of the Hygiene shower in Private spaces, returning to the idea of the shower as a producer human capital.

Appendix I

Figure 18

Shower Baths for Employees in Western Electric machine works, Newark, N.J., 1908



FIG. 60. VIEW OF SHOWER BATHS FOR EMPLOYEES IN WESTERN ELECTRIC MACHINE WORKS, NEWARK, N.J.

Note. From *Modern baths and bath houses* (p. 138), by W. P. Gerhard, 1908. In the public domain.

Essay 3 Showering in Private Spaces as an Essential Everyday Activity

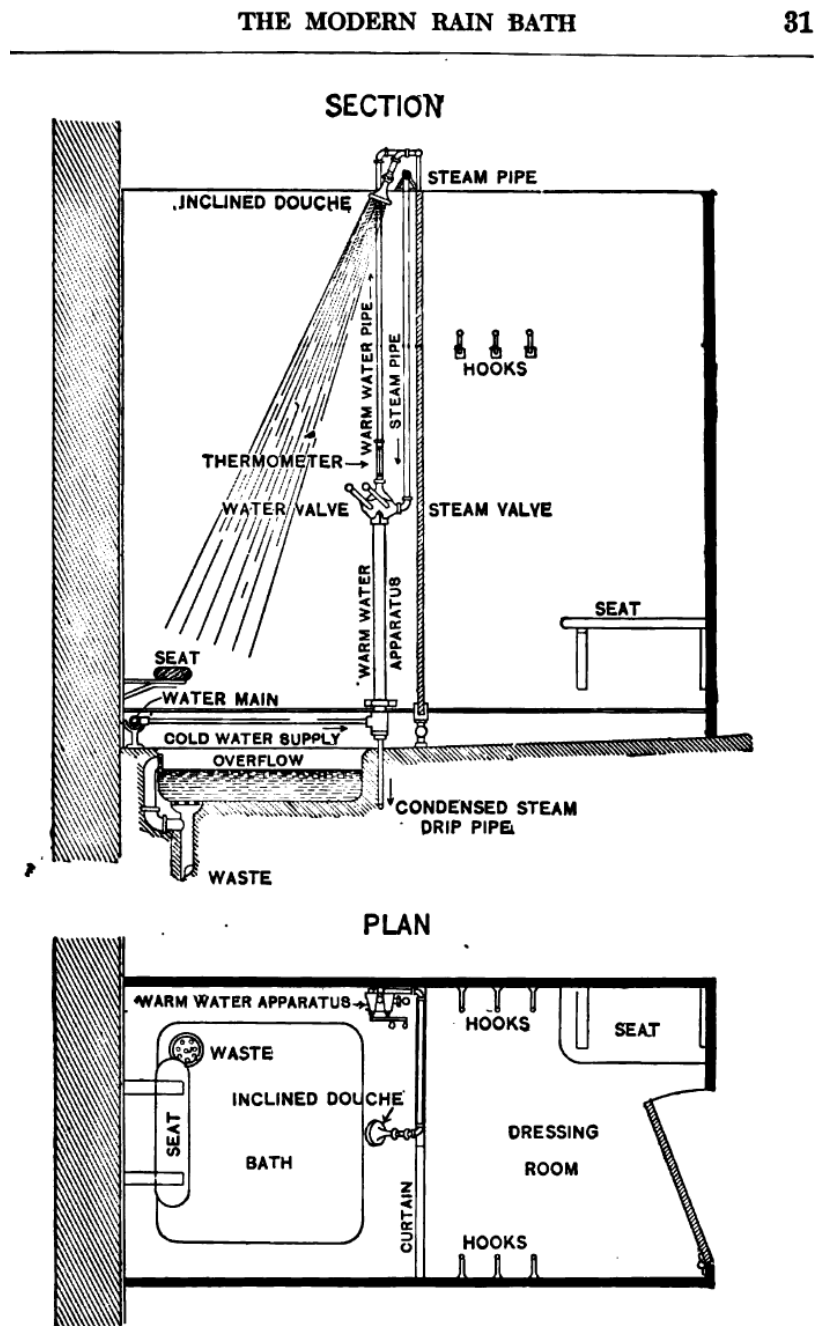


FIG. 9. PLAN AND SECTION OF RAIN BATH COMPARTMENT.
W. P. Gerhard's Rain Bath Compartment (1908).

In 1908 Gerhard proposed a plan for a “Rain Bath Compartment”. This was a Hygiene Shower, designed for use by an individual and able to be installed in a private dwelling. In this Essay, I explore the discourses that established a connection between daily showering in private spaces and the health and wealth of the nation, contributing to a dispositif in which showering would eventually become an essential everyday activity in one’s own home. As noted in Essay 2, by the late 1800s the shower was known to be an economical way to improve the hygiene of populations. However, an 1800s liberal governmentality meant that regulation of water, and thus the government of bathing, ended at the boundaries of the private dwelling (Osborne, 1996).¹¹⁰ Showers within private spaces, therefore, required other governmentalities to connect washing the skins of citizens to the health and wealth of the State. In this Essay, I discuss the material developments that made showers within private dwellings possible, the governmentalities that rationalised these developments. and the discourses that produced a nation of Showerers.

Cold-Water Douche: Private Hydropathy Showers

As noted in Essay 1, the possibility of showering in a private dwelling had been realised from the early 1800s. Hydropathy showers (i.e., Morison’s 1828 design discussed in Essay 1) could be used to treat mania within the private home. In addition, Physician-approved treatments such as the cold-water “Douche” were prescribed for a range of ailments.¹¹¹ Mrs Smedley’s (1873) “Ladies Manual of Practical Hydropathy” suggested cold-water douches for stimulating and strengthening, and to treat rheumatism. Hunter’s (1878) “Hydropathy for Home use” claimed douches could improve circulation and “rouse dormant energies” (p. 107). Claridge’s (1842) “Hydropathy” connected the cold water hydropathy shower to the moving of humours; the treatment of chronic disease; improvement of the skin; strengthening the body, muscles, and nervous system:

¹¹⁰ Osborne (1996) examined a liberal aspect of 1800s public health, namely the “material presence of fast-flowing water in and through each private household” (p. 115) to establish an indirect intervention in sanitation within the private home. As noted in Essay 2, New Zealand’s Municipal Corporations Act 1867 provided local councils with authority over public water supplies. This Act also permitted assessment of the drainage of any house or building within their borough and ensuring that connection to sewers was completed at the homeowner’s expense. However, in addition to getting wastewater away from homes, there was the issue of water supply. Before the development of town waterworks (of which the earliest seem to be Dunedin in 1867 and Wellington city in 1868), water was obtained via wells, rainwater tanks, or natural water supplies such as springs, with some debate as to the health of such supplies (“Hydrooxydocheinology”, 1847; “Report of Colonel Mould”, 1860).

¹¹¹ See Marland and Adams’ (2009) “Hydropathy at Home: The Water Cure and Domestic Healing in Mid-Nineteenth Century Britain” for a detailed exploration of the self-healing and commercial interests involved with hydropathy in private dwellings at this time.

The douche, of all the means employed, is the most powerful in moving the bad humours, and disturbing them from the position which they may have occupied for years: they are also used in the greater number of chronic diseases. The douche corrects the weakness which the skin may have contracted in the process of sweating, and also fortifies it. It hardens the body, and renders it capable of supporting all variations in the atmosphere. It exercises a powerful action upon the muscles and nervous system, by the reaction which it provokes.

(Claridge, 1842, p. 123)

However, the coldness of the hydropathic domestic Shower-Bath was considered dangerous to all but those in good health and with strong constitutions (Beecher, 1846).

While Physicians had employed a discourse of hydropathy to connect the Cold-Water-Shock-Shower to the brain and will, the cold-water douche was proposed to have a more general effect on the health of the body. Practitioners of hydropathy described the therapeutic operations of water as many and varied, and the discursive objects that emerged to apply water to the body were equally diverse (e.g., Smedley's [1873] ascending douche). For the most part, water was applied to the body for specific medical complaints and generally directed at the area of the body that the complaint was associated with (e.g., the abdomen).¹¹² In addition to hydropathic treatments, daily washing of the body was connected to a variety of health concerns. A failure to wash could be observed in a person's movements, and the general shape and appearance of the body:

¹¹² As noted in Essay 1, the practice of directing the water onto the head was born from the idea that mania was located within the brain, and that the qualities of cold water hitting the head with forceful shock could treat the affected area. Foucault's (1963/2003b) "Birth of the Clinic" discusses the shifts in medical discourses to connect disease to the visible structures of the body and thus the focus of diagnosis and treatment of the body as an assemblage of objects.

To one accustomed to Hydropathy, it is exceedingly painful to see the numbers of old and young who pass him in the streets at every turn, with stiffened joints, a dull eye, thickness of breathing, an unnatural tendency to corpulency, wrinkles, baldness, bad sight, and sallowness of complexion. These failings clearly indicate an habitual distaste for water: and the observer regrets the total ignorance which prevails as to the fact that in many of these cases, the mere drinking plentifully of water, and washing of the body at least once a day, would relieve these individuals of their diseases. Nay, more, if they had always been accustomed to this element, it might have warded those diseases off altogether.

(Claridge, 1842, pp. 141-142)

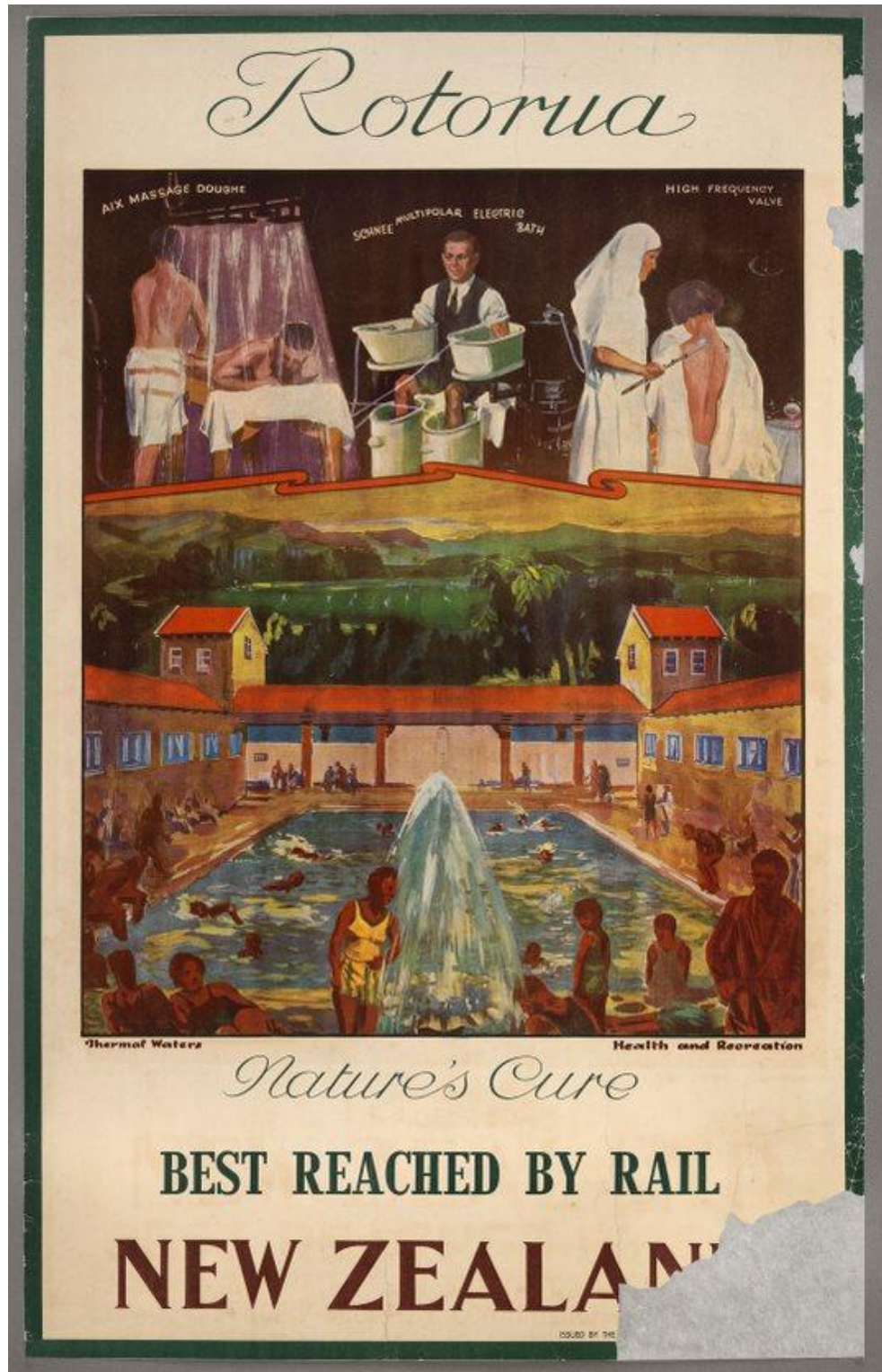
A hydropathy discourse connected the application of cold-water to the body, even daily washing, to health. Despite the wide range of proposed benefits, it was not the hydropathic cold-shower that would come to be established in the private dwelling. It was, instead, the luxury of the private warm shower, experienced first by tourists and travellers, that would endure.

Spas and Hotels: The Emergence of Private Hygiene Showers

While readers of Mrs. Smedley (1873) and Claridge Esq. (1842) may have been able to benefit from cold-water hydropathy in their own homes, those who could afford it also had the option of purchasing hydropathic hot water supplied by nature. In pre-colonial times, Māori made use of natural hot springs for health (Nicholls et al., 2016). In a process of colonisation, many of these natural resources were privatised and converted into commercial ventures (see Young [1998] for an overview of this history). A hydropathy discourse connected the application of hot spring water and health. In Aotearoa New Zealand, such springs entered the dispositive via the bodies of health-seeking tourists who could afford the travel and entry fees to the commercialised springs (“A Trip to the Te Aroha Hot Springs”, 1885). Water, applied through a private shower, or the “Aix Massage Douche” (top left Figure 19), was a luxurious “nature’s cure”, drawing on the idea of the pre-discursive health-giving properties of warm water extracted from these natural springs.

Figure 19

Rotorua Nature's Cure, Aix Massage Douche advertisement, 1933



Note: From "Rotorua nature's cure: best reached by rail," 1933, by New Zealand Railways, (<https://collection.motat.nz/objects/112271/rotorua-natures-cure-best-reached-by-rail-new-zealand>). In the public domain.

In the early to mid-1900s these hot springs and the facilities built around them became connected to Rehabilitation and the first shower for use with a wheelchair which I discuss further in Essay 5.

Alongside hydropathic treatments at spas and resorts with springs, hotels were early adopters of showers. While a discourse of washing the skin for the benefit of cleanliness was circulating during the 1800s (see Essay 2), showers formed from a hydropathy discourse were not generally connected to cleanliness. However, from as early as the second half of the 1700s, personal cleanliness had become desirable and associated with class distinctions in Europe (Ward, 2019). From the time of New Zealand's colonisation, being dirty could exclude one from "good society":¹¹³

WHAT CONSTITUTES A GENTLEMAN.—
Of the principal qualifications two are absolutely necessary, viz, courtesy and honour; and these may be possessed by all. Then comes manners and education which qualify for "good society," and rank and wealth for those who seek to move in the highest classes. The characteristics fatal to the claim to be considered a gentleman, are impudence, self-conceit, falsity, want of cleanliness, and filthy language. Nothing in dress beyond neatness and cleanliness is required.

("What Constitutes a Gentleman", 1868, p. 3)

From the mid-1800s, private bathing rooms for cleanliness appeared in hotels in the USA (Hoagland, 2018). In Aotearoa New Zealand, showers were advertised as being available (for a fee) from the mid-1800s in barber shops and hairdressers¹¹⁴ (e.g., "Louis Schank and Co., Hairdressers", 1864); hotels ("Wellington Hotel", 1857); and bathing establishments ("Dunedin Public Baths", 1864; "Hot, Cold, and Shower Baths", 1864). It appears that showers within the hairdressers or barbers may have maintained some hydropathic connection, providing "BATHS – Hot, Cold, Shower and Medicated Vapour" ["J. Webb's Establishment", 1861, p. 4]). Showers in hotels, however, were listed alongside "home comforts", rather than as therapeutic devices:

¹¹³ I return to the discourse of cleanliness and class further below in relation to the promotion of showers in private dwellings.

¹¹⁴ Primarily for use by the "traveling public" (Gerhard, 1908).

METROPOLITAN FAMILY HOTEL.

CHRISTCHURCH, CASHEL STREET.

No License.

Home comforts for visitors. Baths, hot, cold,
and shower on each floor. Telephone and
private letter-box. Night Porter kept.

Terms—6s per day.

OTTO SCHNEIDER,
Proprietor.

("Metropolitan Family Hotel", 1893, p. 4)

In the USA in 1908 a compact bathroom was provided for every bedroom in one hotel (rather than on each floor), promoted with the catchphrase "A Room and a Bath for a Dollar and a Half"¹¹⁵ (McKowne, 1944, quoted in Gideon, 1948, p. 695), and the smaller rooms had a "shower bath stall". Gideon (1948) argued that such hotel bathrooms, "a cell and an appendage to the bedroom" (p. 697), had a significant influence on the proliferation of private domestic showers and was the beginning of the "democratization" of the bathroom, available to everyone at "slight cost" (Gideon, 1948, p. 694). However, it would take quite different technology to make it possible for people to wash without annoyances and discomfort within the private dwelling and for it to become available to "everyone".

The Rain-Bath-Compartment in Private Houses

This thesis aims to reveal the discourses that have established, ordered, maintained, or disrupted the MOH's funding of showers modified for Disabled-People. In this part of the Essay, I analyse some of the early forms of hygiene shower for use in private dwellings. This includes the shower cell which became established as the dominant shower form in New Zealand. It is important to reveal the introduction of such showers to domestic dwellings since, as Winner (1980) explained, once the structure of a technology becomes established, flexibility vanishes, and the politics of exclusion or inclusion that the object influences endure:

Consciously or not, deliberately or inadvertently, societies choose structures for technologies that influence how people are going to work, communicate, travel, consume, and so forth over a very long time. In the processes by which structuring decisions are made, different people are differently situated and possess unequal degrees of power as well as unequal levels of awareness. By far the greatest latitude of choice exists the very first time a particular instrument, system, or technique is introduced. Because choices tend to become strongly fixed in material equipment, economic investment, and social habit, the original flexibility vanishes for all practical purposes once the initial

¹¹⁵ Approximately NZ\$25 in today's currency.

commitments are made. In that sense technological innovations are similar to legislative acts or political foundations that establish a framework for public order that will endure over many generations. For that reason, the same careful attention one would give to the rules, roles, and relationships of politics must also be given to such things as the building of high ways, the creation of television networks, and the tailoring of seemingly insignificant features on new machines. The issues that divide or unite people in society are settled not only in the institutions and practices of politics proper, but also, and less obviously, in tangible arrangements of steel and concrete, wires and transistors, nuts and bolts. (Winner, 1980, pp. 127-128)

It is this established order of the shower and the divisions that it produces that necessitates the “modified” shower.

As noted above, the liberal State’s interest in hydraulic city meant their interest in the flow of water for hygiene ended at the door of the private dwelling.¹¹⁶ So, in the mid to late-1800s, a market for private showers formed. Patents for showers and shower baths, such as those illustrated in UK’s “J. H. Hopkins Son Wholesale Tin Plater Workers and Japanners” (1850, Appendix I) and the USA’s “Catalogue ‘G’: Illustrating the Plumbing and Sanitary Department of the J.L. Mott Iron Works” (1888 see Appendix II), provided the possibility of showering in private bathrooms with hot and cold water. At this time, private bathrooms and their fixtures were large, luxurious, and adorned to allow individualisation (Giedeon, 1948). By the start of the 1900s, hygiene showers were materialising in the bathrooms of the wealthy in Aotearoa New Zealand (e.g., “Gentleman’s Residence in St Albans”, 1908). However, the relatively low cost of the shower created the possibility of it being more widely available. For example, Groves’ 1890 portable shower bath (a barrel filled with either cold or warm water, pumped by hand to an angled shower rose, see Appendix III) could be used by families. In Aotearoa New Zealand, a shower bath was patented in 1903 under the claim that “it is now within the power of everyone to have a shower bath in his or her home” (“A Valuable Local Industry”, p. 2, see Appendix IV).

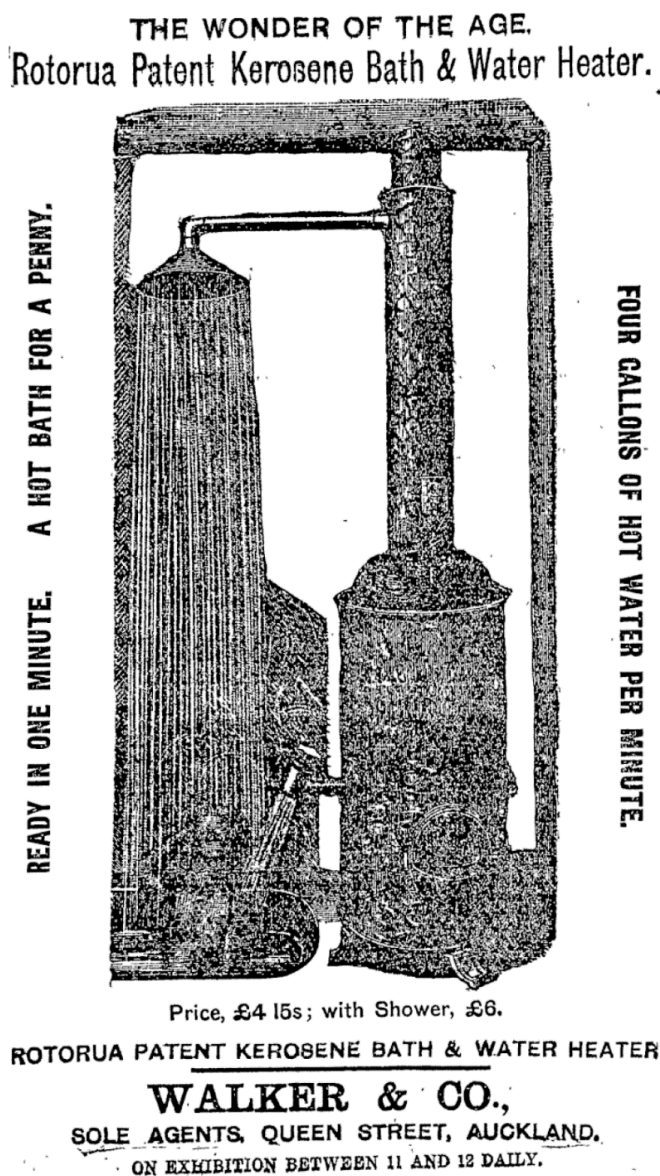
Heating water for collective, confined showers developed in the mid-1800s; however, heating water for an individual showerer was laborious. While getting water to dwellings had been achieved by this time for dwellings within the hydraulic city (see Osborne, 1996) and inventions to overcome the problem of raising water within dwellings were available (e.g., Aikman & Osborn, 1881; Mott, 1886), warming the water was another issue. During the late 1800s domestic water boilers emerged using the “waste heat of stove-pipes and chimneys” (Wheeler, 1883, p. 885), various fuels such as kerosene or woodchips (e.g., “Hot Baths! Hot Baths!”, 1898), or electricity where it

¹¹⁶ As Osborne (1996) revealed, the liberal rationality of government that asserted “a naturalization of the private space of the home as a domain sequestered from the direct impact of government” (p. 117) apart from a basic system of regulation in the interests of maintenance and security.

was available. Such water heaters could be connected directly to a shower head (see Figure 20).

Figure 20

Rotorua Patent Kerosene Bath and Water Heater, 1895



From "The Wonder of the Age," 1895, *Auckland Star*, XXVI(36), p. 7. In the public domain.

The Gegenstrom apparatus (Appendix V), described as a "novel and ingenious form of hot-water apparatus" (Gerhard, 1894, p. 3) was distinguished from other showers of the time by instantly warming any quantity of water to any temperature, being "exceedingly economical", producing no bad smell, taste or noise, and being safe.¹¹⁷ Although

¹¹⁷ For example, Taylor's (1886) earlier needle or spray bath patent which attempted to eliminate the risk of scalding by ensuring the cold water was always on and only the hot water mixed in.

Gerhard did not see a use for the apparatus in private dwellings, perhaps due to the need for a supply of steam,¹¹⁸ within a short time similar devices were patented and produced for use in private homes (e.g., Beaumont, 1896; *Henry Huber Co v Mott Iron Works*, 1902). In Aotearoa New Zealand, an electric hot water storage system for continuous supply became particularly popular following its invention in 1909 as domestic electricity use was gaining popularity (Hyde, 2018; Rorke, 2000).¹¹⁹ While Public Baths had been conceived due to the “the annoyances and discomforts (felt by the working man especially) of washing at home” (Baly, 1852, p. 4) (see Essay 2), by the early 1900s the comfort and convenience of an economical supply of hot water at home had become a possibility.

The problem of catching and draining water was generally overcome by showers being installed over baths during the late 1800s and early 1900s (Gerhard, 1894).¹²⁰ A variety of shower-bath designs emerged at this time (e.g., “Catalogue 'G,': Illustrating the Plumbing and Sanitary Department of the J.L. Mott Iron Works”, 1888]) including “needle” or “skeleton” baths in which water sprayed out of pipes at various heights from a cage-like structure over a small “bath” (see Appendix VI). In 1908 (the same year the “Room and a Bath for a Dollar and a Half” was promoted), the majority of baths in private houses in the USA were “full tub baths, with which an overhead shower or douche is often combined” (Gerhard, 1908, p. 50). Gerhard (1908) proposed that it was possible to have a shower where “*tubs are entirely abolished*” (p. 30 emphasis in original) (see Figure 21) in private houses, although he maintained that the shower without a bath was best suited to public spaces:

¹¹⁸ Rather, Gerhard (1984) thought it suitable for showers at public baths, factories, schools, hospitals, institutions, and steamships; possibly due to the apparatus being suited to places where “large quantities of boiling or hot water are needed for washing or other purposes” (p. 6).

¹¹⁹ Isaacs et al. (2008) outlined New Zealand’s experience of hot water supply to households from the mid-1800s to the modern-day. They noted that water in Aotearoa New Zealand homes continues to be heated using a variety of methods; however, 88% of homes use electric hot water storage systems which appears to be the highest proportion in the world (Isaacs et al., 2008).

¹²⁰ Although Mott depicts a stand-alone shower (Plate 62 ½ and 63), it is noted that such showers are suitable for bathing establishments, or over baths.

In the modern “rain bath” system, however, as recently extensively advocated and applied, *tubs are entirely abolished*, simple spray or shower baths being substituted for the same, and being installed in the bath compartments as a distinct and independent form of bath. While such a rain bath can, of course, also be used in bathrooms of private houses (see Fig. 14, Chapter V), it is for public baths, baths in hospitals and other institutions, for manufacturing establishments, for schools, and for people’s baths that the rain bath is specially adapted.

(p. 30)¹²¹

Figure 21

Plan and Section of Gerhard’s 1908 Rain Bath Compartment

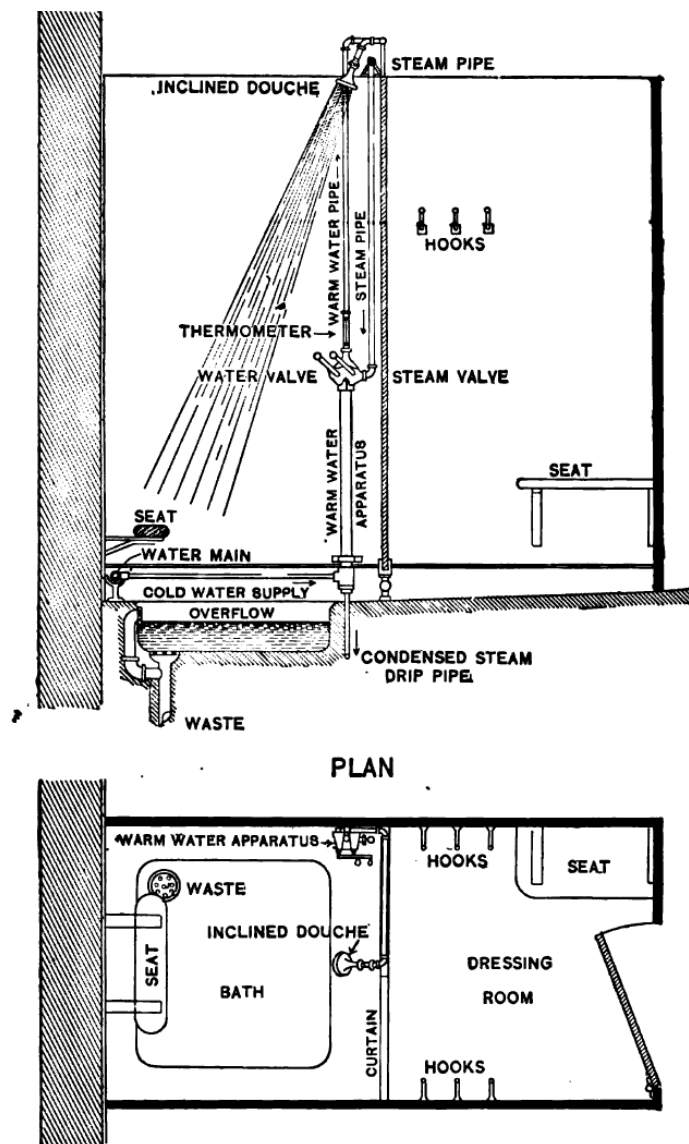


FIG. 9. PLAN AND SECTION OF RAIN BATH COMPARTMENT.

Note. From *Modern baths and bath houses* (p. 31), by W. P. Gerhard, 1908. In the public domain.

¹²¹ Figure 14 depicts a shower-bath.

Gerhard (1894) proposed that his “novel” Rain-Bath-Compartment was superior to the “usual forms of bathtubs” due to the reduced cost of construction, and low running and maintenance expenses. It was economical to fill, there was no time lost in emptying or cleaning after each use, and it took less time to wash. The shower was more hygienic than a bath since “*the body of a person using a rain bath does not come at all in contact with soiled water*” (Gerhard, 1894, p. 32, emphasis in original), and it was more stimulating and refreshing. It used less water to achieve cleanliness, provided greater privacy, could be used in winter or summer, and the danger of spreading disease was reduced. He noted that the angle of the shower head in his design was much more agreeable to the “Bather”. They could stand erect, having control over whether or not the head was wetted.

In terms of material development, the Rain-Bath-Compartment design is an important rupture in the form of showers within the private dwelling. The idea of a shower as a single cell (or compartment) with a bath “*entirely abolished*” within the private dwelling was so novel that it would seem Gerhard himself struggled with such a shift in what was thinkable. Within his Rain-Bath-Compartment the bath remained; however, it was now simply a recess in the floor, so small that one may only stand rather than recline and soak. While he claimed that the Rain-Bath-Compartment was possible within the private house, Gerhard (1894) only suggested showers (in the form of shower-baths with bathtubs) as a preferred option in tenement buildings. Rather than a shower within a private bathroom, this was a shower room where the activities of undressing, washing, drying, and dressing were separated and hidden. It was a shower that was possible within the private dwelling but designed for installation in public spaces. Indeed, Gerhard proposed that the Rain-Bath was the bath of choice in Public Baths, “it is the best form of bath, and is destined to be the bath of the future for people’s baths” (p. 77) and ideal for factories, breweries, abattoirs, public schools, military barracks, armouries, prisons, jails, police stations, hospitals, institutions, orphanages, asylums, clubhouses, gymnasiums, hotels, lodging houses, railroad stations (for railroad employees), quarantine establishments, ships, and barber shops. Despite Gerhard’s reservations, by the 1920s the Rain-Bath divorced from the bath was no longer a novelty and the shower, finally called a shower, materialised in private dwellings (see Figure 22).

Figure 22*New Zealand 1920 Display Bathroom*

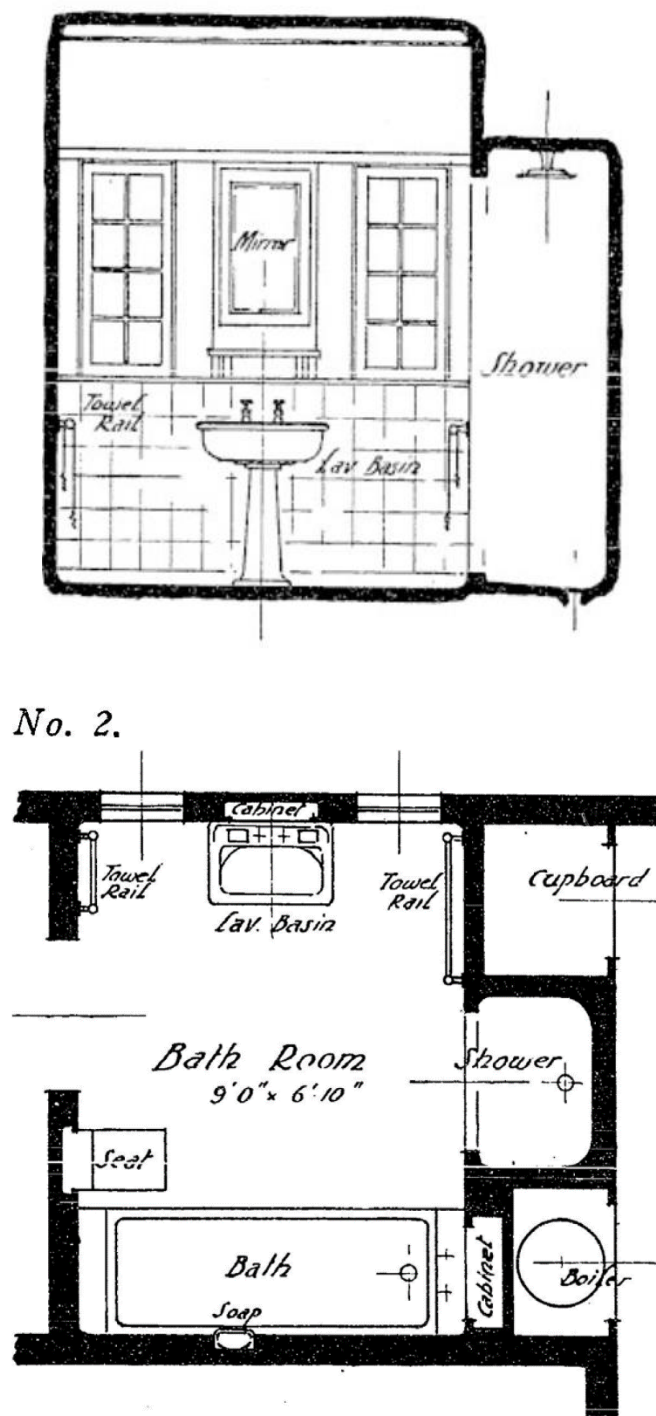
Note. From *Bathroom interior*, by S. F. P. Webb, 1920

(<https://natlib.govt.nz/records/22883310>). Reprinted with permission.

Such shower units were a feature of the bathroom, and a cheap investment in the material capital of the dwelling:

Modern electric and gas appliances play an important part in the convenience and comfort of the occupants of the house. Hot water services are cheap to install and most efficient and economical in operation... A separate shower box is possible at small expense in almost any bathroom... Any house can be so modernised that present objectionable features are eliminated and the property made a better place to live and more revenue producing. ("A Return for Capital", 1934, p. 5)

A home economics discourse with a rationale to "simplify the paraphernalia of existence; to eliminate useless tasks and trappings, and to arrange the remaining necessities [SP] into an orderly scheme of household life" (Massey, 1923, p. 14) suggested "a shower may be built into a recess having dished floor, with a door or curtain hung to prevent water from splashing into the bath room" (Massey, 1923, p. 13) (Figure 23).

Figure 23*1923 Home Economics Pratical Bathroom Suggestion*

Note. From "Practical suggestions to embody in the home," 1923, by H. L. Massey, H. *Ladies' Mirror*, 1(7), p. 13. In the public domain.

In this example, the shower is an extension of the 'Bath Room', a cell for a single upright body. The body gets concealed behind a door, or perhaps a shower curtain, as Gerhard had suggested. The Showerer controls the temperature and duration of the

shower. Within the shower is a shower tray that performs a similar function to the bath of the shower-bath in that it contains and removes the wastewater from the home. However, the tray is distinguished from a bath in terms of economy, taking a minimal amount of material to construct, and capturing only a minimum amount of water for the briefest moments before draining away. While Gerhard had included a seat within the shower, it was no longer seen as necessary within the private Bath Room.

Shower rooms designed for use in collective spaces had been established in the 1800s; however, it took some time for the technological developments necessary for showering to become sufficiently comfortable and convenient to be used for an individual within a private dwelling. Initially, the shower over the bath was the dominant domestic shower form. The economical shower unit, designed for use in collective spaces, proved to be a possible addition to the established private Bath Room. The Rain-Shower, the shower of choice as an economical space for an individual upright body, shrunk the bath down to a small tray that needed to be stepped into and stood within. With the form of the shower arranged for the upright, stepping individual, I next analyse the discourses that induced homeowners to install showers into their homes.

Sanitation and Showers of the Properly-Plumbed-House

As noted in Essay 2, the emergence of the Hydraulic City signalled an early liberal approach to the government of public health through the application of water:

What was at stake with sanitary intervention was not so much a normalization of vital capacities but the regulation of their normativity via the medium of environmental regulation; to free, so to speak, a space for vital normativity through a minimum standardization of the environment... public health represented not so much a realization of liberal philosophy but of a strategy of security appropriate to a liberal rationality of government. (Osborne, 1996, p. 116)

Sanitary Engineering connected water, engineering, and health, which lead to the creation of boards of health, concerned with policing water quality and sewer gases (Hoagland, 2018).¹²² However, importantly, there was “a naturalization of the private space of the home as a domain sequestered from the direct impact of government” (Osborne, 1996, p. 117).¹²³ The limits of government, how much of “**some**

¹²² In New Zealand, the Health Act (1920) introduced a centralised system of policing any nuisance deemed dangerous to health (including water supplies and drainage) and the regulation of standards for water supply and drainage for private dwellings and other buildings, which were to be met at the property owners' expense.

¹²³ Control over the flow of water for sanitation was a focus of authority, with the council awarding ownership and management of water supply and sewers to itself, giving them the power to enter private property, construct sewers through private property, be notified of any private building activity and prevent building over sewers and drains, demand that dwelling buildings provide privies (kept in proper order) and be connected to sewers to preserve the health of the public (e.g., Municipal Council Ordinance, 1860; Municipal Corporations Act 1867).

responsibility” the state had in the private space of the home and the private act of showering, was limited at this time.¹²⁴ Osborne (1996) suggested this new public health “concerned with facilitating the local provision of water and sewerage systems and regulations... signals something of a revolution in styles of political – if not perhaps epistemological – reasoning concerning health and vital well-being of the populace” (p. 103). This “Hydraulic City” would bring water to houses and flush it away like the arteries and veins of a single body. However, the private dwelling would remain the sovereign space of the individual owner.

The liberal government of drains may have ended at the boundary of the private dwelling, but an interest in health within the home remained. A discourse of Sanitation encouraged enterprising property developers to invest in plumbing to bring fast moving clean water into and carry it away from the dwelling from the late 1800s. Plumbing or “Sanitary Engineering” texts established a connection between health, plumbing, and sanitation (i.e., Eassie, 1872, 1874; Gray & Ball, 1916; Plunkett, 1884; Sutcliff, 1901). While these texts were typically directed towards plumbers, Mrs H. M. Plunkett’s (1884) “Women, Plumbers, and Doctors; Or, Household Sanitation” extended the discourse to include women. Within Plunkett’s manual, Sanitation connected proper plumbing to gains in property value and in personal health and strength, while inadequate plumbing was associated with the dangers of numerous diseases:

Showing that, if women and plumbers do their whole sanitary duty, there will be comparatively little occasion for the services of the doctors.

(Plunkett, 1884, title page)

Sanitary Engineers induced the homeowner to invest in plumbing. Plunkett proposed that women “whose destiny it is to remain a large share of the time at home”, whose divinely appointed mission it is “to guide the house” meant they had a greater interest in “preventative medicine and household hygiene” (p. 10) than men. Their family and the entire nation depended on their knowledge of Sanitation and its connection to household plumbing:

¹²⁴ Limited, but not excluded. Foucault (1974/2003d) traced the state’s claim of authority over homes to Europe and the 1832 cholera epidemic. Intervention extended into the private property sphere through demolition of houses to create “aeration corridors”. In England, in 1875, one of the functions of the health service was “localisation of unhealthy places and, if necessary, destruction of these seedbeds of insalubrity” (Foucault, 1974/2003d, p. 335). It was not until the Bubonic Plague spread to New Zealand that the powers of the state extended to the demolition of “buildings and things” (Bubonic Plague Prevention Act, 1900). New Zealand’s first Public Health Act (1872) permitted government agents to enter personal property under suspicion of the presence of disease, filth, or other matter dangerous to health. Following which, inhabitants of dwellings in which disease was reported could be forcibly removed if the house was found to be neglected or filthy.

More than four years ago Dr. B. W. Richardson, President of the British Medical Association, said : "I want strongly to enforce that it is the women on whom full sanitary light requires to fall. Health in the home is health everywhere ; elsewhere it has no abiding-place. I have been brought indeed by experience to the conclusion that the whole future progress of the sanitary movement rests for permanent and executive support on the women of the country.

(Plunkett, 1884, p. 10)

As a "devoted wife and mother" (Plunkett, 1884, p. 9), they had a duty to be involved in house hunting and, thus, be informed of the necessity of "A Properly-Plumbed-House". This included a separate, watertight bathroom. Sanitary engineers advocated for a separate room for sanitary fixtures to prevent contamination of the dwelling with noxious gases and germs. Sanitary fixtures and regulated internal plumbing resulted in the radical redesign of the architecture of dwellings to include a separate, dedicated "bath room" (Penner, 2013). The connection between health, clean water, and an investment in household plumbing produced an inducement for homeowners to "freely" choose to install a bathroom and, eventually, a shower.

The private bathroom, connected to the Hydraulic City, illustrates what Osborne (1996) identified as "a strategy of indirect government; that is, of inducing cleanliness and hence good moral habits not through discipline but simply through the material presence of fast-flowing water in and through each private household" (p. 115). However, increasing concerns regarding the dangers of the poor spreading disease and moral disorder meant that the idea of showering within private dwellings extended beyond the bathrooms of enterprising homeowners. While the hygiene of the working class had initially been promoted through the provision of public baths, concerns regarding sex connected showers to the private bathrooms of the poor. Foucault argued (1976/1978) that from the 1700s, architecture emerged to operate on the sexuality of the poor, "largely based on the assumption that this sexuality existed, that it was precocious, active, and ever present" (p. 28). As such:

The politics of housing, public hygiene... the general medicalization of the population, in short, an entire administrative and technical machinery made it possible to safely import the deployment of sexuality into the exploited class; the latter no longer risked playing an assertive class role opposite the bourgeoisie; it would remain the instrument of the bourgeoisie's hegemony. (Foucault, 1976/1978, pp. 126-127)

In New Zealand, this "politics of housing" and the government of sex is evident in the provision of houses with bathrooms via the Workers Dwellings Act (1905).¹²⁵

¹²⁵ New Zealand has a long history of state housing for the working class. The 1900s Municipal Corporations Act stipulated public funds could be used for the purpose of building Workers'

Worker's dwellings, built to the government's specifications, were for landless, low-income earners who could own the property after paying off all associated costs (including land, surveys, subdivision, and roading), provided they lived in it and maintained it in good order to the satisfaction of the land board (Seddon, 1905b). An example of biopolitical smoothing of liberal government, the Act was intended to reduce the cost of living to the worker, without burdening the capitalist with needing to pay higher wages.¹²⁶ As a therapeutic operator, a comfortable and convenient Family-Home was thought to improve the morals of the working class,¹²⁷ enticing the worker to remain at home with his wife and family rather than seeking enjoyment and pleasure from less savoury establishments:

I think that from another standpoint we may consider the position of the worker under this Bill—from a health standpoint. The more ventilation there is in a dwelling and the more comfort a man has in his home the better work he is able to do, and the more contented he is. Under comfortable circumstances a man has an inducement to remain at home. I would say to the member for Wellington City (Mr. Aitken) and others, who often speak of men seeking pleasures away from their own homes of an evening, that if you give them comfortable homes where they may enjoy themselves with their wives and families it is a good thing to do.

(Seddon, 1905b, p. 84)

In addition to smoothing the harsh effects of capitalism, the idea that the sexuality of the working class is "precocious, active, and ever present" (Foucault, 1976/1978, p. 28) justified the State's involvement in providing a comfortable home that the worker may enjoy with his wife and family.¹²⁸

Alongside ensuring that Workers returned home to their wives rather than seeking pleasures elsewhere, Seddon, New Zealand's Prime Minister at the time, argued that proper sanitation and the provision of bathrooms in workers' dwellings would save lives:

Dwellings. The 1905 Workers' Dwellings Act centralised this responsibility and is claimed to be the first public housing in the western world (Derby, 2010).

¹²⁶ In the USA several companies had built dwellings for their own employees around this time which were referred to as success stories in the Hansard (Ell, 1905).

¹²⁷ Brookes' (2000) "At Home in New Zealand: History, Houses, People" provides a detailed history of the government of houses in New Zealand. Tennant's chapter "The decay of home life?" outlines the history of the connection between housing in New Zealand and the morals of the inhabitants.

¹²⁸ Preventing "overcrowding" or requiring a sufficient number of bedrooms to ensure boys and girls were separated, was also argued to be essential to uphold morality.

I should like to ask how many there are of these homes where the workmen have a bathroom. A very small percentage have a bathroom in their homes for the use of themselves and family, and I say it is almost indispensable to their health that there should be bathrooms attached to their homes. In regard to the erection of tenements for workers, I would make it a standing law that no house should be allowed to be occupied unless it had its bath and bathroom and proper sanitary arrangements. I believe we could save a good many lives if that were stipulated.

(Seddon, 1905, pp. 84-85)

These houses were required to have bathrooms; however, these were considered by some to be an extravagance (providing shower-baths was held up as the extreme of such). The suggestion of communal bathrooms was fairly quickly dismissed, however, with the comment “communism” (An Hon. Member, 1905, p. 320). While bathrooms were seen as an unnecessary extravagance for workers in 1905, by the 1930s they were established as an essential feature of a sanitary home. Isaac and Olssen (2000), in their chapter regarding the Seddon’s Labour Government housing scheme, explored the discourse of ‘the slum’ and outline how disease (particularly the influenza epidemic of 1919), town planning, and state housing emerged in Aotearoa New Zealand. Concerns with the health of the population were connected at this time to water and electricity supply, overcrowding, and sanitation of private dwellings.¹²⁹ The great depression connected the problem of housing to the economic health of the nation and, in 1937, the state conducted extensive housing surveys (which I discuss further in Essay 8) which aimed to identify the condition of the nation’s dwellings, in particular those that should be demolished in the name of health (Isaac & Olssen, 2000). These surveys closely connected the presence of a bathroom and bathing facilities to favourable private dwellings, with 80% of dwellings where the repair was deemed impractical (i.e., those that should be demolished) having no bathroom, while 95% of satisfactory houses did.¹³⁰

In 1945, disease, this time tuberculosis, continued to connect the state to the government of dwellings. However, at this time, the idea of the nation’s duty to provide dwellings for returning Soldiers (which I discuss further in Essay 6), and the growing view that dwellings should have modern amenities including hot water and bathing

¹²⁹ Isaac and Olssen (2000) noted that New Zealand was characterised by single unit private dwellings (not apartments) at this time.

¹³⁰ Isaac and Olssen’s findings indicate that rather than class, the age of the house and the inhabitant were most closely associated with the lack of bathroom and dwelling deemed “beyond repair”.

facilities to maintain the health of the people, prompted further debate about the role of the state in governing private dwellings (“Allocation of State Rental Houses and Address in Reply”, 1945; “Housing Improvement Bill”, 1945). The Housing Improvement Act (1945) and associated housing improvement regulations required all dwellings, existing and new, to contain a bathroom, and an “approved bath or shower”:

- (2) Every bathroom shall contain an approved bath or shower with an adequate supply of wholesome water. Adequate means of heating water shall be provided.

(Housing Improvement Regulations, 1947, s 9.2)

State security in Aotearoa New Zealand was from that time connected to the presence of a shower or bath within all private dwellings. While the Regulations stipulated either a shower or a bath, the following year problems with importing the raw materials needed to make enamel baths and the high cost of imported baths tipped the shower into favour (Semple, 1948). State funded houses, which were otherwise ready to be tenanted, could not be occupied due to a shortage of baths. However, installation of a “shower-room” (Semple, 1948, p. 24), instead of a bathroom, could make such dwelling inhabitable (Skinner, 1947). By the 1970s, showers were being marketed as a feature of low-cost dwellings (“The Home Your Heart is Set On Must be Here!”, 1975, p. 13). A “definite trend” for showers in Aotearoa New Zealand homes was established, helped, in part, by the local invention of a low-pressure showerhead mixer combination (the “Feltonmix”) (“Definite Trend for Showers in the Bathroom”, 1978).

Discourses connecting State, workers, and bathrooms within private dwellings were possible within a biopolitical governmentality, creating a milieu in which the health of the worker and his family was made more favourable through an extension of the Hydraulic City into the private dwelling. Sanitation (of the Properly-Plumbed-House and the working-class’s sexuality), and the associated production of separate bath or shower-rooms within the dwellings of the population ensured the security of the state. Thus, the earlier liberal division between public and private was disrupted. Next, I discuss the discourses and governmentalities that induced the population to shower, since it is not just the material presence of the shower, but also showering as an essential everyday activity that is of interest to this study.

Showering as an Investment in Personal Capital

In the early 1900s, experts emerged to promote individual self-government of hygiene as an essential everyday activity. In Aotearoa New Zealand, in 1923, “Health week” experts advised the public that they must take responsibility for their own health. These experts advised that healthy habits needed to become part of daily living to have an effect:

Health Week will remind you of what personal hygiene means. But personal hygiene must be a habit, not a mere spasmodic occurrence synchronising with a temporary outburst of good resolution.

(“How to Live”, 1923, p. 7)

Physicians advocated for self-imposed discipline that would, as Bresgen had hoped, produce the habit of regular bathing to promote health. As such, daily bathing or showering, if possible, was advised:

Health Commandments

Dr. Thomas Darlington, former Commissioner of Health of New York City, is responsible for the following ten commandments of health, which are worth reprinting:

1. Keep your mouth closed when breathing; also when angry.
2. Drink cold water with your meals; also between meals.
3. Bathe daily; a shower if possible.
4. Eat slowly; this leads to eating sparingly. Make your meal a ceremonial pleasure.
5. Exercise daily and breathe deeply while so doing, but avoid over-exertion, and never eat when fatigued.
6. Never read or transact any business while eating.
7. Work ten hours, sleep eight, and use the balance for recreation and meals. Always rest on Sunday.
8. Ever keep a contented mind. Equanimity means longevity.
9. Neglect no portion of the body. Employ a physician to examine you at regular intervals and so watch for the beginnings of disease and build up resistance and pay some attention to his opinion and direction.
10. Moderation in all things.

(“Health Commandments”, 1925 p 14)

As this example illustrates, advice regarding personal health management is similar to anatomo-political discipline. The focus is on daily conduct (“bathe daily, shower if possible”), and the body is an object that can be surveilled to identify merits and faults (“neglect no portion of the body. Employ a physician to examine you”). However, the individual is no longer under the gaze of the Physician, Prison Guard, Attendant, or Comrade. The individual subject is self-policing, only seeking the counsel of the physician to periodically surveil the body and provide “his opinion and direction”.

Martin (2018) argued that discourses connect “free” rational citizens to state interests through pastoral power. Pastoral power helps to construct and thus govern particular subjectivities; subjectivities that align with more distant governmental aims: “Pastoral power is distinctive in the way it attends to the wellbeing and moral propriety of both individuals and communities simultaneously, and thus offers ‘a tricky combination in the same political structures of individualization techniques and of totalization procedures’” (Foucault, 1982, cited in Martin, 2018, p. 1293). Experts employ discourses to shepherd the choices that good, responsible subjects should make, thus connecting the “free” choices of individuals to the interests of the nation. This pastoral power is defined in part by “the fact that this teaching must be a direction of daily conduct” (Foucault, 1979/2007, p. 236). Discipline of the subject, becomes discipline *by* the ethical subject, extending the conduct of conduct into the unseen or “private” lives of citizens. Ensuring that one has a “properly plumbed home” becomes the “right choice” for the citizen concerned with health. A personal hygiene discourse then connects “free” citizens to an apparatus of health in which expert advice conducts the conduct of those willing and able to invest in their health.

The private domestic shower of the early 1900s was advertised as promoting both general health and hygiene. A “healing” portable shower bath invented in Aotearoa New Zealand for domestic use claims a range of health-giving benefits from daily showering:

THE HEALING SHOWER

The Shower Bath is the most natural healer and invigorant of tired nerves and sick body known. It stimulates the blood and brings instantly a refreshing glow and delicious sense of cleanliness to the whole body. Its daily use means increased vitality, a fresh skin and complexion, and a healthy body that is able to withstand both extreme cold and heat, and that has the power to ward off illness.

Young's Patent Portable Shower Bath.

makes this condition possible to everyone without the great expense of one of the more elaborate permanent fixtures. Water must fall from a height to be of value and produce the desired result. Both volume and distribution are given by

YOUNG'S PATENT PORTABLE SHOWER BATH.

SMALL 22/6 LARGE 27/6.

Obtainable from—

**Harrowby & Knight, Wanganui, or
D. Young & Co., Patea & Waverley.**

(“The Healing Shower”, 1905, p. 4)

Daily use of the shower is an investment in “vitality”, bringing forth fresh skins and complexions, and a “healthy body” that is strong and able to resist penetration from the environment (hot, cold, or disease).¹³¹ In addition to the health benefits of this shower, the design is economical, free of elaborate designs of showers of the past, making showering “possible to everyone”.

While showering may be connected to vitality and a healthy body, a particular association with skin remained. Ward (2019) outlined how for women washing the skin

¹³¹ These proposed therapeutic operations were not limited to discourses that promoted the sales of products. Medical scientists studied the trembling of a middle finger lifting a small weight after the subject showered in various temperatures and various forces of water (Baruch, 1913). In a strategic elaboration of the hydropathic psychiatry discourse of showers (see Essay 1), these scientists reconnected the therapeutic operations of water to blood vessels and nerves and deemed the shower to be at least as important for “neurovascular training” and physical and mental refreshment as for washing the skin. They also claim that showering is in the interests of the nation. The poor bathing habits of the Russians compared to the plentiful bathing facilities of the Japanese attest to the fact that frequent washing is connected to the superiority of bathing nations and their “great military and commercial achievement” (Baruch, 1913, p. 540).

was particularly connected to one's appearance: "Marketing campaigns often depicted women as romantic or erotic objects, sensuous or languid when they weren't coquettish or alluring, and emphasized soap's benefits for beauty's major asset: the complexion" (p. 129). Daily showering provided an opportunity to use soap, producing skin free of blemishes and luxurious hair for women (see Appendix VII). While showering was associated with beauty (see also Essay 1 Army "Beauty shops"), showering also had a particular connection to strength. A discourse of women being unable to tolerate the shock of cold water could disconnect them from the shower (e.g., "How to take a shower", 1928). However, Appendix VIII illustrates that strong, upright women who participated in outdoor sports could also benefit from washing in the shower to cool, soothe, and heal their sunburnt skin. In addition to being suitable for strong women, the shower was promoted as being able to produce strong women:

**DELICATE WOMEN
AND
TEPID BATHS.**

Delicate Women find an occasional Tepid Shower Bath strengthening and refreshing. Tepid Showers were impossible in most houses until the advent of

**Young's Patent Portable
Shower Bath**

This handy little utensil may be used in any room and the shower may be made any temperature. No woman should be without one. A bathing cap will keep the hair dry if necessary.

Young's Patent Shower
Makes Weak Women Strong.

PRICE, 22/6.

Obtainable from—
Harrowby & Knight, Wanganui
D. Young & Co., Patea & Waverley.

("Delicate Women and Tepid Baths", 1905, p. 4)

The shower was no longer just for those with strong constitution, it was suitable for even the weak woman. While the cold shower may be too much of a shock for the delicate woman, the tepid shower was suitable for the weak woman's body and would even make it strong. Not only was this shower suitable even for women, but it was for use in "any room" and could be made to "any temperature". This shower was a vastly

different character to the Fall-of-Water for women who would not sleep with their husbands (see Essay 1). It was the antithesis of cold shock and breaking of wills in which, rather than the Showerer being subjected to the shower, they are the Showerer, in control of the temperature and duration of the water.

While showers could benefit women by making them strong, showers could make either gender more desirable. The need to shower was connected to men keeping their job by eliminating “Body Odour” (see Appendix IX), and was an efficient way for working women to maintain beauty (see Appendix X). The removal of “B.O.” (body odour) was then connected to success in sexual pursuits for men (see Figure 24 and Appendix XI), and marriage for women (see also Appendix XII):

Figure 24

“Shower over... bow tied... all set for a wonderful evening”, 1951



Note. From “Shower over... bow tied... all set for a wonderful evening,” 1951, *New Zealand Journal of Agriculture*, 83(5), p. 410. CC BY-NC-SA 4. New Zealand licence.

Showering (with Guardian Soap) was even a possibility for country folk who lived far away from the conveniences of urban civilisation (see Figure 25):

Figure 25

A Guardian Shower on the Range, 1945



Note. From "At home on the range", 1945, *Manawatu Standard*, LXV(289), p. 8. CC BY-NC-SA 3.0. New Zealand licence.

The shower, showering, and shower products were thus an investment in personal capital. A way to make the body more attractive, and to be "fresher"—visually, olfactorily, and productively. A way to distinguish the strong, healthy, and sexually fit from the rest of the population. As Ward (2019) explained:

In order to attain full membership in society one must look, smell, and be clean, and in order to do so one had to buy and use the products that promised

cleanliness... [In the first half of the 1900s] The reinvention of the clean body as a commodity was unfolding everywhere in the Western world. (p. 203)

While those marketing their showers and soaps might have sought to induce all of the population to shower to increase sales, these discourses are working to produce subjects. The activities of the human and non-human subjects are productive of a particular type of favourable citizen, a subject who is aligned with more distant governing interests. Foucault (1976/1978) outlined how, from the middle of the 17th century, health, sex and race were used by the middle class to distinguish themselves from the working class: “works, published in great numbers at the end of the eighteenth century, on body hygiene, the art of longevity... attest to the correlation of this concern between the body and sex to a type of ‘racism’” (p. 125). While this mentality is connected to biopolitical racism (see for example, Hou, 2021) within shower advertising it was deployed to create an element of competition to induce those who can, to shower. Those who cannot remain dirty, unhealthy, smelly, unrefined, and not worth reproducing with.

Although appealing to individuals to shower so that they may have sexual intercourse might seem distant from a governmentality that aims to produce and maintain a “middle class”, Foucault (1979/2008d) pointed out that:

We are at the heart of the problematic of the invisible hand... that kind of bizarre mechanism which makes homo oeconomicus function as an individual subject of interest within a totality which eludes him and which nevertheless founds the rationality of his egoistic choices. (p. 278)

In the mid-1900s, showering came to be understood an investment in health, and health is capital.¹³² An environment is fostered in which Hygiene becomes personal capital, and showering produces winners in the competition to find a mate. A discourse of Hygiene connects the act of showering to producing a strong, attractive body induces subjects to make showering an everyday essential activity. To be a showering subject, is to be an accepted member of society who is able to compete with others to obtain, maintain and further reproduce capital.

Governmentalities that induce individual self-regulation are central to the emergence of showering as an everyday essential activity in one's own home. The showers of collective, confined spaces discussed in Essay 2 are designed to make the Showerer visible and subject to external discipline. Within the private dwelling, such external monitoring is typically absent.¹³³ While the shower advertisements above may be appealing to an individual entrepreneur who can compete for advantage through

¹³² Foucault notes: “All the problems of health care and public hygiene must, or at any rate, can be rethought as elements which may or may not improve human capital” (1979/2008a, p. 230).

¹³³ Technology is, however, developing that could make this possible, such as Google's noninvasive health-monitoring bathroom (Rogers, 2015).

investing in their personal hygiene, the discourse connecting hygiene and desirability suggests that biopolitical normalisation and biopolitical disablism is also in effect. I discuss these governmentalities in relation to showering in following Essays. The discourse of Hygiene suggests that the body is an object that is seen and smelt by others. While the act of showering in a private dwelling may not be visible, the body reveals those who are unsanitary and unhygienic. A failure to shower will make a subject visible via their unhealthy complexion, hair, and smell, resulting in rejection from society. With the possibility of showering without annoyance or discomfort made possible through the Hydraulic City and a discourse of Sanitation, the idea of Hygiene induced individuals to make this “free choice” to wash regularly, thus promoting the health of the population.

Summary: Showers for Individuals in Private Spaces

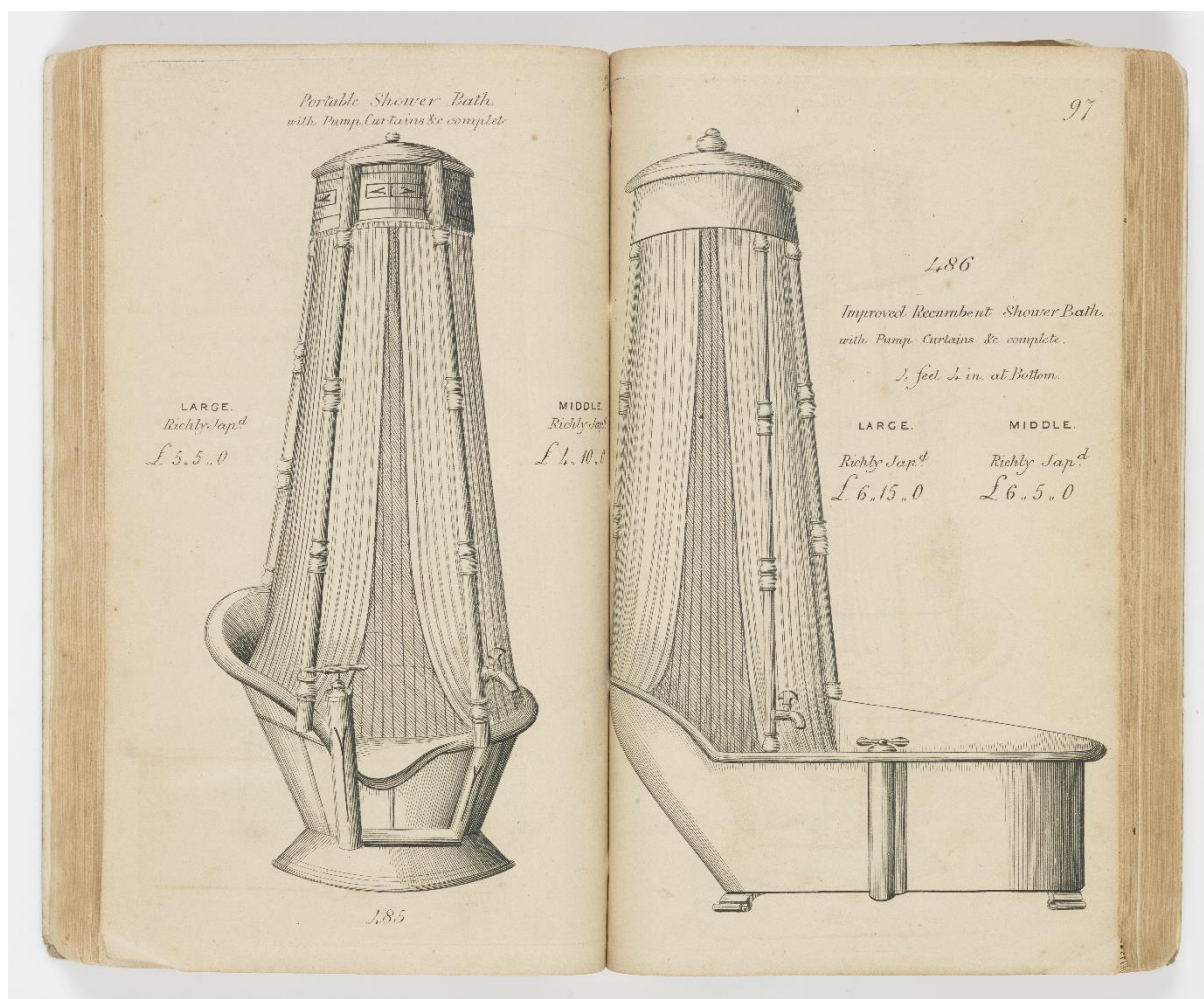
Private showers initially emerged as personal hydropathic devices, employed as a technology that one could use to address a number of health complaints through directing cold-water to specific parts of the body. The warm-water hygiene shower first emerged as a luxury, available only to the wealthy in Spas, Hotels, and eventually in the private dwelling. However, the private hygiene-shower would become an economical technology to maintain the security of the state, and a key feature of the dispositif that was established to wash away disease within the population. While a liberal governmentality had initially limited the state’s interest in the flow of water within private dwellings, a discourse of Sanitation connected the owner of the Properly-Plumbed-House to the Hydraulic City and the private bathroom. Initially there were many forms of shower, but the Rain-Bath-Compartment emerged as the ideal economical hygiene device. It was initially connected to contained, collective spaces, but eventually appeared as an appendage to the private bathroom. *The shower cell, for the upright, standing and stepping body became the established order.*

For those who did not own a home, biopolitical government of the milieu connected the working class to Family-Homes with modern comforts and conveniences. The New Zealand government become involved in the provision of showers within the homes of low paid workers. Eventually regulation required all private dwellings to have a bathroom containing an approved shower or bath. With private showers now a possibility in the home, pastoral power employed a discourse of Hygiene to induce the population to wash and the idea of the washed body as human capital emerged. Showering promised to produce strong, upright desirable bodies, suitable for the production of further human capital. Within the shower, the body becomes part of the Hydraulic City. As Osborne (1996) argued the flow of water

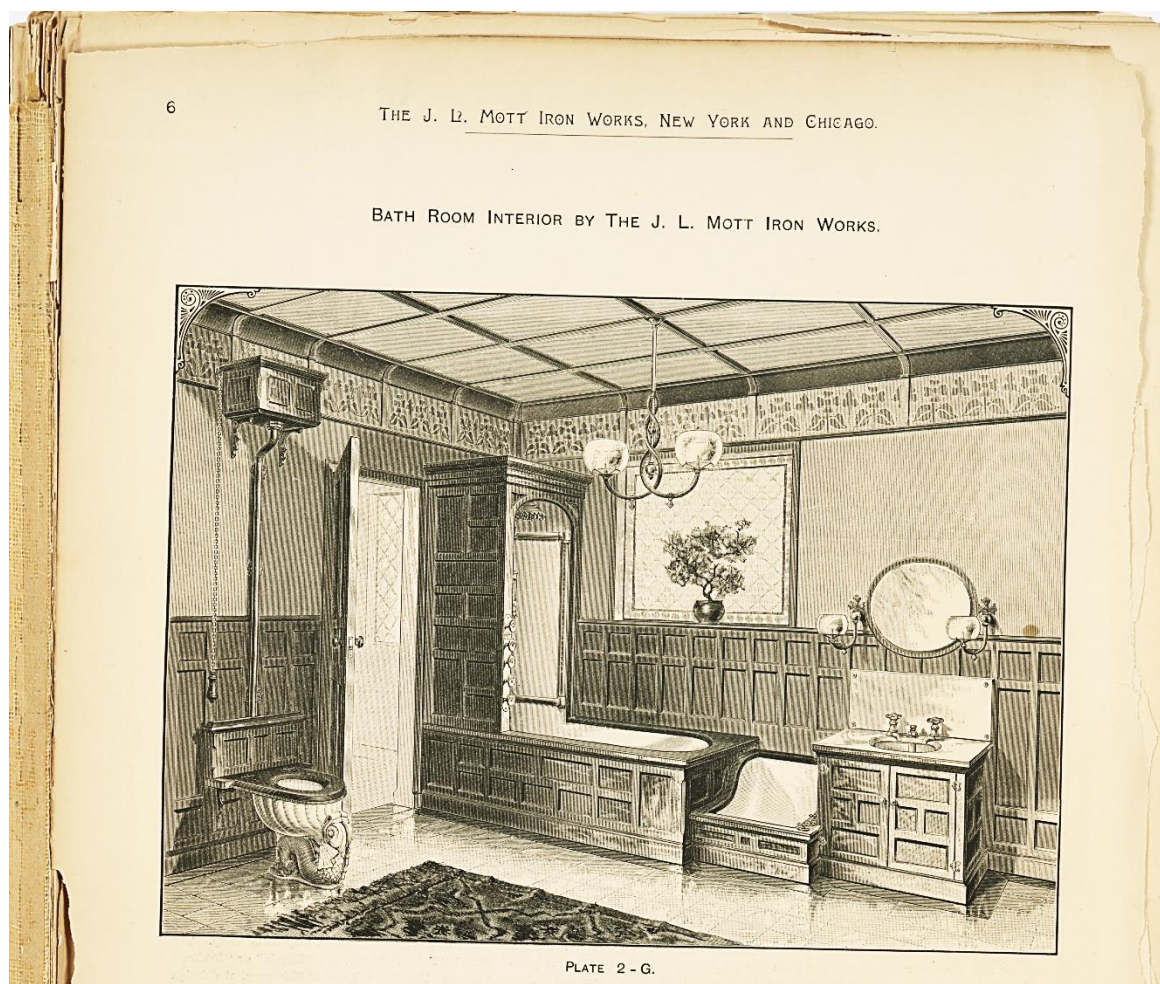
becomes “coupled... directly and literally to the vital economy of the body... tying the body, city and economy together into one system” (p. 114). However, this was not only through the flushing away of excreta (Osborne, 1996), it was also through washing away disease, weakness, unattractiveness, odour, fatigue, and moral disorder.

Appendix I**Figure 26**

1850 Portable Shower with Pump and Curtains



Note. From J. H. Hopkins Son Wholesale Tin Plater Workers and Japanners, 1850, by J. Hopkins Son (<https://collections.tepapa.govt.nz/object/1529379>). In the public domain.

Appendix II**Figure 27***Mott's 1888 patent bath and shower combination*

Note. From "Catalogue 'G': Illustrating the Plumbing and Sanitary Department of the J.L. Mott Iron Works," 1888 (https://digitalcollections.nypl.org/collections/catalogue-g-illustrating-the-plumbing-and-sanitary-department-of-the-jl-mott?format=html&id=catalogue-g-illustrating-the-plumbing-and-sanitary-department-of-the-jl-mott&per_page=250&page=1#/?tab=about&scroll=1). In the public domain.

Appendix III**Figure 28**

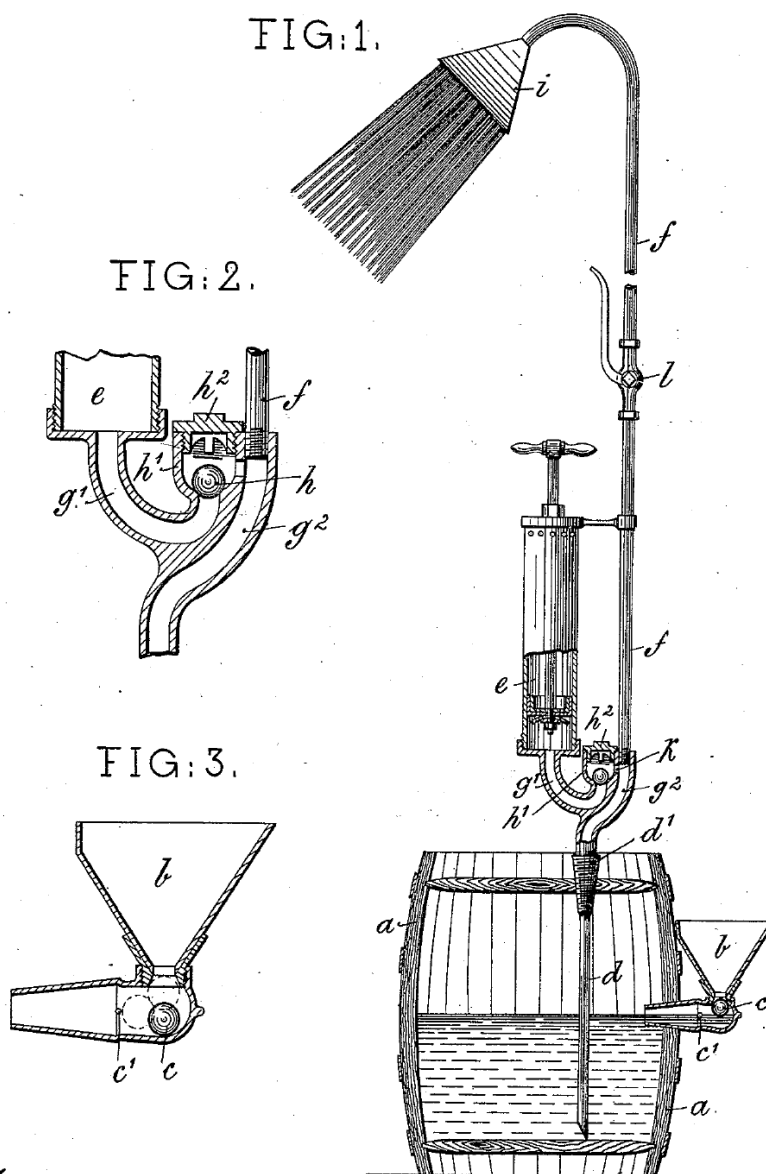
Grove's 1890 Portable Shower Bath Patent

(No Model.)

D. GROVE.
PORTABLE SHOWER BATH.

No. 426,798.

Patented Apr. 29, 1890.



Witnesses:

H. de Vries
G. L. Richards

Inventor:

David Grove.

By

Richardson
Attorneys.

Note. From U.S. Patent No. 426,798, by D. Grove, 1890. In the public domain.

*Appendix IV***MESSRS D. YOUNG & CO.'S
PATENT SHOWER BATH.**

The remarkable success attending the sales of Messrs Young & Co.'s patent portable shower baths, and the fact that they are pushing this valuable invention further afield, indicates that ere long the manufacture of these baths will be one of Patea's most valuable local industries. The shower bath is without doubt a most useful contrivance, for it is now within the power of everyone to have a shower bath in his or her home. There can be no two opinions as to the health giving and health preserving benefits of a regular shower bath, but the cost of installing a shower bath, absence of water pressure, and even in some cases insufficiency of water, have hitherto been lions in the path. With Young's patent shower bath all these difficulties have been removed. The bath can be filled from a bucket, a trough, a creek, anywhere where there are a few inches of water, and eight gallons will provide a plenteous daily shower. Another important point is that the user may have the water any temperature he desires, which means the pleasure of a shower bath right through the winter. Nor is this all. Very few women are strong enough to take an absolutely cold shower bath, but, with this bath, women, as well as men, may enjoy the luxury.

("Messrs D. Young & Co's patent shower bath", 1903, p. 2)

Appendix V

Figure 29

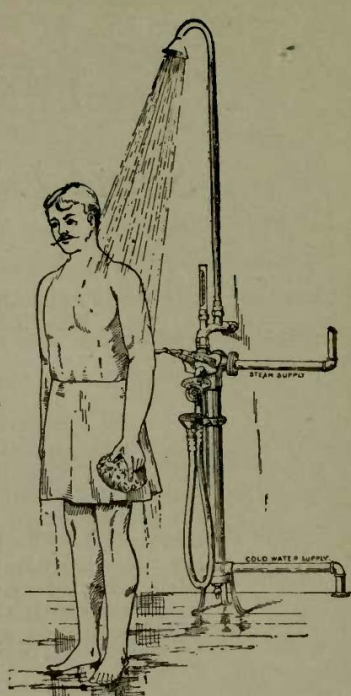
"Huber's 'Gegenstrom' Hot water apparatus", 1897

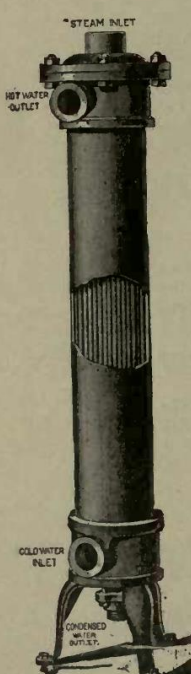
HUBER'S "GEGENSTROM"

Hot Water Apparatus

FOR INSTANT PRODUCTION OF WARM AND
HOT WATER BY MEANS OF STEAM.

*ESPECIALLY ADAPTED for RAIN BATHS
IN PEOPLE'S BATH ESTABLISHMENTS,
INSTITUTIONS, REFORMATORIES AND
PRISONS, HOS-
PITALS, INSANE
ASYLUMS, GYM-
NASIUMS, CLUB
HOUSES, Etc., Etc.*





"Gegenstrom" Water Heater

For Instantaneous Production of Hot Water
at Any Desired Temperature by means of
Exhaust or Low-Pressure Steam.

*ESPECIALLY ADAPTED FOR BREWERIES, FAC-
TORIES, LAUNDRIES, APARTMENT HOUSES,
HOTELS, COMMERCIAL BUILDINGS, Etc.*

**Some Special
Features of the
"Gegenstrom"
Water Heater:**

1. Instantaneous production of hot water at any temperature and in any desired quantity.
2. Perfect condensation of the exhaust steam without back pressure on the engine.
3. Small size, allowing its being placed in corners and cramped spaces.
4. Simplicity and adaptability, not only to new buildings, but to all places where other systems for providing hot water are already fitted up.

ALSO MANUFACTURERS OF

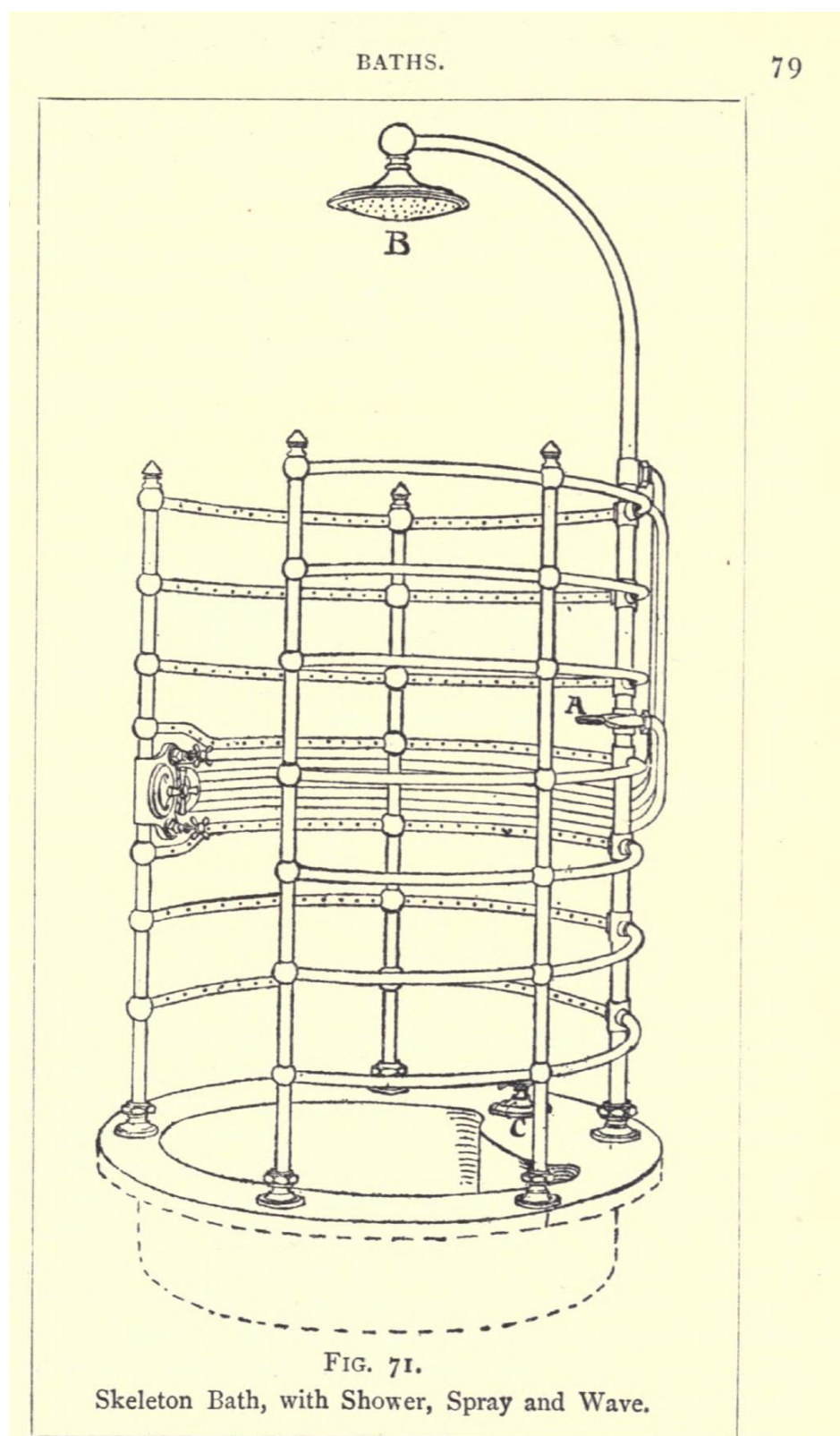
PNEUMATIC and JET SYPHON WATER CLOSETS, LAVATORIES, BATH TUBS, Etc.

WRITE FOR
DESCRIPTIVE
CIRCULARS.

The Henry Huber Co.

81 Beekman St.,
NEW YORK.

Note: From "Huber's 'Gegenstrom' hot water apparatus especially adapted for rain baths", 1897, The Engineering Record, p. 268. In the public domain.

Appendix VI**Figure 30***1901 Skeleton Bath, with Shower, Spray and Wave*

Note. From *Sanitary fittings & plumbing*, (p. 79), by G. L. Sutcliffe, 1901, Whittaker. In the public domain.

Appendix VII**Figure 31***"Rexona soap: A friend for all time", 1922*


Miss Violet and Doris Brennan
(from a Photo.)

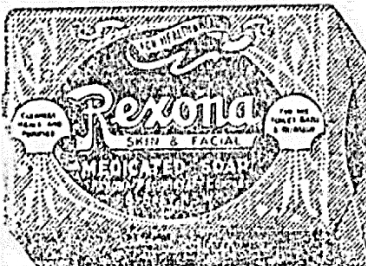
Rexona Soap A Friend for All Time

"We are sending you our photo, for we are true Rexona Girls, and never use any soap but Rexona. It is the nicest soap we have ever used, and we find it delightful as a shampoo for the hair. There is nothing like it for the skin, and we always make a point of using Rexona Soap when taking a shower after a dip in the surf. We shall always recommend Rexona Soap to all our girl friends.

(Sgd.)
VIOLET and DORIS BRENNAN,
17 Bridge Road, Glebe, N.S.W."

Rexona Soap Unequalled for the Skin and Hair

Rexona Soap makes good complexions, and banishes all pimples and blotches, and is unequalled as a shampoo for the hair, making the hair soft and luxuriant.



Note: From "Rexona soap: A friend for all time," 1922, *Evening Star*, (18045), p. 10. CC BY-NC-SA. New Zealand licence.

Appendix VIII

Figure 32

"Surfing Time is Rexona Time", 1926

Surfing Time
is
Rexona Time



Rexona
SKIN & FACIAL
MEDICATED SOAP

TO all lovers of outdoor sports, a dip in the roaring breakers on a summer's day is indeed romance. Next day the sunburnt, blistered hands and scarlet face are painful realities. Why suffer such distress and disfigurement from sunburn when it can easily be avoided by using Rexona Soap when you have your shower, and then applying a little Rexona Ointment, the cooling, soothing and healing balm?

If you want to make doubly sure of avoiding sunburn, also apply a little Rexona to the exposed parts. This prevents both the action of the salt water and the sun on the most delicate skin.

If this is done there will be no after effects from exposure to the sun, no regrets after a happy day, for the skin, soothed by the wonderful influence of Rexona, the Rapid Healer, will quickly regain its normal temperature and comfortable coolness.

You will find Rexona Skin and Facial Soap ideal as a shampoo for the hair after your dip.

Rexona Soap and Rexona, the Rapid Healer, in its dainty pot, should stand on the toilet table of all who indulge in outdoor sports.

Rexona—The Rapid Healer
1/6 and 3/-

Rexona Soap
FOR HEALTH AND BEAUTY
1/6
PER TABLET

MISS EDITH PICKUP
A Beautiful Rexona Girl, of Orange Street, Eastwood, N.S.W., writes: "Rexona Soap is a wonderful soap for keeping the skin and hair in perfect condition."

"I am an enthusiastic surfer, and every morning after my dip in the surf, I always use Rexona Soap for my shower. It keeps the skin and hair in the pink of condition."
MISS LILIAN OWEN,
Thornton Street, Manly, N.S.W.

Note. From "Surfing time is Rexona time," 1926, *Ladies' Mirror*, 4(8), p. 67. In the public domain.

Appendix IX

Figure 33

"A husband who always got sacked", 1936

A HUSBAND WHO ALWAYS GOT "SACKED"

YES, BOB'S LOST HIS POSITION AGAIN. BUT I'M TRYING NOT TO WORRY. HE'LL GET SOMETHING ELSE SOON.

POOR BETH! BOB SIMPLY CAN'T KEEP A JOB. HE WORKED IN YOUR OFFICE ONCE, FRED. WHAT WAS THE TROUBLE THEN?

BOB'S CLEVER. THE BOSS LIKED HIS WORK. BUT ONE BAD FALLING GOT HIM IN WRONGS WITH EVERYBODY.

YOU MEAN "B.O."? IS THAT WHY HE LOSES SO MANY JOBS? OH, I WISH I COULD TELL BETH TO GET LIFEBOUY.

A WEEK LATER

HOW I ENVY YOUR SMOOTH, CLEAR SKIN! BUT I CAN'T AFFORD BEAUTY TREATMENTS. WITH BOB OUT OF WORK.

YOU CERTAINLY CAN AFFORD MY BEAUTY TREATMENT, BETH. I JUST USE LIFEBOUY.....

TIED BOB? HAVE A LIFEBOUY SHOWER! YOU'LL FEEL LOADS BETTER.

I'M HEADING STRAIGHT TO THE SHOWER, NOW.

Let Lifebuoy Lather Refresh YOU! When you feel that rich —the tiredness vanishes! On hot summer days, there's just nothing like a Lifebuoy shower to freshen you up—and the clean hygienic scent vanishes as you rinse.

Lifebuoy leads to Skin Health A skin free from unsightly blemishes, free from unpleasant "B.O." (body odour)—in other words a truly healthy skin.

That's what everyone wants and that's what Lifebuoy offers you. Lifebuoy's rich, deep-cleaning lather not only deodorizes, it makes your skin fairly bloom with a new, healthy radiance.

Millions say.. "It agrees with my skin."

A LEVER PRODUCT MADE IN NEW ZEALAND

2.257.81NZ

I SHOULD HAVE REALIZED BOB IS CARELESS AT TIMES. AND PERHAPS EVEN I... ANYWAY, LIFEBOUY FOR US BOTH NOW!

YES FOR FACE AND BATH! FRED DOES, TOO. HE WON'T TAKE CHANCES WITH "B.O." HE'S SEEN MEN LOSE THEIR JOBS BECAUSE....

"B.O." GONE... he keeps his job now!

WELL, BOB'S BEEN IN HIS NEW JOB SIX MONTHS. A RECORD FOR HIM.

BETH SAYS SHE'S SO GLAD SHE TOOK MY HINT ABOUT LIFEBOUY

Note. A husband who always got sacked," 1936, *Manawatu Times*, 61(80), p. 11. CC BY-NC-SA 3.0. New Zealand licence.

Appendix X**Figure 34**

"Beauty Should be Seen and Not Heard", 1937

Beauty Should Be Seen And Not Heard

NO girl should make beauty her main topic of conversation. One who talks about face treatments, discusses weight problems and pesters everyone she meets for advice about her coiffure is likely to be pretty much of a bore. Correct care of complexion, hands, figure and hair is a personal problem and others are interested only in the results—certainly not in details of the methods.

Furthermore, it is a mistake to devote more time to physical glorification than is absolutely necessary. One who spends all of her leisure hours with cold cream pot and nail file and never has time to read a newspaper or a book or to relax and think has a poor sense of values.

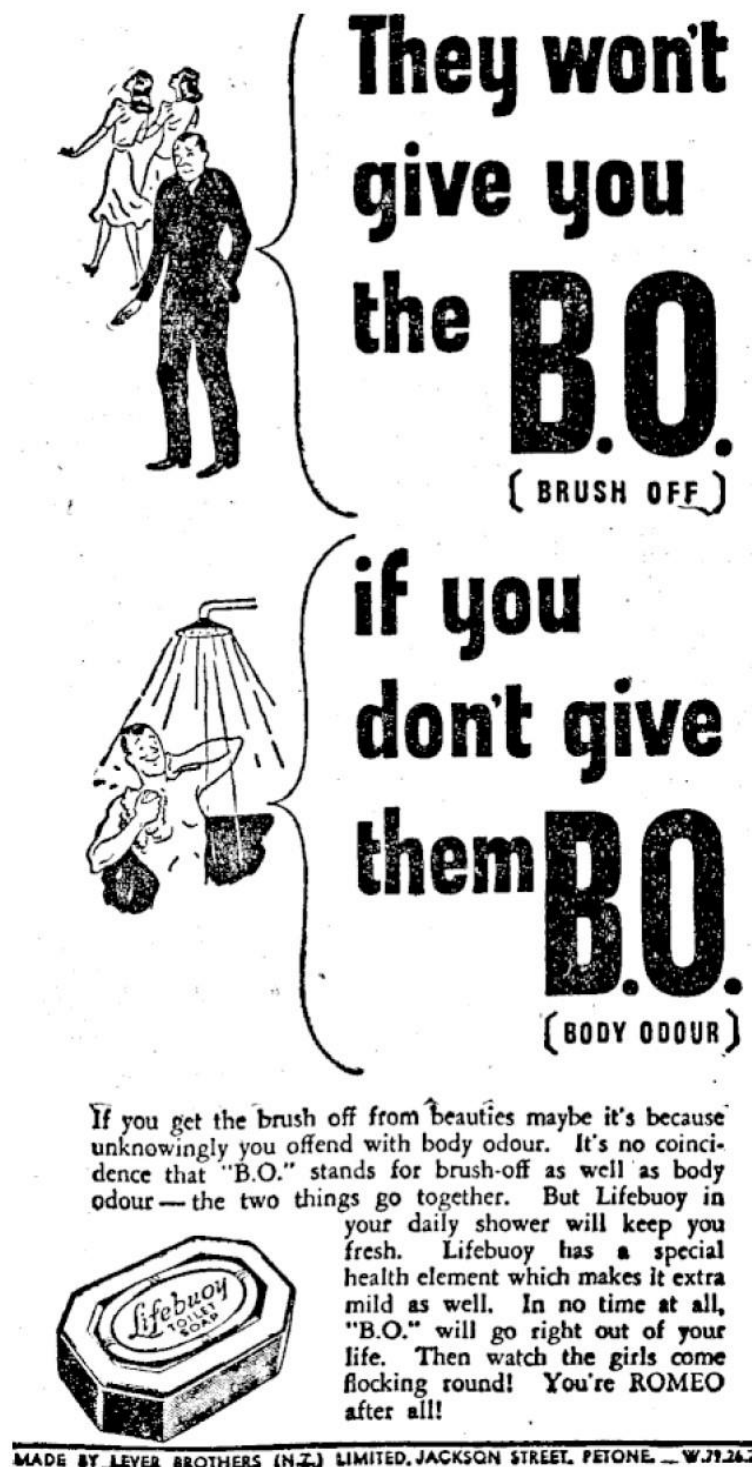
For the average individual, with no particular defects that need special attention, 20 minutes in the morning and forty minutes at night every day, plus two hours a week for the beauty shop or a shampoo, should suffice. Business women, especially, have trained themselves to get through several setting-up exercises, a quick shower, creaming and application of make-up in 20 minutes. At night, a warm bath, simple face treatment, thorough brushing and a couple of whisks with nail file or emery board should require no more than 40 minutes.

Note. From "Beauty should be seen and not heard," 1937, *Poverty Bay Herald*, LXIV(19278), p. 20.

Appendix XI

Figure 35

"They won't give you the B.O. (Brush off) if you don't give them the B.O. (Body Odour)", 1944



**They won't
give you
the B.O.**
(BRUSH OFF)

**if you
don't give
them B.O.**
(BODY ODOUR)

If you get the brush off from beauties maybe it's because unknowingly you offend with body odour. It's no coincidence that "B.O." stands for brush-off as well as body odour—the two things go together. But Lifebuoy in your daily shower will keep you fresh. Lifebuoy has a special health element which makes it extra mild as well. In no time at all, "B.O." will go right out of your life. Then watch the girls come flocking round! You're ROMEO after all!

MADE BY LEVER BROTHERS (N.Z.) LIMITED, JACKSON STREET, PETONE. W. J. 262

Note. From "They won't give you the b.o. (brush off) if you don't give them the b.o. (body odour)," 1944, *Manawatu Times*, 69(99), p. 2. CC BY-NC-SA 3.0. New Zealand licence.

Figure 36

"Home late... special date", 1961


**HOME LATE ...
SPECIAL DATE**

**and the
'FEELING FINE' FRESHNESS**

After a Gelven shower, a shave, and refreshing Gelven Lotion puts you on the top of your form for the evening ahead. This Impeccable preparation has a brisk, bracing effect not only on your new shave but on your whole personality as well. It tones and invigorates the skin, heals nicks, soothes razor burn, and its clean tang clears the last mists of sleep from a morning mind too ... Gelven After Shave Lotion with G.11 (or any of Gelven's other popular men's preparations) transforms the mundane business of the shower and shave into a highly stimulating aspect of the civilised life. Have you discovered this yet?



Gelven WITH G.11
SKIN'S GUARDIAN ANGEL

Gelven After Shower Talc., Stick Deodorant, Foot Cream, Scalp Shampoo and the well known Gelven Germicidal Soap give you a Cleanliness that Clings. This hour after hour bactericidal protection of G.11, found in all Gelven products destroys up to 95% of skin bacteria. Fresh up with Gelven to-night you'll be glad you did ...

*G.11 is the regd. N.Z. Trade Mark for Hexachlorophene.

Manufactured in N.Z. by Wilfrid Owen Ltd., Christchurch

Note. From "Home late... special date," 1961, *Press*, C(29593), p. 18. CC BY-NC-SA 3.0. New Zealand licence.

Appendix XII

Figure 37

"A Plot that Worked Both Ways", 1936

A PLOT THAT WORKED BOTH WAYS

IT'S A DARLING LITTLE APARTMENT, BESS AND IF WE SHARE IT THE RENT WILL BE VERY REASONABLE



LET'S DO IT, KAY! WE'LL BE TWO HAPPY BACHELOR GIRLS TOGETHER

BUT A MONTH LATER

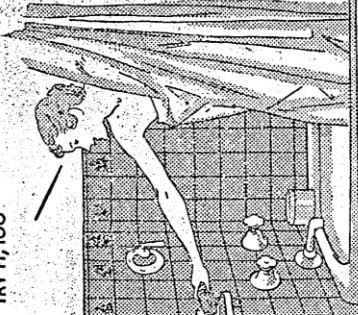
BESS WAS THINKING YOU CERTAINLY NEVER KNOW A PERSON'S FAULTS TILL YOU LIVE WITH THEM KAY'S A DARLING, BUT IF I'D EVER DREAMED SHE WAS CARELESS ABOUT "B.O."...



AND KAY WAS THINKING BESS ALWAYS LOOKS SO DAINTY, BUT SHE'S NOT CAREFUL ENOUGH ABOUT "B.O." WISH SHE'D USE LIFEBOUY... I KNOW, I'LL START USING IT MYSELF, I'LL PRAISE IT TO THE SKIES....



HURRAH, KAY'S REFORMED! SHE'S USING LIFEBOUY, SAYS IT'S WONDERFUL. I BELIEVE I'LL TRY IT, TOO

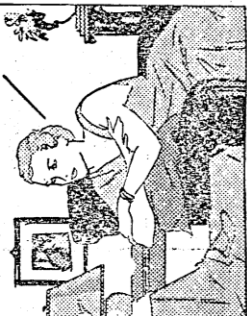


TWO MONTHS LATER

BESS, YOUR SKIN LOOKS MARVELLOUS THESE DAYS. NO WONDER THE BOY FRIEND KEEPS COMING



WHAT ABOUT YOUR COMPLEXION AND YOUR BOY FRIEND? LIFEBOUY'S HELPED BOTH OUR SKINS. AND IT'S SO REFRESHING! I'D NEVER USE ANY OTHER SOAP



"B.O. GONE" — "Bachelor Hall" breaks up!

YOU LADIES GOING TO RENEW YOUR LEASE FOR ANOTHER YEAR?



NO, WE HAVE OTHER PLANS. YOU SEE, WE'RE GETTING MARRIED... A DOUBLE WEDDING



YOU LOOK TIRED, BESS



I AM NOW, BUT I WON'T BE AFTER MY LIFEBOUY SHOWER.

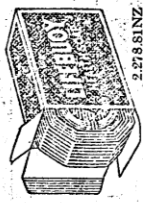
Refreshing and Healthy—Lifebuoy is a gloriously refreshing bath soap—and it's a sure protection against "B.O." (body odour) but don't think that's all it keeps your skin healthy too! Use it regularly and watch the radiances creep back to your skin. When its purifying lather gets to work impurities deep down in the pores don't have a chance—that lather is truly *deep-cleaning*.

Wash away Tiredness! You can, with Lifebuoy! Come home worn out after a hard day's work and just relax in a Lifebuoy bath. You'll feel grand—the tired feeling just disappears like magic. Try it!

Millions say... "It agrees with my skin"

2.278 SINZ

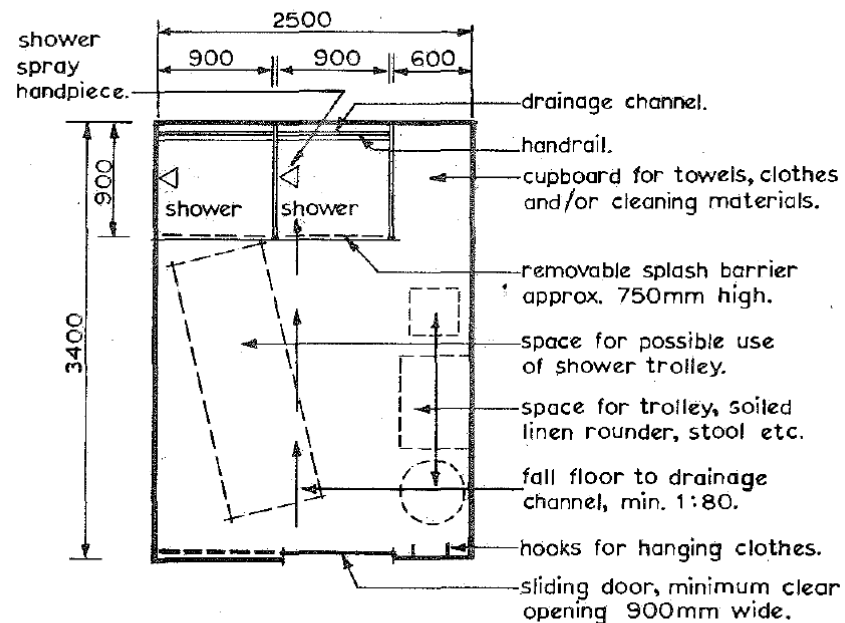
A LEVER PRODUCT—MADE IN NEW ZEALAND



Note: From "A plot that worked both ways." 1936, *Nelson Evening Mail*, LXX, p. 3. CC BY-NC-SA 3.0. New Zealand licence.

Essay 4 Showers in Large-Permanent-Homes for Disabled-People

SHOWER ROOM – SUGGESTED LAYOUT



DRAWING No.2

SCALE 1:50

The Hospital Design and Evaluation Unit's Psychopaedic Shower Room suggestion (1979).

In the previous Essays I analysed the discourses that produced showers for various populations. This is the first of a series of five Essays in which I analyse showers for particular subjects who might be considered Disabled-People. These Essays reveal discourses that emerged within a *dispositif* that aimed to reduce the deficit to the nation associated with units of unsound physical and mental health. As noted in the introduction to the Essays, the distinction between confined, collective spaces and private spaces is important in this thesis. This Essay is about the discourses that connected Disabled-People to Large-Permanent-Homes, which were confined, collective spaces for Disabled-People. The domestic shower was becoming established in the early 1900s and, although advertisers promoted the shower cell to the population, it formed at a time when Disabled-People were being excluded from living in Family-Homes. I trace the discursive construction of this exclusion and analyse the showers that were established in these Large-Permanent-Homes.¹³⁴ The collective shower within these spaces became problematized in the mid-1900s. Shower designs emerged that attempted to produce more individualising spaces, such as that recommended for the “Psychopaedic Facility” by the Hospital Design and Evaluation Unit (HDEU, 1979). Modification of the shower within such facilities allowed the Large-Permanent-Home for Disabled-People to remain a thinkable thing despite shifts in the acceptance of the discourses that put them there.

Eugenics, State Security, and Exclusion from Life

In the early 1900s, a Eugenics discourse advocated for the removal of Disabled-People from their Family-Home. Eugenics connected Disabled-People to the proliferation of defective genes within the population. Constructed as a risk to the continued existence of the “Intellectual Class” (Triggs et al., 1925, p. 5), Eugenics proposed some extreme measures to remove Disabled-People from society.¹³⁵ Of interest to this Essay is the idea of collecting Disabled-People together into confined

¹³⁴ It is important to note that I analyse showers connected to Disabled-People in other collective, confined spaces in later Essays. As such, this Essay does not provide a chronological account of the development of showers connected to Disabled-People; rather the shifts in discourse associated with the Large-Permanent-Home, a space in which Disabled-People live outside of the community. I return to the idea of the Permanent-Home and its successes and contradictions within the *dispositif* in subsequent Essays.

¹³⁵ See Mostert (2002) for a detailed study of the management and murder of people with disabilities as a population of “useless eaters” in Nazi Germany. In New Zealand, sterilization (“Dealing with degenerates,” 1923, p. 6), euthanasia (“Segregation of unfit,” 1935, p. 6) including the use of “lethal chambers” for “imbecile children” (Spencer, 2017) were discussed. In addition, the Plunket Society, established to promote the health of infants excluded children who would grow up to be “an imbecile or mentally defective” from their services (Dr Truby King, cited in “Saving the Babies”, 1917, p. 7). Despite this level of acceptance of the eugenics discourse in New Zealand, World War II newspaper articles such as “Peace Talk - Nazi Brutality: Mass Murder of Mental Defectives” (1941, p. 10) indicate that there was a repugnance to the practice of state-sanctioned murder.

spaces in which they would be separated from the community. In 1905, New Zealand's Eugenics Society suggested that town planning be used to improve the health of the nation by investing in those of good breeding stock and isolating "undesirables" in large state-funded institutions to prevent them from breeding (Fleming, 1981).¹³⁶ Findlay, (recently retired Attorney-General) was of the view that such investment was necessary, even if it involved "great expense":

If the proper
accommodation requisite to segregate
our degenerates means great expense,
it should be promptly undertaken if
it will materially reduce the present
multiplication of these degenerates so
inevitable when they are free and
under no proper control.

("The Control of the Unfit", 1912, p. 5).

Systematic identification of the "degenerate" and Large-Permanent-Homes in which to permanently exclude them were approved by New Zealand health boards ("Maintenance of degenerates", 1910, p. 4; "Segregation of female degenerates", 1911), educators ("Defective children", 1914; "Defective children", 1917), and business networks ("Home for degenerates", 1924). One of the primary concerns justifying this segregation was that "degenerates", the "unfit" ("those who, through age or infancy, illness, or mental or physical abnormality, would fare badly in the cosmic struggle for life" ["The Road to Ruin", 1912, p. 2]) or the "Feeble-Minded" would multiply.

In 1925, a Committee of Inquiry into Mental Defectives and Sexual Offenders (Triggs et al., 1925) considered such "unrestricted multiplication" of the Feeble-Minded a serious menace to the wealth and happiness of the nation:

PART II.—PROBLEM OF THE FEEBLE-MINDED.

SECTION 1.—A MENACE TO MODERN CIVILIZATION.

The Committee are of opinion that the unrestricted multiplication of feeble-minded members of the community is a most serious menace to the future welfare and happiness of the Dominion, and it is of the utmost importance that some means of meeting the peril should be adopted without delay. The position is the more serious because, while the feeble-minded are extraordinarily prolific, there is a growing tendency among the more intellectual classes for the birth-rate to become restricted.

(Triggs et al., 1925, p. 5)

Just as the bourgeois had been concerned about the sexuality of the working class being "precocious, active, and ever present" (Foucault, 1976/1978, p. 28; see Essay 3),

¹³⁶ This risk of infecting the population through breeding seemed to be particularly directed towards women. In establishing the Mental Defectives Act 1911, a member of parliament noted that two "imbecile" women had 15 illegitimate children who were now dependent on the state, and that "it is necessary that in such cases we should have the power to lay kindly hands on them and have them committed to one of these institutions, if need be, for the rest of their lives" (Findlay, 1911, p. 302). Such sentiments were echoed by hospital boards (Maintenance of Degenerates, 1910, p. 4; Segregation of Female Degenerates, 1911, p. 3).

degenerates and the Feeble-Minded were thought to pose a similar threat. “Cases”¹³⁷ of families were described by the Committee to illustrate the connections between lineage, the production of criminals, the poor, the diseased, the morally corrupt, failure at school, feeble-mindedness, and financial costs to the state.¹³⁸ Employing biopolitical disablism, such cases were used to compose an unfavourable “species” who could be “excluded from life”.

As noted in my methodology, Foucault described exclusion from societal life as a form of indirect murder¹³⁹ (“to let die”) associated with biopolitical disablism. Within a Eugenics discourse, Disabled-People became constructed as a population of bodies with defective genes that were “unfit” and a danger to society. This danger rationalised the states involvement in their lives:

In the case of all feeble-minded persons living outside institutions, whether with relatives or otherwise, the State should, in the interest of both such feeble-minded individuals and of society, have the ultimate right of supervision.

(Triggs et al., 1925, p. 12)

Their exclusion from life was argued to be necessary for the security of both the members of that population and society:

Institutional care is necessary for mentally defective persons whose helplessness or anti-social traits would render them either the victims of the unscrupulous or a menace to society. Such individuals should be segregated in farm and industrial colonies, so that not only is the community freed from the responsibility of their presence, but they themselves are afforded opportunity of leading much happier and more useful lives, and of becoming, to some extent, self-supporting.

(Triggs et al., 1925, p. 11)

The idea of segregation into Large-Permanent-Homes being advantageous to the Defective and their family was deployed. Pomare (1923) suggested that in addition to the Defective becoming “happier”, “more useful” and “self-supporting”, placement in a “permanent home” would “lighten the burden which their care and control places on the conscience and resources of the community” (p. 2). He suggested that Large-Permanent-Homes would function as a utopia in which the “deficient” could be trained for simple employment, could avoid coming into conflict with the law, and would not have to suffer from the knowledge of their unfavourable state. Triggs et al. (1925) agreed, proposing that to leave “subnormal” children in normal schools not only impeded the progress of the class, but removed the chances of self-respect and happiness for such children, leading them feeling themselves “to be aliens” (p. 11).¹⁴⁰

¹³⁷ See Foucault’s (1963/2003b) “The Birth of the Clinic” for an interesting discussion of signs, symptoms, and the emergence of medical “cases”.

¹³⁸ The financial cost of just one family in America was proposed to be more than \$1,300,000 in one year (Triggs et al., 1925). The equivalent of over \$21,000,000 in today’s currency.

¹³⁹ A discourse of literal death was also circulating within the Eugenics discourse in New Zealand at this time. See Paul (2017).

¹⁴⁰ Teachers had earlier argued that the normal classroom was dangerous for defective children and that defective children in the classroom was unfair to normal children. Newspapers reported

Within the “permanent home” they would be “as happy as possible” (Pomare, 1923, p. 2). Pomare also proposed that such containment was of benefit to the family: The defective child was a symptom of a family as a case of defective genes. Next, I discuss the categorisation of the “deficient” children who would become attached to the Psychopaedic facility that was the subject of the HDEU review in 1979.

Custodial Institutions for Feeble-Minded Children

While the idea of a “mentally defective” child might be limited to those with intellectual or psychological issues, the Mental Defectives and Sexual Offender Committee of Inquiry cast a wide net when identifying populations of children¹⁴¹ who “present problems”:

To quote from the “Mental Hygiene Bulletin,” published by the National Committee for Mental Hygiene for the United States of America: “Children showing definite problems are selected for more intensive study and treatment. The grossly mentally handicapped child, who is likely to become a social problem if not properly dealt with in childhood; the psychopathic and mentally maladjusted child, who later in life may develop mental disease; the child manifesting conduct disorders which may be the beginning of a delinquent or criminal career; the retarded child; the epileptic; the child with speech-defect or with some physical disability; the child with gross personality difficulties; the exceptionally brilliant child—all present problems that demand attention during the child’s school life.

(Triggs et al., 1925, p. 14)

The Committee argued that these children needed to be identified and examined by experts, since “only those fully qualified to estimate accurately all the evidence available are fitted to decide the destiny of children” (Triggs, et al., 1925, p. 14). Once examined and classified, where such children should be schooled and where they should live could be established.

Categories (or “grids of specification” [Foucault, 1969/2002, p. 46]) included, “the child who has been handicapped by illness and lack of opportunity, the child who is inherently dull and backward”. Such children would benefit from the “ordinary public school” where he may associate with his “normal fellows” in preparation for life in society, but where the curriculum is modified “with the object of making him a useful member of society” (Triggs et al., 1925, p. 11). Residential (or live in) schools were

“A Teachers’ Conference now sitting in Auckland advocates the establishment of sub-normal schools for the education of mentally defective children... It is not fair to normal children that they shall be thrown into intimate association with children of defective intelligence: it is not fair to defective children that they shall be exposed to the undoubted risk of over-pressure that must result when they are taught with normal pupils” (“Defective Children”, 1914, p. 6).

¹⁴¹ While the discourse was primarily related to the “child”, feeble-mindedness was identified by the Committee as “children in classes lower than should be expected at their age” (Triggs et al., 1925, p. 12). However, psychological testing could identify Feeble-Mindedness in adults, with reduced intelligence being associated with a lower “mental age” (e.g., Grade D – Mental age 10 Very inferior intelligence”, p. 5). Adults who performed poorly on such tests could then be reconstructed as a Problem Child, expanding the potential population of deficients who would need to live in Permanent Homes.

preferable for children who lived in homes that were “unsuitable” or too distant from specialist services, who were delinquent, or whose capabilities were unclear.¹⁴² The Feeble-Minded included children with either “mental or physical deficit” (or both) who could be sent to a “special school”. However, for those who the normalising function of the Special School could not be realised, segregation within a Large-Permanent-Home was recommended:

The special school is to be regarded as a training-centre for such feeble-minded children as are expected as a result of the training received there to be fitted to take a place in the community and to perform useful work under adequate supervision. There is a danger of filling the special schools with children whose poor mental endowment renders them incapable of receiving benefit at all commensurate with the energy and expense devoted to them. Such children are subjects for custodial institutions.

(Triggs et al., 1925, p. 11)

The Large-Permanent-Home was, thus, for the subject who was considered permanently mentally and/or physically deficient. While other populations could be connected to disciplinary spaces in which they may benefit from “the energy and expense” of training, children destined for the Large-Permanent-Home did not warrant this expense. While the idea of the institution being a utopia was employed, taking them into “custody” functioned to protect the state from their defective genes, and the burden that their care placed on the economic interests of society. It was a place for them to be guarded, both from and for society, and to be hidden from the nation’s conscience. It was a heterotopia,¹⁴³ a place for exclusion from life, an alternative community for those who were deemed a depreciation of the nation’s capital.

Connecting Large Mental Hospitals to the Disciplinary Society

So, what came of this vision for the exclusion of defectives from society? The HDEU (1979) “Psychopaedic Services Hospital Facilities: Study of In-Patient Accommodation” shows that Large-Permanent-Homes had materialised and were being maintained and developed until at least the early 1970s. However, by the middle of the 1900s, Large-Permanent-Homes and the showers within them were being problematised. In the following discussion I explore the problematisation of the Large-Permanent-Home and their showers. By the 1950s, the Eugenics discourse had fallen

¹⁴² A private school to train “Deaf and Dumb” children had already opened in 1880 (“Deaf and Dumb Institute”, 1880) and another, a charitable institute to provide instruction and training in arts and crafts to adults and children, was established in 1890 (“Jubilee Institute for the Blind”, 1890).

¹⁴³ Heterotopia is a concept I draw on in the following Essays: Foucault (1967/1986 explains: “There are... places that do exist and that are formed in the very founding of society— which are something like counter-sites, a kind of effectively enacted utopia in which the real sites, all the other real sites that can be found within the culture, are simultaneously represented, contested, and inverted. Places of this kind are outside of all places, even though it may be possible to indicate their location in reality. Because these places are absolutely different from all the sites that they reflect and speak about, I shall call them, by way of contrast to utopias, heterotopias” (p. 24).

out of favour, and a governmentality that promoted individualisation and self-responsibility had been established. I show how the shower that had been established in Large-Permanent-Homes was then seen to be a contradiction to these shifts and, as such, necessitated a strategic elaboration.

In 1953, the World Health Organization took an interest in the accommodation and care of patients and produced a report on “The Community Mental Hospital” (Blain et al., 1953). An “Expert Committee” reported that people with psychiatric disorders “fill about 40% or more of the total hospital beds” (Blain et al., 1953, p. 4) in western Europe and North America, creating a “major health problem” (p. 4).¹⁴⁴ Since the Eugenics discourse of eliminating defective genes within the population had been largely abandoned, the discourse returned to the need to reduce the cost of maintaining them in “hospital beds”. The report continued to advocate for the provision of Large-Permanent-Homes;¹⁴⁵ however, the authors proposed that the architecture and location of the facilities must maintain a connection with society.

The World Health Organization’s 1953 expert committee was critical of the exclusion from life that Large-Permanent-Homes were associated with. They argued that rather than the Community Mental Hospital being a custodial space, where those who were a danger to society could be guarded and hidden, it should be a “therapeutic community”. A discourse of the architecture of the space being “modelled” on “a community” called for smaller spaces in which individuality could be promoted:

If the hospital is to become a therapeutic community, as the committee is convinced it must to be successful, it must model its architecture and its plan on that of a community. If it is to support and recreate the sense of individuality in patients, it must not dwarf them by its size and by herding them together in thousands in giant monoblock buildings.

(Blain et al., 1953, p. 29)

They proposed that the “atmosphere” of the mental hospital is “the most important single factor in the efficacy of the treatment given” (Blain et al., 1953, p. 17).

As noted in my Methodology chapter, by 1953 significant changes to the way that western societies were being governed had been established, associated with a Fordist disciplinary society governmentality (Fraser, 2003).¹⁴⁶ Rather than attempting to

¹⁴⁴ While this was argued to be an emerging problem, it echoes the concerns of New Zealand’s 1883 Inspector of Hospitals that hospital beds were filled with patients very like the “permanent pauper inhabitants of an English union workhouse” (Graham, 1883, p. ii).

¹⁴⁵ In Aotearoa New Zealand, new legislation (the Hospitals Act 1957) retained the same provision as the Hospitals and Charitable Institutions Act (1885) for providing Permanent Homes or “institutions” “for the reception and treatment or care of “aged, infirm, incurable, or destitute persons” (Hospitals Act, 1957, p. 421).

¹⁴⁶ Interestingly, for Henry Ford himself, the economical bathroom cell was the ideal design for individual self-management of hygiene for the masses. Within the Ford hospitals “there are no wards. All of the rooms are private and each one is provided with a bath. The rooms—which are

correct the vessels of the hot brain (see Essay 1), psychiatry of the mid-1900s aimed to transform patients by maintaining their connections to the disciplinary society from which they had come and returning them to that society.¹⁴⁷ Therapy would operate through the architecture and atmosphere of “a community” and would produce self-respecting individuals:

Another important element in the creation of this atmosphere is the *preservation of the patient's individuality*. In too many psychiatric hospitals still the patient is robbed of her personal possessions, her clothes, her name and, should her head be lousy, even her hair. Every step, therefore, that can encourage the patient's self-respect and sense of identity should be taken, even at the cost of considerable inconvenience.

(Blain et al., 1953, p. 18)¹⁴⁸

Here, the patient is constructed as a subject whose belongings and body (material and human capital) are their own territory, the possessions of an individual who must be encouraged to maintain responsibility for them.¹⁴⁹ While the experts advocated for the continuation of contained, collective spaces, these spaces aimed to connect the subjects within to the disciplinary society, linking the hospital to the network of institutions working towards the same end.

The eugenicists' vision for the custodial institution included the idea that some form of community would develop. Within the confined, collective space of the 1950s mental hospital, social relations within the disciplinary society took on a significance that they had not before. Subjects were constructed to be capable of taking responsibility for the production of the therapeutic community:

in groups of twenty-four—are all identical in size, in fittings, and in furnishings. There is no choice of rooms. It is planned that there shall be no choice of anything within the hospital. Every patient is on an equal footing with every other patient” (Ford, 1922, p. 125). While Ford's vision sounds like a democratic levelling for the purpose of equality “for the people”, this standardisation of the milieu is economical, designed to bring more of the population under the “expertly designed” control of the hospital. Subjects are separated into private spaces in which they are subjected to individualised discipline.

¹⁴⁷ In Aotearoa New Zealand, returning patients to society was also being promoted “The fact that good proportion of persons are discharged relieved indicates the willingness of medical officers to allow their patients to return to the care of relatives and friends when they can be cared for by them” (Howard, 1949, p. 1)

¹⁴⁸ Emerging Occupational Therapy practice in Aotearoa New Zealand at this time was also concerned with knowing and treating the individual (Orton, 2021).

¹⁴⁹ With regards to Mental Hospitals in Aotearoa New Zealand at this time, a policy of “brightening the furnishings of the villas and improving the general standard of variety in the clothing of patients is making itself apparent throughout the hospital” (Howard, 1949, p. 7) was seen to have resulted in the patients having “benefited in personal comfort, but more important in self-esteem and consequently self-confidence” (p. 4). This suggests the idea of individuality and self-responsibility was also emerging in New Zealand, however resourcing limitations were noted to limit how much change could be achieved (Howard, 1949, p. 2).

As an example, if patients protest against inaction and boredom they should be encouraged to create clubs for the organization of workshops, series of conferences, musical groups, and various instruction courses. In this way the patients are gradually led to accept some responsibility for the general atmosphere of the hospital. They can help to transform it into a community whose way of life is better adapted to their needs because they themselves have established it.

(Blain et al., 1953, p. 23)

Alongside promotion of individual responsibility, a democratic governmentality is employed to induce individuals to act for a collective good. Associations (“clubs”) are created to encourage the patients to produce their own disciplinary society within the hospital. Just as the right way to govern patients is to ensure they self-govern their possessions and bodies, they are seen to possess the attributes to be conscripted “as agents of social control” (Fraser, 2003, p. 164). This shift in the discourse to individual responsibility and an aesthetic of the community within the institution called the architecture of 1900s Large-Permanent-Homes into question.¹⁵⁰

By 1959, segregation in state funded facilities was falling increasingly out of favour with the experts. A further World Health Organization report on Psychiatric Services and Architecture stated that hospital care should only be a temporary measure “if the family is unable to help the patient, or if the patient is too disturbed for the family unit to remain reasonably stable” (Baker et al., 1959, p. 11).¹⁵¹ The hospital should be close to the community it serves, regarded as “a temporary treatment unit... Its function should be to re-train the patient within a therapeutic community to meet the normal stresses of an ordinary community” (Baker et al., 1959, p. 11). Indeed, remaining within the facility became seen as dangerous, potentially making the patient incapable of returning to “normal life” (Baker et al., 1959, p. 22).¹⁵² The expense of “long-term custodial care” was argued to diminish any therapeutic effect of the hospital. Thus, rather than reducing costs to the nation, Large-Permanent-Homes were positioned as creating them. At this time, the Mental Hospital was still to exist;

¹⁵⁰ It was not only psychiatric hospitals that a discourse of large permanent homes being transformed into “a community” applied to. In New Zealand, Pukeora Home for Physically Handicapped Young People was described as a “village” within which 70 people would be accommodated, and those “confined wholly or almost wholly to bed” would live in groups of four to five (The New Zealand Crippled Children’s Society, Ca. 1957). Despite the idea of connection to community emerging in the 1950s, Pukeora was situated a considerable distance from any town and was not closed until 1998 (“Pukeora Home for the Disabled”, n.d.)).

¹⁵¹ See Foucault, the Family and Politics in Duschinsky and Rocha (2012) for a fascinating analysis of the role of the family in relation to discipline and deviancy.

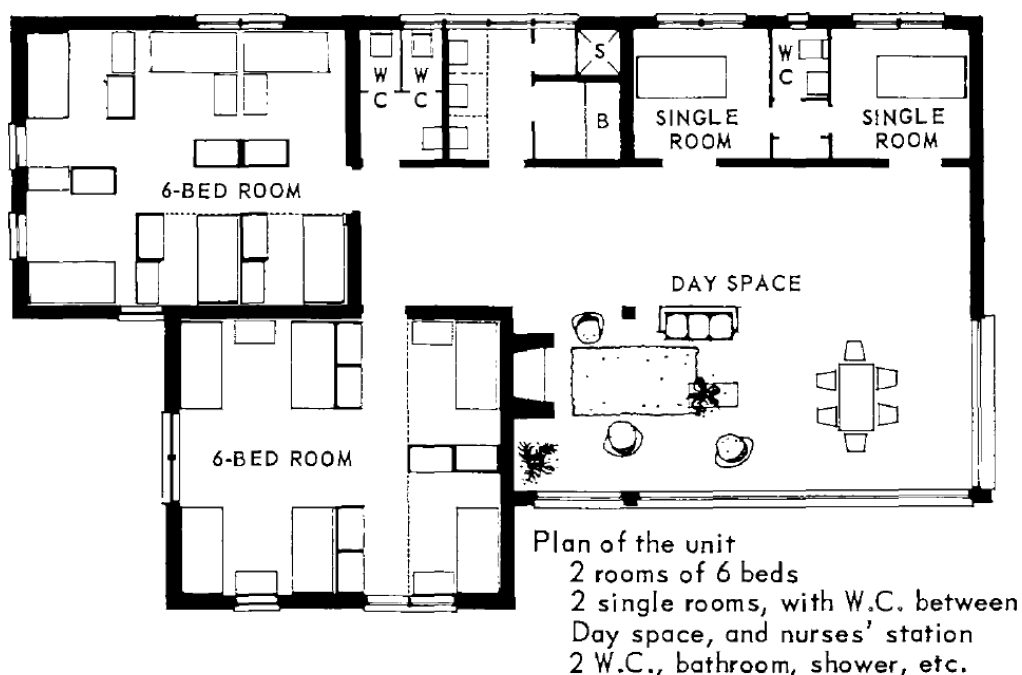
¹⁵² However, they did state that “with our present resources we must admit that some patients, particularly those suffering from schizophrenia, are not likely to recover sufficiently for a normal life in the community to be possible. They are hampered by personality defects, eccentricities, or persistent symptoms which are unlikely to be well tolerated in most civilized cultures” (Baker, et al., 1959, p. 37) and should reside in “working settlements” (p. 37).

however, within a mid-1900s governmentality it should remain connected to the disciplinary society.

To create a community atmosphere, Baker et al. (1959) proposed that patients should initially “enter a group of 5 or 6 – like a small family... as he improves he will be able to mix with the ward group of perhaps 20 to 30 patients” (p. 11). While the facilities were still large (the recommended size for the hospital was “300-beds”), these “wards” comprised of two of these “small family” groups (Figure 38):¹⁵³

Figure 38

World Health Organisation Psychiatric Unit Design, 1959



Note: From *Psychiatric Services and Architecture* (p. 29), by A. Baker, R. Llewelyn Davies, & P. Sivadon, 1959, World Health Organization. CC BY-NC-SA 3.0.

Bedrooms created a space for the “5 or 6” patients to establish “a small family”, an artificial association of comrades. These units remained outside of society, a Heterotopia in which the Family-Home of the outside world was represented. An aesthetic of the family-home was desirable to produce “small family” connections and to “re-train” the patient for community life, however, Baker et al. advised that the hospital should not appear too much like a family-home:

¹⁵³ As the numbers of patients in the hospital increase, units are added that remain somewhat separate but conjoined by collective spaces that combine staff and patient facilities (see Appendix I).

A hospital is not a home, and a building to house 30 people cannot be the same as an ordinary home designed for a family of 4 or 5. Further, it is not really desirable or helpful to the patient to dress up the mental hospital to look like something it is not. It has a social purpose, and the patient will appreciate a certain sense of purpose in the architecture as well as the comfort and friendliness of a semi-domestic environment.

(Baker et al., 1959, p. 39)

Baker et al.'s (1959) design thus has features of a Family-Home, although the scale was different (6 in a bedroom, 2 toilet stalls, and 3 handbasins),¹⁵⁴ and facilities such as a kitchen and laundry were missing.¹⁵⁵ The unit had a shower and a bath, which was being promoted for private dwellings at that time (see Essay 6). This was a Hygiene Shower, a private cell for washing the body. It was designed to perform the same therapeutic operations of the shower in the Family-Home.¹⁵⁶ The shower would produce subjects who habitually attended to their hygiene needs, and who with their clean, healthy, upright, desirable bodies could be re-trained and return to the community as a more favourable subject. While some aspects of the units should not be "dressed up" to look like something they are not, the Hygiene shower (now established in the Family-Home, but with origins as a Rain-Bath-Compartment that would be ideal for asylums [Gerhard, 1908]), could be inserted back into the Mental Hospital, helping to produce "the comfort and friendliness of a semi-domestic environment" (Baker et al., 1959, p. 39).

While the therapeutic operations of the shower within Mental Hospital still aimed for normalisation (re-training to "meet the normal stresses of an ordinary community" [Baker et al., 1959, p. 11]), the operations were quite different to psychiatry of the 1800s. Rather than the Cold-Shock-Shower transforming the hot brain or the impetuous will, the shower was connected to the Mental Hospital as a feature of the domestic Hygiene shower within the disciplinary society. It was a space within which the patients could be Showerers, being subject to the same forces of society that compelled the rest of the population to shower. The body (and its hot brain, disordered mind, or defective genes) was no longer the site of disorder. Dysfunction became a failure to manage the stressors of community life and the breakdown of family

¹⁵⁴ The collection of single beds in a room may have been typical of arrangements for children's bedrooms at the time, a system more economical for disciplinary surveillance.

¹⁵⁵ The specialised "mother and baby units", however, "will have a small area for simple occupational therapy. Instead of workshops outside the hospital there will be a domestic training area. Here the mother will have a replica of the domestic interior appropriate to her culture, in which she can function as a housewife and receive any training in cooking, hygiene, or family care that is needed" (Baker et al., 1959, p. 32).

¹⁵⁶ Compare this to Figure 6. Bathroom of the Utica Psychiatric Centre (Gerhard, 1895b, p. 34) in Essay 1 where a row of shower heads within an open shower room illustrates the modern psychiatric facility shower of the day.

relationships. Abnormality was social rather than corporal.¹⁵⁷ Families, the community, society, and the patients within “small families” became part of the production of subjects who could be “re-trained” to become responsible for themselves and to leave the state funded facility. In Aotearoa New Zealand, the combination of concerns regarding the costs of institutionalisation and maintaining connection to community life was later connected to the nationwide “deinstitutionalisation” of psychiatric patients (Brunton, 2003). I now return to the institutions that were established for the Feeble-Minded children and show that while some of the same ideas of shifting responsibility were applied, the idea of the Large-Permanent-Home remained.

Psychopaedic Hospital Collective Showers Made “Private”

In the early 1960s, in Aotearoa New Zealand, the idea of the “Psychopaedic Hospital”¹⁵⁸ emerged as a space for specialised medical care for Intellectually Handicapped children (“All People Need to Feel Needed”, 1961). While some “special” schools had been designed for children, many “Feeble-minded” children had been living in Psychiatric Hospitals since their removal from the family-home (“Services for Mentally Retarded “Desperate””, 1965). A discourse of exclusion and the need for Large-Permanent-Homes for such children was not in question in the late 1960s; although the size of the facility, its “character” and connection to the community, and a “comprehensive scheme of services” was:

There had never been any argument, he said, on the need for the psychopaedic hospital or regional hospital for the mentally retarded, as some would prefer to call it, but there was room for discussion on its size, its location, its character, and its integration into a comprehensive scheme of services for the mentally retarded.

(“Small Units Wanted for Intellectually Handicapped”, 1968, p. 22)

Large-Permanent-Homes were a problem and small unit type villas were needed (“Small Units Wanted for Intellectually Handicapped”, 1968).

Given that the Large-Permanent-Homes of the early 1900s were for removing Disabled-People from society’s conscience, it is perhaps not surprising that there is

¹⁵⁷ Braddock and Parish (2001) provide a detailed account of the emergence of the social model of disability.

¹⁵⁸ Psychopaedic is a uniquely New Zealand term. The “paedic” distinguished between adult and child psychiatry and reportedly, “the New Zealand medical fraternity came up with the term ‘psychopaedic’ to differentiate between those who were mentally ill and those who were mentally retarded” (Gourley, 2016, para. 3)

little information about what happened within them.¹⁵⁹ However, in the late 1960s and early 1970s investigations into the numbers of people in Large-Permanent-Homes in Aotearoa New Zealand were commissioned. These included Kemp et al. (1967), "Report of Board of Health Committee on Care of the Aged in New Zealand"; the HDEU (1974), "Bathing Facilities for Long-Stay Geriatric Patients", which I discuss further in Essay 8; Densem (1972), "Persons with Mental Retardation in Auckland and Northland: Report on an Accommodation Survey"; Hutchinson et al. (1973), "Services for the Mentally Handicapped" and the HDEU (1979), "Psychopaedic Services Hospital Facilities: A Study of In-Patient Accommodation". This renewed interest in where and how Disabled-People lived led the HDEU into various Large-Permanent-Homes that had been established over the preceding 59 years, revealing what had been previously hidden from the community's conscience. While the Psychopaedic Hospital may have been established for Intellectually Handicapped children, the review found that the Villa accommodated both adults and children, and included "multi-handicapped" patients.

The HDEU (1979) visited four hospitals that provided Large-Permanent-Homes for Psychopaedic Patients. Each hospital had a number of "Villa" designed to accommodate up to 50 patients (although numbers had "been reduced" [HDEU, 1979, p. 19]). The oldest hospital (Hospital A) had two Villas built in 1920 and 1925 (see Appendix II for a description and plan). Hospital B had three Villas built between 1930 and 1937 (see Appendix III). Hospital C had five Villas, the first four being built between 1957 and 1959 and C5 in 1970 (see Appendix IV). Finally, Hospital D had only one Villa, Villa D1, which was built in 1970 (see Appendix V). This review of hospitals found that none of the shower facilities within the Villa met the reviewers' standards. A lack of "privacy" appeared to be particularly problematic:

¹⁵⁹ Braddock and Parish (2001) have outlined the challenge of writing a "history of disability" in the West that they associate with problems accessing primary source evidence (although Longmore and Goldberger [2000] dispute this), limited data regarding the perspectives of "persons with disabilities" and their families, and a tendency for histories of disability to focus on one category of disabled (e.g., only mental or only physical) rather than a "broad cross-disability perspective" (p. 12).

With the exception of Villa D¹ bathrooms contained more than one bath and/or showers, no attempt having been made to give patients privacy. The emphasis was rather on throughput and ability of staff to assist each other.

At any one time, there could be a number of patients and staff in the room especially when individual nurses were allocated specific tasks such as undressing patients, washing, drying and dressing them. As these tasks were performed at different rates, a group of four or five naked or scantily clad patients could be standing or sitting, waiting to be bathed and a comparable number perhaps waiting to be dried, dressed or escorted back to the day room.

While the H.D.E.U. does not support this bathing system, it was clear that bathrooms could not be tightly planned. Space was required for accessories such as shelving or trolleys to hold toilet requisites, clothing and clean linen, soiled linen rounders and sometimes plinths for drying and dressing patients.

(HDEU, 1979, p. 43)¹⁶⁰

As with other collective showers (such as the Army-Division-Shower-Bath-Facility, the Changing-Rooms-&-Baths-for-Miner's and the Army Shower), the shower within the Villa functioned as an economical way to maintain the hygiene of a population. The patients were primarily a feature of the nurses' environment, a component of the showering task to be completed as efficiently as possible. The shower design produced patients "queueing to use facilities, 'assembly line' bathing... all of which help to produce the 'institutionalised' patient" (HDEU, 1979, p. 71). However, "while the HDEU does not support this bathing system" (HDEU, 1979, p. 43) the necessary presence of objects (shelving, trolleys, clothing, linen and plinths) meant that the report found that "tightly planned" Hygiene showers of the private dwelling were not possible.

These economical collective shower spaces, "with an emphasis on throughput" (HDEU, 1979, p. 48), were the materialisation of Pomare's (1923) vision for the Large-Permanent-Home as a space "to lighten the burden which their care and control places upon the conscience and resources of the community" (p. 2). The materiality of the showers within the Villa made the discourses they were the product of durable. In a discourse where the patient is an object within the environment of the nurse, the walls, doors, and curtains that might create privacy for an individual to shower in simply present barriers to the "assembly line" of bathing. By the late 1970s, the ideas and practices that the Large-Permanent-Home shower maintained appeared problematic in their failure to provide "privacy". While a concern with privacy could have been

¹⁶⁰ Villa D had two domestic style showers in a room across and down the hall from an 8-9 bed unit.

problematized from the perspective of the danger of the patients' proclivity towards "precocious, active and ever-present" (Foucault, 1976/1978, p. 28) sexuality, it was the inhumanity of seeing the naked or scantily clad patient, standing or sitting, waiting to be processed, that was viewed as unacceptable. Though showering in some collective spaces remained acceptable,¹⁶¹ nakedness was dangerous and should not be seen in the "public" spaces of the Large-Permanent-Homes. Within a discourse of collective, confined spaces producing individualised Disabled-People connected to the disciplinary society, the right to privacy (or perhaps the right to be protected from nakedness in public) was established. Robbing the patients of the possibility of self-governing their privacy comes to be seen as inhuman. Coll (2014) stated:

Like sexuality, privacy involves the acquisition of rights, the diffusion of values, and the development of statements that regulate its implementation. In this sense, privacy, like sexuality, is a 'power-knowledge' (Foucault, 2003, p. 252) related to moral standards defining what privacy should be... biopower is producing subjects owning a privacy, feeling concerned about it and willing to protect it. (p. 1253)

Rights are connected to possession of territory and the capital that can be extracted from that. In addition to public spaces as the territory of a population who needs to be protected from the danger of sex, autonomy over one's body produces a territory that self-governing subjects should defend. A sexuality that is capital becomes connected to privacy. Standing or sitting while naked or scantily clad, is contradictory to the production of a subject who has a right to privacy, and can self-govern their sexuality. The naked body exposes their sexuality, making it visible, vulnerable, and knowable to anyone who sees it.¹⁶²

Within the Villa, the idea of the "right" to privacy did not, however, extend to a "right" to not be surveilled. The privacy that the HDEU felt was lacking was a specific form of privacy, a particular moral standard that allowed them to define "what privacy should be". While some of the Villas had confined private dwelling style shower cells, these were also seen as problematic in that they did not allow staff to surveil the patients:

¹⁶¹ For example, the Waiheke Rugby Club shower rooms remains a group shower room to this day.

¹⁶² It is interesting that although Large-Permanent-Homes were constructed due to the danger of the sexuality of "defectives", that the shower spaces within these spaces exposed naked subjects to each other. It is perhaps that the discourse which constructed adults as Feeble-Minded Children through the assessment of their "mental age" meant that within the disciplinary space of the custodial institution the problem of sex was seen to be secondary to the production of spaces for supervision and economical care. Furthermore, it has emerged that unconsented sterilisation was used to ensure that Intellectually Disabled patients could not reproduce (Satyanand et al., 2007).

In most other villas showers were of the usual domestic type. However when there was restricted access and/or restricted associated "dry" areas staff felt they could not adequately supervise patients using them. A number of other unsatisfactory features were noted such as fixed shower heads instead of hand-held sprays, no or poor water temperature control, no handrails and raised upstands at the thresholds.

(HDEU, 1979, p 49)

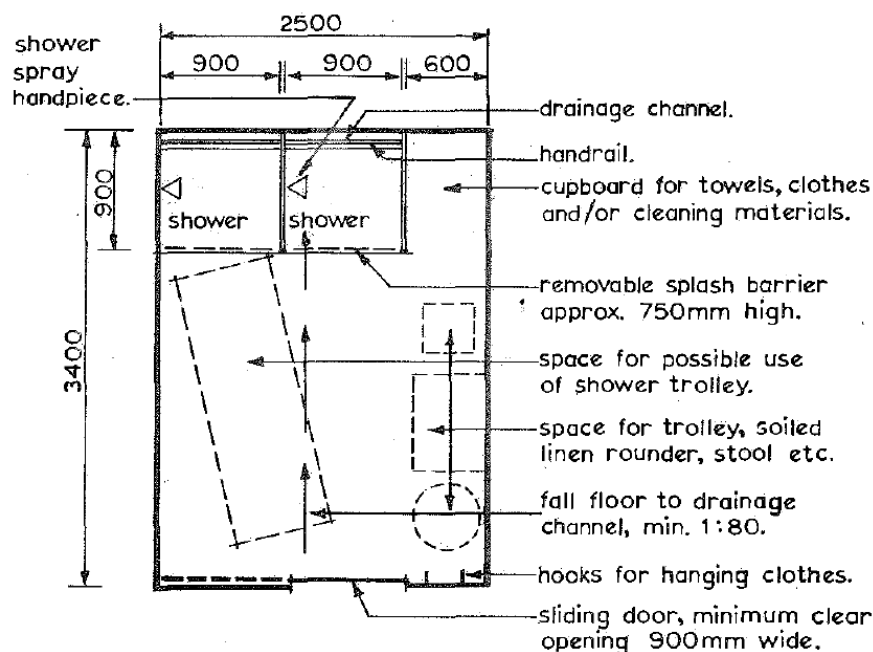
While it was not desirable for "groups of four or five naked or scantily clad patients" to be standing or sitting around, it was also unsatisfactory for the patient's right to privacy to reduce their visibility to staff, or to make the shower inconvenient for the nurse to wash the patient. It may have become desirable for Disabled-People to take some responsibility for their privacy, but the therapeutic operations of the shower must continue to enable the medical gaze to surveil (and thus discipline) the patient. The entirely concealed space of the private dwelling hygiene shower made it unsuitable for the Psychopaedic Hospital. Other features of the private dwelling form of shower as a feature of the Nurses' environment were also problematic. For example, fixed shower heads caused the nursing staff to get wet; the water could be too hot or too cold; and the shower could be dangerous and slippery, with raised upstands contributing to this danger (HDEU, 1979).

While the HDEU (1979) problematised the existing showering facilities of the Villas, they also observed that bath time (which included showering) within all of the Villas were an operator of pleasure:

It was obvious that bath time was one of the most pleasurable events in the patients' day as they clearly enjoyed the feel of water. However, the time that they were in the bathroom and were actually being washed depended on many factors:

(HDEU, 1979, p 43-44)

Although the existing shower designs may have been problematic, the experience of showering or bathing was not necessarily problematic. Indeed, not showering for long enough was seen as an issue. Observations of showering found that nursing practices caused patients to be under the water for anything between 2 and 15 minutes. Those who had the longest showers or baths were either those who were "multi-handicapped" and who needed braces and splints to be fitted, or those who required "very little supervision" and who "bathed in a leisurely manner" (p. 44). Those bathed in groups had the shortest times, while nurse training, scheduling of bathing and the design of facilities were all thought to be factors contributing to these less desirable short showers. In light of all these problems, the HDEU proposed an ideal "shower room" (Figure 39):

Figure 39*Psychopaedic Hospital Shower Room Suggestion, 1979***SHOWER ROOM – SUGGESTED LAYOUT****DRAWING No.2****SCALE 1:50**

Note. *Psychopaedic Services Hospital Facilities: A Study of In-Patient Accommodation* (p. 105), by Hospital Design and Evaluation Unit, 1979, Department of Health. CC-BY 4.0.

In this Psychopaedic-Shower-Room there were two shower cells, similar to the private dwelling hygiene shower cell. These showers had shower spray hand pieces so that the nursing staff may control the direction of the water. Rather than a curtain there was a 750mm high removable “splash guard” to prevent water from splashing out onto the floor and onto the nursing staff. In addition to the shower cells, the shower room provided space for the objects involved with showering patients (such as shelves and linen). The shower was no longer the “tightly planned” private dwelling shower, the cell became the entire room where a shower trolley, soiled linen, and clothes may be placed. It was unlike the domestic bathroom which may contain a bath and vanity with the shower as an appendage. Like Gerhard’s 1908 Rain-Bath-Compartment, it was a space exclusively for undressing, showering, drying, and dressing. However, in this room, the shower tray was entirely absent, and the entire floor of the room sloped towards a drainage channel. The room accommodated two upright patients who might take some responsibility for themselves as a Private Showerer within a cell, or two

children who could stand and be showered by the nurse. The Psychopaedic-Shower-Room also accommodated the reclining patient, the body who could not stand erect within the domestic shower cell. However, rather than soaking in a bath, the reclining body could be manoeuvred on a shower trolley, into the bathroom assembly, under and out of the shower as directed by the nurse with the shower spray hand piece.

While the HDEU advocated for the development of “Community” or “Family” homes, the idea of confined, collective spaces (or wards) of between 20 and 24 patients remained. The shower cells of the Psychopaedic-Shower-Room operated to provide some privacy between the patients; however, the absence of a door or curtain in the opening of the cell meant that the patient remained visible to anyone in the shower room who was not showering. The HDEU (1979) stated that the room should only be used by two children (for who “the requirement for privacy” was less [p. 86], perhaps as their bodies are thought to not expose a sexuality) or one adult.¹⁶³ Although there were two shower heads, the room was to function as “one facility” (p. 87), an expanded Rain-Bath-Compartment that could accommodate upright and reclining bodies.¹⁶⁴

For the adult, nakedness in the collective space of the Large-Permanent-Home was dangerous, and as such the sexuality of the subject must be governed. In the disciplinary society the subject who can take some responsibility for this government should be produced. The cells of Delabost’s Prisoner Ablution-system (Essay 1) and Bresgen’s Army-Division-Shower-Bath-Facility (Essay 2) saw the shower cell as architecture that would improve the efficiency of external surveillance.¹⁶⁵ However, within a discourse regarding the production of a self-governing Showerer, the cell also produced a subject who could look out and surveil whoever might look in.¹⁶⁶ The cellular system within collective spaces separated subjects within the population from each other, and the individual cell provided the Showerer with a defined space, a

¹⁶³ The dressing and drying space is collective if there are two showerers. While this may be rationalised by the requirement for privacy for children to be “less”, even Gerhard (1908) who had produced the compartment for private showering and dressing had advocated for a shared drying and dressing area for children as this “fosters habits of neatness as regards the undergarments” (p. 167).

¹⁶⁴ A “wheelchair shower” had materialised by this time which I discuss further in Essay 8; however, the HDEU (1979) reported that a “wheelchair shower is not required as multi-handicapped patients cannot sit on toilet chairs because of gross body distortion so often present” (p. 87).

¹⁶⁵ The cell system had been employed within the prisons to keep subjects from the influence of others to establish and maintain disciplinary control (see Foucault’s [1975/1995] discussion of the Panopticon).

¹⁶⁶ Although not discussed in relation to showers, it was noted that within the toilets of the Psychopaedic Hospital “doors to compartments were not necessarily shut but this could have been because their size interfered with observation. However independent patients did ensure privacy from the observer by always using the furthestest away compartment” (HDEU, 1979, p. 54).

territory that they may defend. This contrasted with the few Private showers within the democratic Changing-Rooms-&-Baths-for-Miners where government through comradeship (literally shared territory) was employed. In a space in which some Disabled-People may be able to shower, or trained to shower, with very little assistance, the individual shower cell is justified. Responsibility for governing sexuality may be somewhat shifted to the subject through establishing Private territory in which they may wash out of sight of any other member of the population. However, the privacy of these showers within a collective space did not extend to placing limits on the visibility of the subject to the Nurses.

The Psychopaedic-Shower-Room is designed to produce the possibility of separating Showerers from each other, while remaining a space for nursing work and surveillance. It is a discursive object in which self-governing individuals, with associated privacy rights within Large-Permanent-Homes, had become problematised. The shower is a therapeutic operator, the walls and doors put the discourses into operation. The shower makes material the aim of producing new subjects who are individualised and may take some responsibility for the government of themselves, while remaining under the supervision of medical authority.

Summary: Showers for Disabled-People in Collective Spaces

The Large-Permanent-Home, as a collective, confined space for Disabled-People, emerged within the dispositif as a way to reduce the cost of units of unsound physical and mental health to the nation. A Eugenics discourse employed biopolitical disablism to construct the genes of Feeble-Minded children and other “defectives” as a risk to the security of the state. Containing such subjects in Large-Permanent-Homes was argued to protect interests of the individual and the nation. This discourse made the removal of Disabled-Children from their Family-Home to custodial care in a facility such as the Psychopaedic Hospital a thinkable thing. Showers were established in these Large-Permanent-Homes as they had in other collective, confined spaces (see Essays 1 and 2) as a biopolitical technology to maintain the health of a population. Gathered together and isolated from the community, Disabled-People came to be governed as a feature of the Nurses’ environment, a unit within an assembly line of showers, creating the least expense to the conscience and capital of the nation.

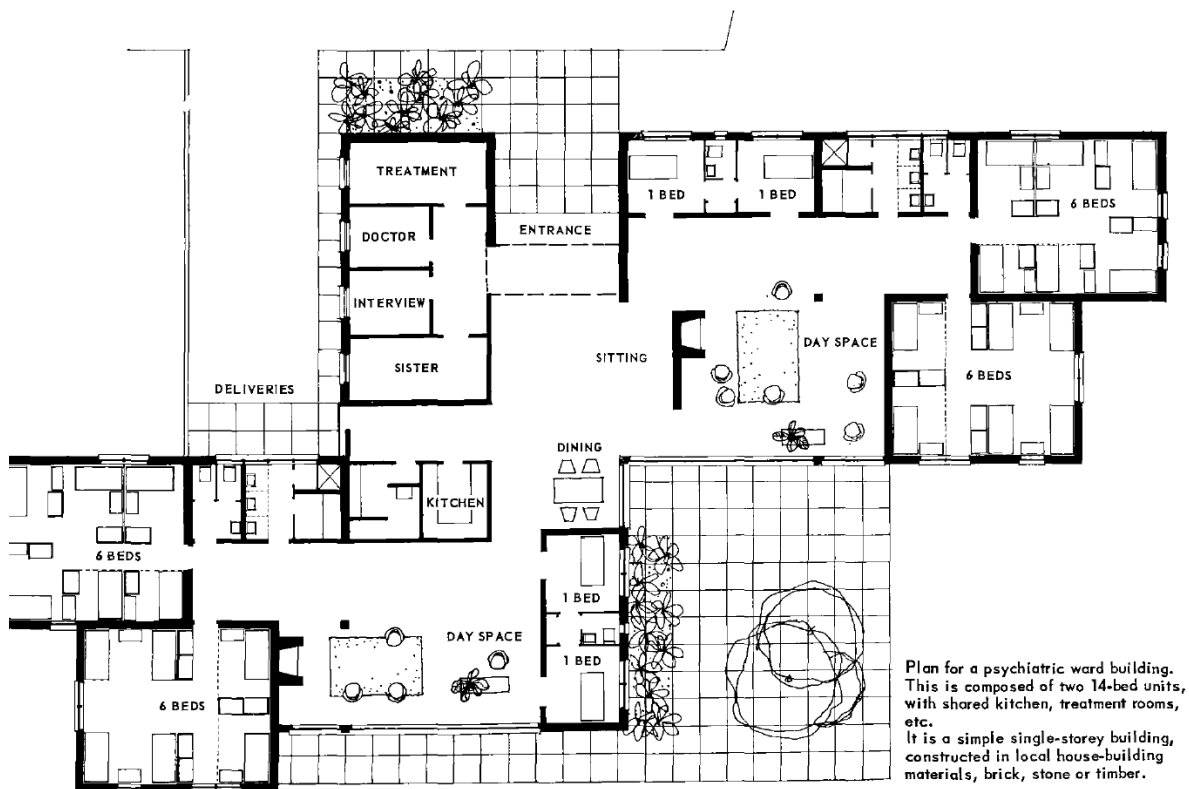
Resistance to this practice of exclusion from life, and the extension of the Fordist disciplinary society into the mental hospital, resulted in a strategic elaboration of the dispositif whereby the Large-Permanent-Home are shifted from a space of exclusion into part of a network of spaces that aimed to produce self-responsible individuals. This governmentality supported the idea of the individual’s body as a

territory that they could govern and promoted the idea of privacy within Large-Permanent-Homes. These shifts can be seen through the problematisation of the Large-Permanent-Home shower. Concerns regarding a lack of privacy in large collective showers were associated with the production of self-governing subjects. The continuation of disciplinary practices of Nurse surveillance made it clear that there were limits to the private territory of patients. The HDEU (1979) Psychopaedic-Shower-Room provided shower cells within a large shower room. While it was possible for two children to be showering at once, the designers promoted it as a “single facility” for a showering adult. Provision of the shower cell and space to dry and dress satisfied a discourse of the right to privacy, while the absence of the doors satisfied the established disciplinary surveillance of the custodial institution. It was also a space in which the reclining Disabled-Person, connected to a shower trolley, may be wheeled in, and showered by a Nurse. While shower rooms had existed previously within Large-Permanent-Homes as spaces in which Disabled-People could be assembly line showered, the HDEU Psychopaedic-shower-room produced the possibility of a single, reclining subject being showered in “private”. Such subjects were still attended to by a nurse, but the shower design transformed the exclusion from life space of the Large-Permanent-Home shower into a facility that was coherent within the disciplinary society, and where Disabled-People could continue to live.

In Essay 8, I return to the idea of the Permanent-Home and the shower-room within the domestic dwelling. However, in the following three Essays I analyse the discourses that connect Disabled-People to private dwellings and the showers that were associated with these discourses. I show how a Rehabilitation discourse emerged within the dispositif to transform units of unsound physical and mental health so that they could become assets to the nation and return to the Family-Home in the community.

Appendix I**Figure 40***World Health Organisation 28-Bed Ward Unit Design for Psychiatric Patients, 1959*

FIG. 6. A 28-BED WARD UNIT FOR PSYCHIATRIC PATIENTS



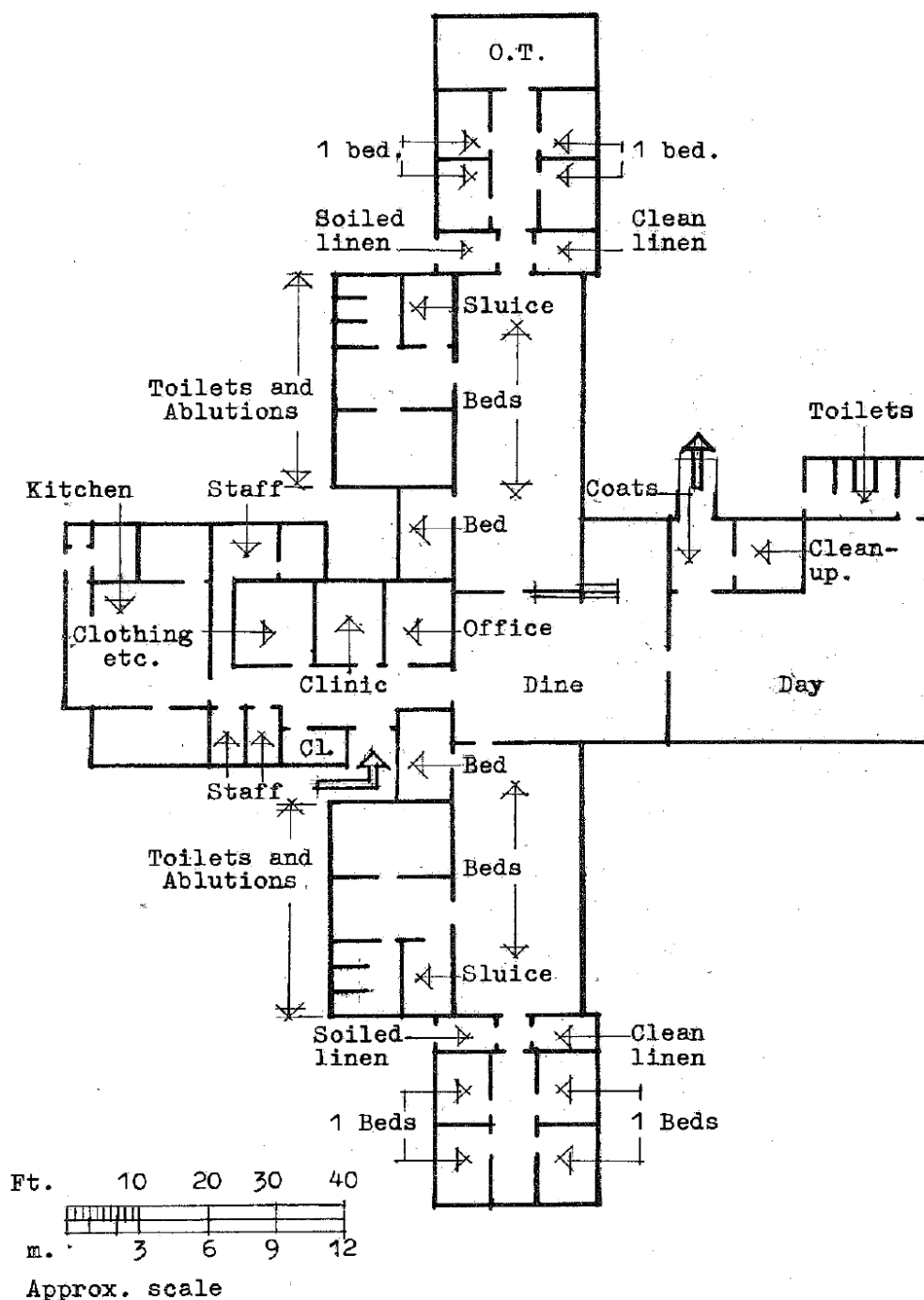
Note: From *Psychiatric services and architecture* (p. 30), by A. Baker, R. Llewelyn Davies, & P. Sivadon, 1959, World Health Organization. CC BY-NC-SA 3.0.

Appendix II

Villas A1 and A2. The "toilets and ablutions" (which included showers) were a separate "facility", however the bathrooms were connected to the bedroom areas, with the whole being formed by two mirror image bedroom/bathroom areas connected by collective areas.

Figure 41

HDEU 1979 Study of Inpatient Accommodation: Villas A1 and A2



TYPE A

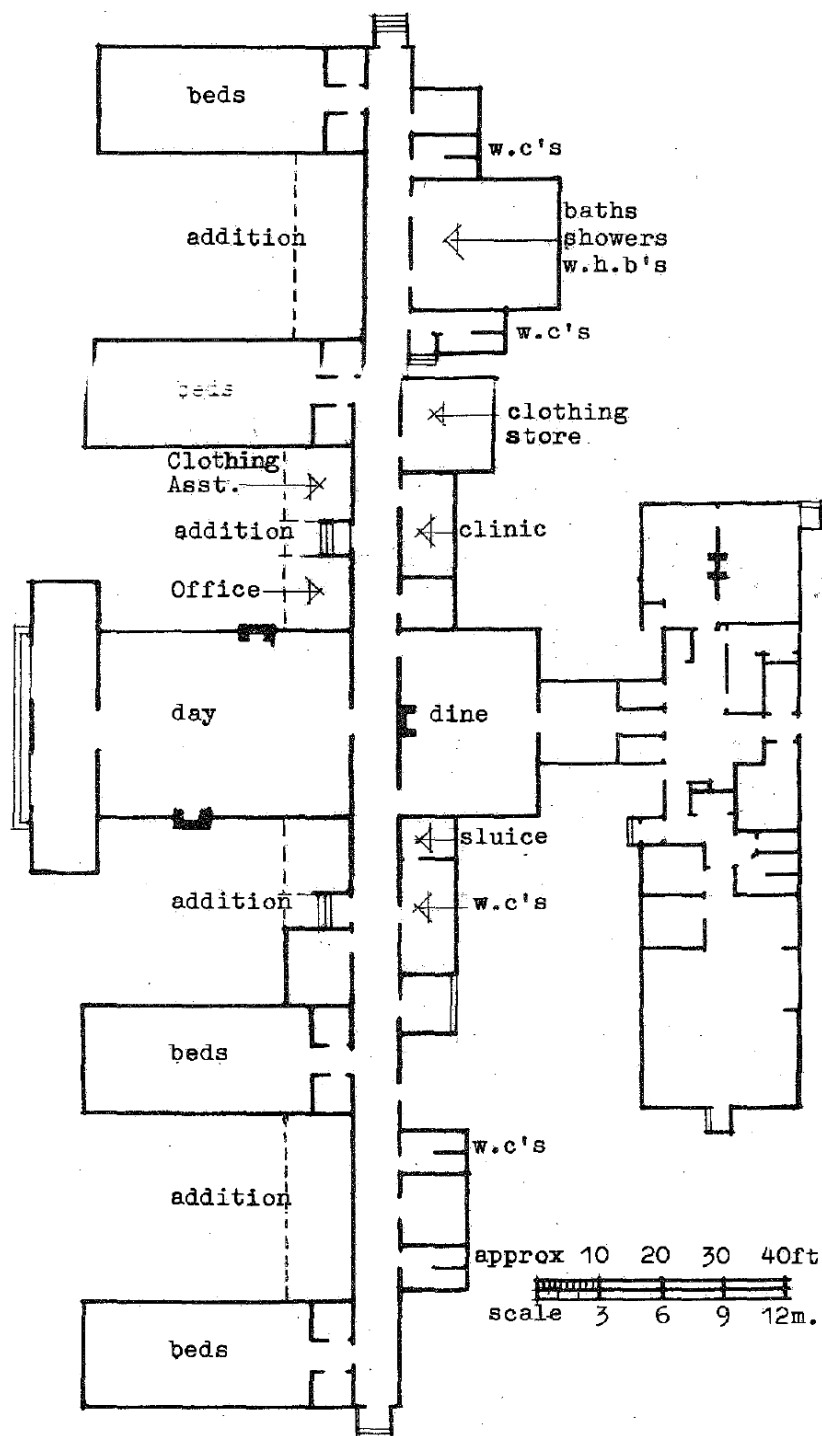
Note. *Psychopaedic Services Hospital Facilities: A Study of In-Patient Accommodation* (p. 21), by Hospital Design and Evaluation Unit, 1979, Department of Health. CC-BY 4.0.

Appendix II

Villas B1, B2, B3. These Villas are also formed by two mirror image bedroom units. Each unit has toilets, however both bedroom and bathroom are separated by a hallway. Showers and baths are “at one end of the long building” (HDEU, 1979, p. 24).

Figure 42

HDEU 1979 Study of Inpatient Accommodation: Villas B1, B1, B3



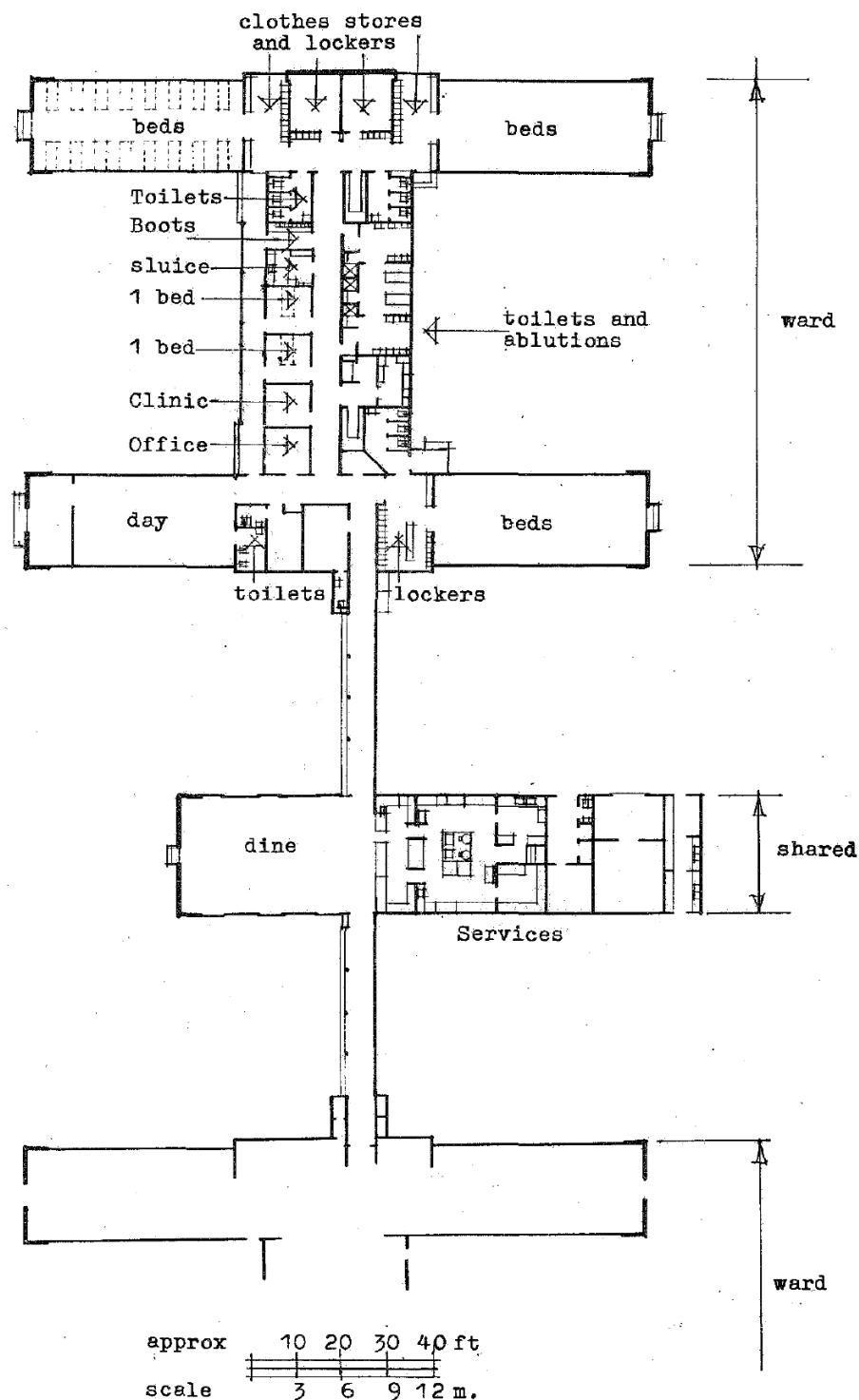
Note. *Psychopaedic Services Hospital Facilities: A Study of In-Patient Accommodation* (p. 21), by Hospital Design and Evaluation Unit, 1979, Department of Health. CC-BY 4.0.

Appendix IV

Villas C1, C2, C3, C4. These Villa were comprised of “wards” that had large bed rooms disconnected from the toilet and ablutions which were down the hall, but not such a great distance as that of the B Villas. Provision of individual wardrobes was seen as “some limited degree of personalisation of patients’ clothing” (HDEU, 1979, p. 26).

Figure 43

HDEU 1979 Study of Inpatient Accommodation: Villas C1, C2, C3, C4



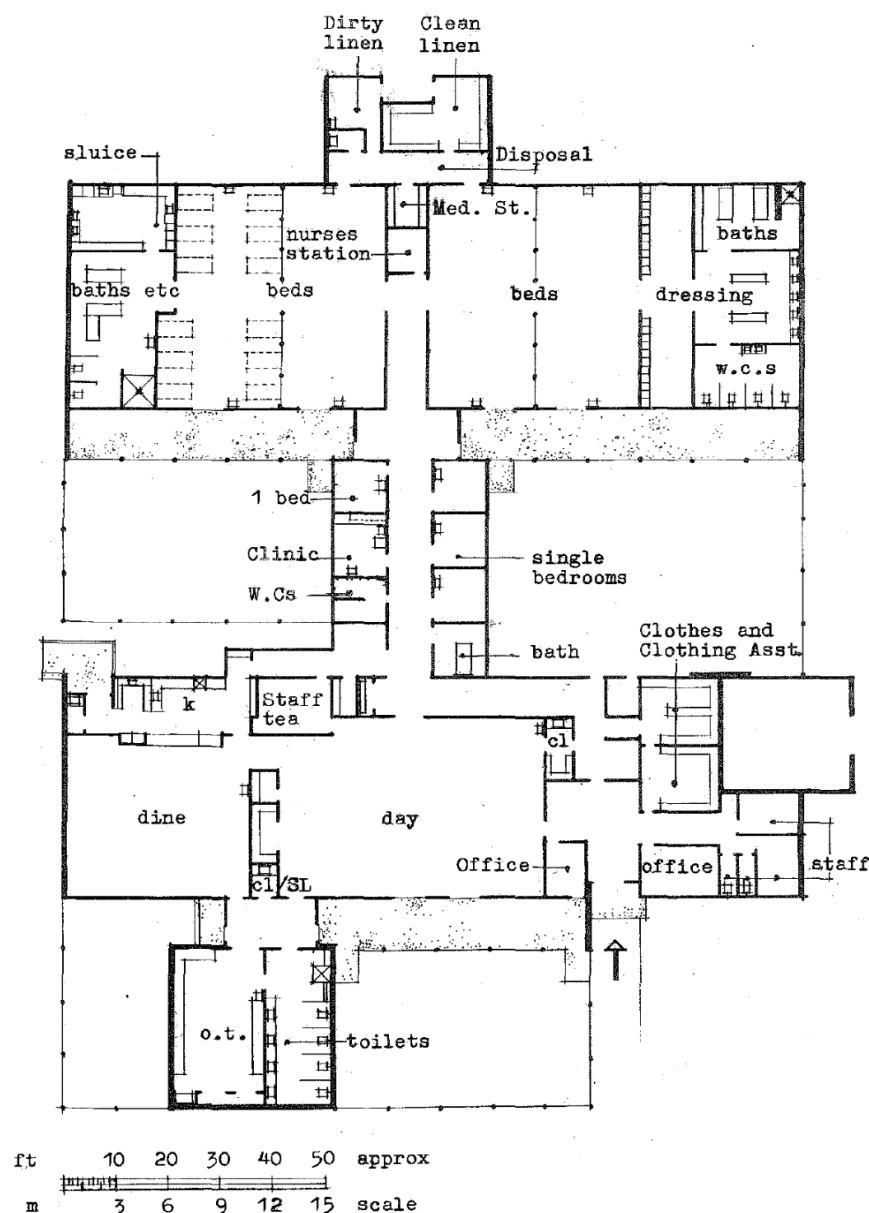
Note. *Psychopaedic Services Hospital Facilities: A Study of In-Patient Accommodation* (p. 27), by Hospital Design and Evaluation Unit, 1979, Department of Health. CC-BY 4.0.

Appendix V

Villa C5, “specifically evolved to meet the anticipated needs of the multi-handicapped, 50% of whom it was assumed would be ambulant and a fair proportion trainable” (HDEU, 1979, p. 28) had more distinctive units with bathrooms connected to the bedrooms. The Villa housed “46 grossly retarded patients and two less retarded but physically very dependent” (HDEU, 1979, p. 28). A shower was also connected to the Occupational Therapy department.¹⁶⁷ It was proposed that the separation of the bedrooms and bathrooms from the “day” facilities “seemed to be intended to give the patients at least some feeling of the normal daily routine of leaving and returning home” (HDEU, 1979, pp. 28-30).

Figure 44

HDEU 1979 Study of Inpatient Accommodation: Villa C5



Note. *Psychopaedic Services Hospital Facilities: A Study of In-Patient Accommodation* (p. 29), by Hospital Design and Evaluation Unit, 1979, Department of Health. CC-BY 4.0.

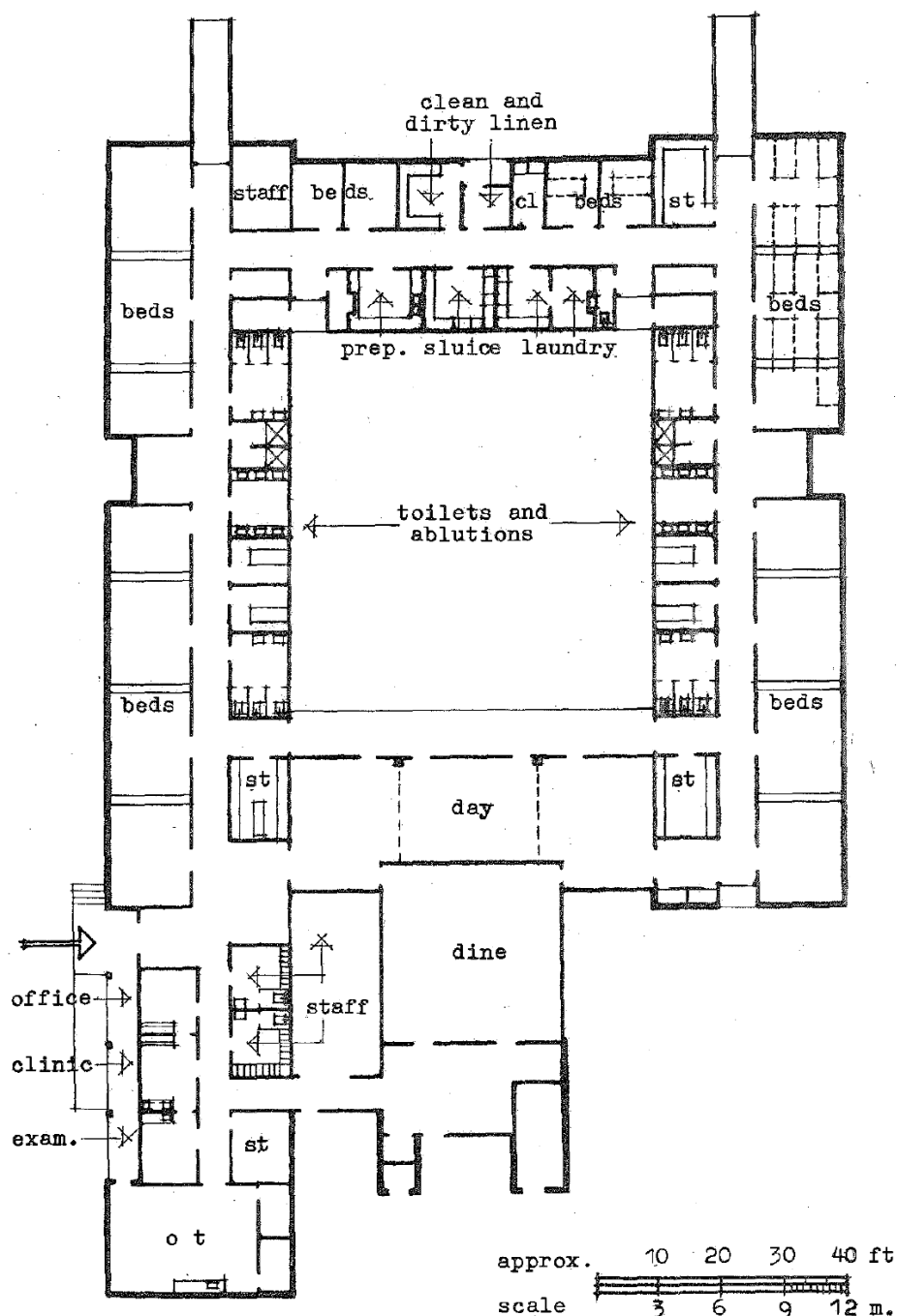
¹⁶⁷ Although the report states “there was no evidence that the occupational therapy room received any use” (p. 30)

Appendix VI

Villa D. This was designed as four connected units, with a smaller number of beds somewhat connected to shower/bath and toilet facilities across the hall. As with the other Villa, social spaces were not connected to the units, but were rather separate collective spaces.

Figure 45

HDEU 1979 Study of Inpatient Accommodation: Villa D



TYPE D

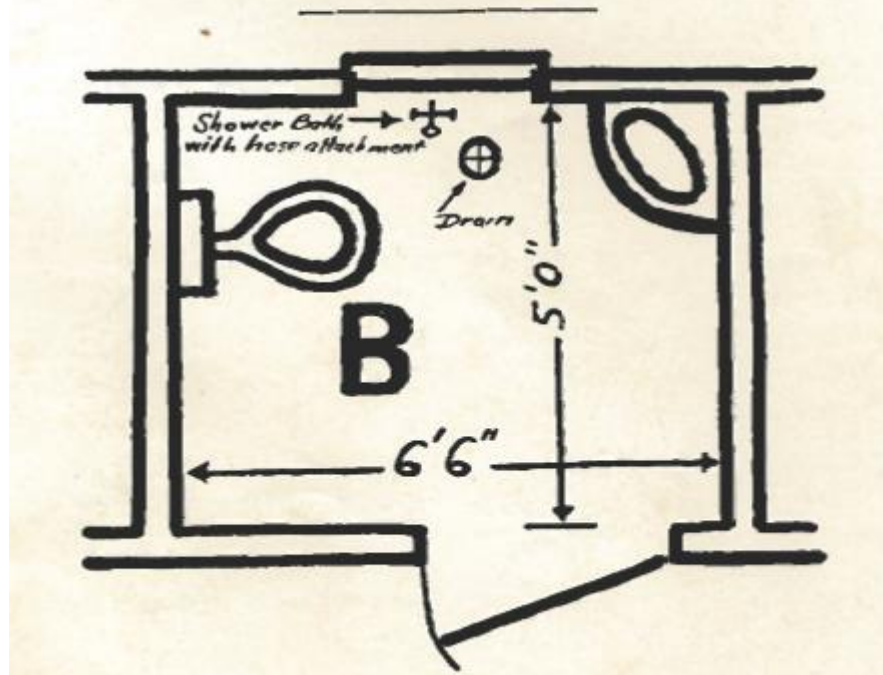
Note. *Psychopaedic Services Hospital Facilities: A Study of In-Patient Accommodation* (p. 31), by Hospital Design and Evaluation Unit, 1979, Department of Health. CC-BY 4.0.

Essay 5 Rehabilitation Showers for Independent Disabled-People

Bathroom B (see diagram) has proved to be an excellent arrangement for a Polio who prefers a shower. The floor has a drain. For a shower, the patient sits on the water-closet seat and has a needle shower attached to a rubber hose, with its mixing valve conveniently located at hand.

The toilet seat is preferred to a stool or chair in that it prevents the dangerous possibility of slipping.

The corner lavatory in this instance is quite convenient.



H.J. Toombes' Arrangement for a Polio who Prefers a Shower (1931)

In 1931, a drawing of a shower room that “can materially add to a polio patient’s comfort” (Toombs, 1931, p. 4) emerged from the Roosevelt Warm Springs Institute for Rehabilitation. This shower room was designed for “Polio Patients” to be able to shower “Independently”. In this Essay, my focus is on a second collective, confined space. However, rather than being connected to the permanent custody of Disabled-People, these were Rehabilitation spaces, designed to transform Disabled-People and reconnect them to Family-Homes. In this Essay, I analyse the discourses and governmentalities associated with the idea that Disabled-People could be transformed to become an asset to the nation. This led to their containment and subsequent release from disciplining facilities such as Warm Springs.

Disciplining Disability

As noted in Essay 2, anatomo-political discipline emerged in the mid-1700s as a biopolitical governmentality to normalise individuals within populations. Delabost’s prison cell showers (Essay 1) and Bresgen’s Army-Division-Shower-Bath-Facility (Essay 2) were brought into existence by discourses that sought to reduce disease and improve productivity. The therapeutic operations of these showers made it possible to produce docile bodies, Showerees who were subjected to external ordering of activity, timing of actions, and movement of body parts (or as Foucault [1975/1995] would describe it, “efficient gesture”). Another feature of discipline is establishing “the body-object articulation” (Foucault, 1975/1995, p. 152). Foucault (1975/1995) explained that in relation to body-object articulations:

Discipline defines each of the relations that the body must have with the object that it manipulates. Between them, it outlines a meticulous meshing... fastening them to one another. It constitutes a body-weapon, body-tool, body-machine complex. (pp. 152-153)

Objects and bodies thus become a body-object complex or a synthesis of what may have been conceived of previously as separate objects. The emergence of body-object articulations with a discourse of Rehabilitation of Physically-Disabled-People is an important feature of the dispositif within which showers modified for Disabled-People were established. The body-object articulations associated with Disabled-People within the Rehabilitation discourse aimed to produce “Independent” subjects, which I discuss throughout this Essay. Foucault (1975/1995) connected, the production of such complexes with the physical capital of the nation:

Thus disciplinary power appears to have the function not so much of deduction as of synthesis, not so much of exploitation of the product as of coercive link with the apparatus of production. (p. 153)

I first briefly outline the connection between Disabled-People, Body-Object articulations, and industry before analysing another confined, collective, but this time

temporary, space that was established for the Rehabilitation of Physically-Disabled-People

As Hamraie (2017) explained, in the early to mid-1800s an interest in the interactions of bodies with machinery emerged and body-object articulations became central to industrialised production:

Viewed by industrial managers as extensions of factory machinery, users' bodies became manipulable and engineerable. Body, energy, and labor were entangled in the possibility of a compliant and malleable user, who would be responsible for the smooth functioning of the industrial system. (p. 44)

At this time, the human factor was taken to be uniform—a standardised anthropometric body. It was the upright male, who was able to articulate with the standardised factory or war machine; while females, the disabled, the defective, the diseased, were not counted at all (Hamraie, 2017). However, alongside anthropometrics, a discourse of Rehabilitation was emerging for Veterans (a subject I return to in Essay 6).¹⁶⁸ In response to acquired physical injuries, artificial mechanical limbs emerged which aimed to perform as “functional and mechanical extensions of the working body” (Hamraie, 2017, p. 51). In contrast to anthropometrics, where body-object articulations were designed for a normed upright male, the Rehabilitation prosthetic required close attention to the specifics of the individual (Hamraie, 2017), an important point I return to later.

During and following World War I, a renewed interest in the transformation of Soldiers who were ‘crippled’ emerged. The idea of “The Engineer, the Cripple and the New Education” (Gilbreth & Gilbreth, 1917) connected discipline to Disabled-People and aimed to connect a greater number of people to the standardised factory machine. In addition to the established practice of training bodies for efficient movement,¹⁶⁹ Gilbreth and Gilbreth (1917) proposed that the Engineer could be involved in inventing or creating body-object articulations that would connect Cripples to the apparatus of production, or even “improve on nature” (p. 11). In addition to injured Soldiers, such devices could address “the problem of the cripple in general” (p. 3) such as the “industrial” cripple, or even the “unmaimed worker” (p. 11).¹⁷⁰ As noted in Essay 4, at this time the Fordist disciplinary society was emerging, in which individuals were

¹⁶⁸ See also Williamson (2019) for a detailed discussion of prosthetics in the USA following World War II.

¹⁶⁹ Gilbreth and Gilbreth (1917) also connected this idea of disciplinary training to the subjects discussed in Essay 4, stating that “this new education... which originated in an effort to discover the best method of training subnormals, proved so successful in that field and demonstrated such underlying principles of general applicability that it now occupies an important place in the training of normal and subnormal children... is spreading through the general interest in reeducating military cripples to the reeducation of all cripples, into the manual training schools, corporation schools and the general education fields” (pp. 4-5)

¹⁷⁰ For example, workers could have an extra number of limbs at their disposal.

connected to discipline through a network of institutions spread throughout society (Fraser, 2003). Factories were one such institution, and in Ford's own factory "Blind men" and "Cripples" worked alongside "wholly able-bodied" men within the assembly line of production:

We have found it possible, among the great number of different tasks that must be performed somewhere in the company, to find an opening for almost any one and on the basis of production. The blind man or cripple can, in the particular place to which he is assigned, perform just as much work and receive exactly the same pay as a wholly able-bodied man would. We do not prefer cripples – but we have demonstrated that they can earn full wages... There were 7,882 different jobs in the factory... 670 could be filled by legless men, 2,637 by one-legged men, 2 by armless men, 715 by one-armed men, and 10 by blind men... their production was about 20 per cent., I believe, above the usual shop production... They slept and ate better and recovered more rapidly. (Ford, 1922, pp. 79-80)

Ford advocated for the idea that subjects who may have been seen previously as units of unsound physical health had body parts that could articulate with objects within the factory. Importantly, this productivity was good both for the factory and the individual who would benefit (better sleep, eating better, recovering more quickly) through their participation in work.

While in the USA there was a clear connection between factory machinery and Engineering the Cripple, in Aotearoa New Zealand, where the landscape of work was very different to the USA, the ability of Physically-Disabled-People to fit into the jobs that were needed was limited (Fadyl, 2013). However, artificial limbs were produced locally that aimed to connect subjects to work. Constructed from recently invented metal alloys and "vulcanised" rubber, "limbs" were designed for dressing or to hold "a table knife... a claw or a riveting hammer... a file or a chisel... a shovel, a saw, and knives for such purposes as boot repairing, hedge cutting, rabbit skinning... The idea was to restore a limbless man his independence" ("Artificial Arms", 1924, p. 3). While a limbless subject may have been considered dependent in the past, the emergence of body-object articulations designed for Physically-Disabled-People made it possible for them to be transformed into someone who was "Independent" and potentially connected to the apparatus of production.¹⁷¹ Though it may have been possible for a body-object complex to produce this transformation, the addition of training bodies for efficient movement was an important development in the Rehabilitation discourse. Next, I discuss the confined, collective Rehabilitation spaces that were established for such training in the early 1900s and analyse the showers that emerged within them.

¹⁷¹ See Gibson (2016) for a critical analysis of assemblages and the idea of In/dependence in relation to Rehabilitation.

Hydropathy, Hydrotherapy, and the Disciplining Hospital

The idea of the hospital, as a space to contain units of unsound physical and mental health appears to have existed from the end of the 2nd millennium BC (Cilliers, 2002). However, Foucault (1978/2016) explained in “The Incorporation of the Hospital into Modern Technology” that before the 1700s hospitals were primarily spaces of exclusion for the diseased poor, where they could be ministered to until their death.¹⁷² He suggested that in the middle of the 1700s such hospitals came to be seen as dangerous, a centre for economic and medical disorder. Hospitals then entered into an art of anatomo-political discipline. Technologies were employed for the spatial distribution of individuals to surveil and evaluate them, and transform them from the diseased to the productive.¹⁷³

Patients would be individualized and distributed in a space where one could oversee them and record the events that took place; one could also modify the air they breathed, the temperature of the environment, the water to drink, the regimen, so that the hospital panorama imposed by the introduction of discipline had a therapeutic function... it would be necessary to create about each patient a small individualised space environment, specific to them and modifiable according to the patient, the disease, and its evolution... the architecture must be the agent and instrument of care. (Foucault, 1978/2016, pp. 211-212)

While the Large-Permanent-Home discussed in Essay 4 was a space for exclusion from life, at around the same time a very different confined, collective space emerged. This was a disciplining hospital space, a Rehabilitation Facility where the architecture would become “the agent and instrument of care” for Disabled-People.

In the early to mid-1900s, Rehabilitation Facilities would become established in Aotearoa New Zealand to temporarily contain injured-soldiers, and later those with Poliomyelitis (Polio). Interestingly, although a Hydropathy discourse had fallen out of favour, these facilities would initially be connected to natural hot springs in Aotearoa New Zealand, USA, and England. As noted in Essay 3, natural hot springs became connected to showers, health, and tourism in the early 1900s. The connection between hydropathy and Soldiers can be traced back to a number of such English hydropathic hotels (some in disrepair) being annexed to treat soldiers during World War I (Sawdon, 1917; Webb, 2006). The therapeutic effects of “radio-active waters” were used to treat

¹⁷² “Before the 18th century the hospital was essentially the institution of assistance of the poor. It was at the same time an institution of separation and exclusion. The poor, as such, required assistance; and as a patient, he was the carrier of disease and risked spreading them. In sum, he was dangerous. Hence the necessity of the existence of the hospital, as much to keep him apart as to protect others from the dangers he represented. Until the 18th century the ideal person of the hospital was not the patient, there to be cured, but the poor person on the point of death. It is a question of a person who needs help, material and spiritual, who has to receive final care and the last rites. This was the essential function of the hospital” (Foucault, 1978/2016, pp. 201-204).

¹⁷³ Bresgen’s Army-Division-Shower-Bath-Facility in Essay 2 was similarly designed for the same purpose.

ailments such as “rheumatism, fibrositis, neuritis, shell shock, neurasthenia, spondylitis” (Sawdon, 1917, p. 42). In particular, the “Scotch douche” which applied alternating hot and cold water to the spine was “most useful in shell shock” (Sawdon, 1917, p. 43). Just as the showers of the asylums employed pipes, water, temperature, time, and pressure to normalise the brain and the mind, these showers applied water to a body part to transform unseen sites of disorder within.

In Aotearoa New Zealand, two such spas (in Rotorua and Hanmer Springs) became attached to hospitals (King George V Hospital and Queen Mary Hospital respectively) and were employed to treat soldiers returning from World War I. As part of the military hospital, the springs were used to treat rheumatism (Maclean, 1932), shell shock, and neurasthenia (“Returned Soldiers”, 1923). In Rotorua, children with infantile paralysis or “Polio” were also treated (“Soldier Patients”, 1921). Both hot springs functioned as tourist destinations prior to and after their connection to the military hospitals (Dixon, 2020; “The Hanmer Hot Springs”, 1896, p. 5).¹⁷⁴ As shown in the two photographs below, there appears to be little difference between the Tourist (Figure 46) and the Solider (Figure 47) shower:

¹⁷⁴ Indeed, I have been a tourist in both destinations myself – here I am at the Hanmer Springs Queen Mary Hospital, the site of New Zealand’s first Occupational Therapy Department:



Note. Photo of me at the closed Queen Mary Hospital Occupational Therapy Department by K. Davies, 2020. Reprinted with permission.

Figure 46

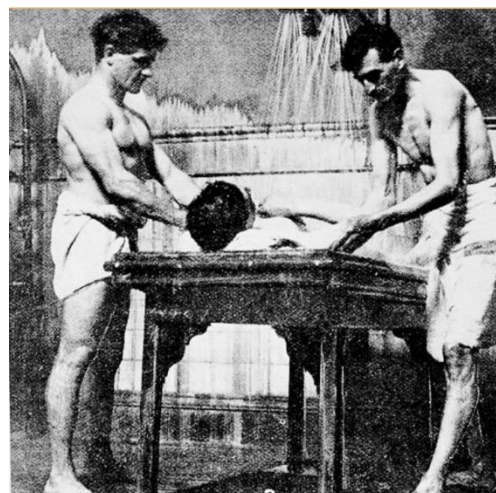
1926 Tourist Aix massage douche, Sanatorium, Rotorua



Note: From "Aix massage douche, Sanatorium, Rotorua", Ca. 1926, Alexander Turnbull Library. CC BY-NC-SA 3.0.

Figure 47

1916 Soldier Treatment, King George V Hospital



Note. From "King George V Hospital", 1916, <https://nzhistory.govt.nz/media/interactive/king-george-v-hospital>. In the public domain.

In the photographs, the tourists and their attendants wear bathing suits, while the Soldier and his attendants are mostly naked, suggesting the necessity for the water to communicate directly with the body.¹⁷⁵ The tourist and the soldier are docile bodies, and as such the temperature, force, and direction of the water are controlled by the attendants and shower assemblages.

In the early 1900s, in response to the Polio epidemic, Physicians began recommending warm baths and swimming for treatment of paralysis (Lovett, 1916). "Hydro-therapy" or the application "warm baths, hot limb baths, hot and cold douches, wet or dry hot packs" (Vulpius, 1912, p. 31), to improve blood flow was recommended for the treatment of paralysis. Therapies prevented "atrophy of muscles, contractures, circulatory disturbance, tropic lesions of the skin and impairment of growth" (Vulpius, 1912, p. 33). While there would seem to be little difference between the discourses connecting health and water that Physicians were employing and 1800s Hydropathy,

¹⁷⁵ Given there is no text connected to the photos, it is difficult to determine the discourses that justified this difference. It is possible that the body of the patient is seen as the territory of the physician and the therapeutic operations of the water override a desire for privacy, such as was seen in Bresgen's Army-Division-Shower-Bath-Facility. It is also possible that the comradery of the Soldiers means that they are expected to tolerate being naked together, as the Miners in the Changing-Rooms-&-Baths-for-Miners were. It is also possible that the dress of either the tourist or the soldier was particular to the moment, set up for the purpose of the photograph. In Hanmer, bathing suits were forbidden for tourists until 1978 (see Young, 1998).

the term Hydropathy was falling out of favour and came to be replaced by Hydrotherapy. This shift is interesting because it suggests a strategic elaboration in the dispositif from a discourse of employing the pre-discursive effects of water on the unseen interior of the body¹⁷⁶ to the discipline of applying water in a prescribed way.¹⁷⁷

The most well-known facility for the treatment of Polio was Warm Springs (the site of the Arrangement-for-a-Polio-who-Prefers-a-Shower pictured above). Warm Springs had originally been a space where Indigenous peoples reportedly made use of the natural hot springs to recover from war wounds (Georgia Warm Springs Foundation, 1947). Converted into a spa tourist resort in the late 1800s, but having fallen into disrepair by the 1920s, the hot springs were then employed to treat Polio. In a strategic elaboration of the site, the resort was reborn through a discourse of Hydrotherapy for the treatment of Polio.¹⁷⁸ As a disciplining space, where the architecture could be an “agent and instrument of care” (Foucault, 1978/2016, p. 212), the facility needed to be designed specifically for the patient and the disease. Initially a patient at the resort, Franklin D. Roosevelt purchased Warm Springs so that it could be converted into a facility for the treatment of Polio.¹⁷⁹ As Roosevelt (1940) explained, hydrotherapy was a useful “experiment”; however, the conditions of the facility and the buildings themselves needed to participate to ensure scientific care:

The conception of the Foundation at Warm Springs was an experiment in treating by hydrotherapy individuals who had been handicapped as a result of infantile paralysis, and in caring for them under certain psychological, climatic and geographical conditions not always present in the usual hospitalization of such patients. Such an institution really required building from the very base and necessitated at the same time maintaining a flexibility that would enable it to conform to any changes in the scientific care of the after-effects of infantile paralysis.

(p. 3)

¹⁷⁶ “-pathy word-forming element Meaning “feeling, suffering, emotion; disorder, disease”, from Latin -pathia, from Greek -patheia “act of suffering, feeling” (from PIE root *kwent(h)- “to suffer”). Meaning “system of treatment of disease, method, cure, curative treatment” is abstracted from homeopathy (q.v.).” (Harper, n.d.b).

¹⁷⁷ “therapy (n.) 1846, “medical treatment of disease”, from Modern Latin therapia, from Greek therapeia “curing, healing, service done to the sick; a waiting on, service”, from therapeuein “to cure, treat medically”, literally “attend, do service, take care of”. (Harper, n.d.c).

¹⁷⁸ See Lippman (1977) for a detailed account of the establishment of the facility.

¹⁷⁹ Initially the resort was designed to accommodate both paying “first-class” holiday makers alongside treatment for Polio. However, “the vacationers were worried about becoming infected by sharing a pool with the polios, and the polios resented the disapproving looks they got” (Lippman, 1977, p. 47). By 1927, the resort became exclusively for the use of Polio treatment (Lippman, 1977).

The disciplining hospital needed to be a collective, confined space designed “from the very base” to produce psychological, climatic, and geographical conditions for care and hydrotherapy treatment “modifiable according to the patient, the disease, and its evolution” (Foucault, 1978/2016, p. 211).

Warm Springs included typical features of disciplining spaces, such as gathering discipliners (physicians, physiotherapists, nurses) and docile bodies together in an enclosed space.¹⁸⁰ A Hydrotherapy discourse that constructed the shower as a therapeutic agent, attempted to divorce the practice of discipline from the historical “magical properties” of the hot springs.¹⁸¹ However, the origin of the space as a tourist destination was not entirely lost, and would become an important distinction from the disciplining hospital:

You see crutches in use, and canes, and braces. But not for a moment do you find anything which seems like a sanitarium or a hospital. There is, when you come and when you go, and all the while you've stayed, the spirit of a country club or a hotel at some popular resort. Serious as is the work carried on—strictly scientific as is every part of the procedure, there is, somehow, nothing institutional, nothing oppressively “organized.” The machinery of routine is kept almost incredibly human. There seems only a simple, common-sense schedule for the day's hard work-out, then every chance for rest and recreation in the grove of pines and oaks where the Foundation family has its habitation.

(Donnelly, 1932, p. 3).¹⁸²

Warm Springs was a space unlike any other space. A space of juxtapositions where the practice of disciplinary power (scientific procedure, machinery of routine, schedule, the day's hard work-out) occurred within the aesthetic of a space of leisure for the

¹⁸⁰ As noted in my methodology chapter: “This constant supervision of a discipliner is enhanced by the creation of spaces in which the subjects can be brought together and made visible. Such spaces are characterised by “enclosure, the specification of a place heterogeneous to all others and closed in upon itself. It is the protected place of disciplinary monotony” (Foucault, 1975/1995, p. 141). The concentration of subjects into these disciplinary spaces further functions to “eliminate the effects of imprecise distributions, the uncontrolled disappearance of individuals, their diffuse circulation, their unusable and dangerous coagulation” (Foucault, 1975/1995, p.143).

¹⁸¹ “Magical properties of the warm springs long have been discredited” (Georgia Warm Springs Foundation, 1947, p. 4).

¹⁸² Rogers (2009) gives a detailed account of the maintaining the resort aesthetic of Warm Springs and the establishment of the Warm Springs Foundation.

wealthy (a popular resort, human, rest, and recreation). Warm Springs appeared to be outside of society, performing as the disciplining hospital, but appearing as a luxury spa resort. Foucault might describe such a space as a heterotopia, or a space that represents, contests, and inverts the “real” world. While the hospital and the resort might be juxtaposed by Donnelly, the “spirit” of a space to visit, the “incredibly human” routine and the establishment of the “Foundation family” (which I discuss further in Essay 6) were essential in the “effectively enacted utopia” (Foucault, 1967/1986), for disciplining the subject. Just as the atmosphere of the psychiatric hospital was an important operator for maintaining a connection of the disciplinary society, the architecture of the Rehabilitation facility was designed to maintain a link to the ‘inside’.

Rehabilitation Shower Arrangement-for-a-Polio-who-Prefers-a-Shower

Unlike the feeble-minded children of the Large-Permanent-Home discussed in Essay 4, the children and adults attached to a space such as Warm Springs had been afflicted by an external contagion or object. The danger of individuals handicapped by Polio or crippled by injury was limited to the effects of their paralysis, as opposed to the risks to society presented by the genetics of the untrainable, criminal, and reproductively prolific subject of a Eugenics discourse. They had been of sound physical and mental health before the disease or injury attached itself to them. Importantly, therapies led to the possibility of transformation, or “complete functional recovery” (Lovett, 1916, p. 19). Thus, it was thinkable that they might be able to be released from the “outside” space of the heterotopia, and return to the “inside” as an asset to society. Indeed, not only was this return to society possible, but it was a requirement for admission at Warm Springs:

It is at once apparent that the Foundation's Polio Institution can make no real dent in this national problem, nor could it do so were its facilities and funds multiplied by ten. It must serve as an example and inspiration, a catalytic agent, the yeast in the loaf of bread. And the direct treatment of patients in the Institution can be only a part of the Foundation's broader program.

It is, therefore, our purpose to select from the applicants for admission unusual individuals as patients, those who can go home and help carry on the battle.

(Georgia Warm Springs Foundation, 1934, pp. 2-3)

In contrast to the Large-Permanent-Home designed to remove Disabled-People from society's conscience, the Polio Institution is designed to be visible, to “serve as an example and inspiration” (Georgia Warm Springs Foundation, 1934, p. 2). A “catalytic agent” designed to transform, but just part of “the Foundation's broader program”. Established within a disciplinary society, the Polio Institution is a disciplinary space within a network of institutions spread throughout society.

A Fordist governmentality employed discipline to produce self-governing subjects. As such the purpose of the “Direct Treatment” of the individual within the Polio Institution at Warm Springs was to “secure independence”:

The object of this training is to secure independence. To be entirely independent, the patient must be able, first, to stand and walk on a level surface without the aid of another person. It may mean that artificial support such as braces, crutches or canes is necessary, but at least it must be done alone. The second necessity is to get up from a chair into a standing position and then sit down again, unaided. The third and hardest is the ability to go up and down stairs either with or without a railing.

Patients are often afraid to try to do new and different things which are necessary to their independence. But if these things are attempted systematically under daily supervision they can be done quite safely and without fear.

(Plastridge, 1931, p. 3)

Patients become discursively constructed as *entirely* Independent if they were able to “to stand and walk on a level surface... get up from a chair to a standing position and then sit down again... to go up and down stairs”. Body-object complexes were included in the construction of this *entirely* Independent subject (“artificial support such as braces, crutches or canes”), but these movements “must be done alone”. Thus, the body-object complexes become more than articulations with factory machinery, they become a transformed subject, who “without the aid of another person”, “alone” and “unaided” can stand, walk, sit and step up.¹⁸³

In addition to being able to achieve and maintain correct movements (or efficient gestures) to stand and walk, being able to step up is a distinguishing feature of such Independence. The problem of the “step” is an important point that I return to shortly. However, in addition to these specific movements, a more general “endurance” and “ability to take care of his personal needs” and “do all of the normal activities of everyday life” without human assistance qualified subjects from Warm Springs to return to society (or “an environment of normal associates”):

¹⁸³ For further discussion regarding this conceptualisation of Independence see Fine and Glendinning (2005); and Gibson (2016) for a critical analysis of assemblages and the idea of In/dependence in relation to Rehabilitation.

During the latter part of the prescribed treatment program, every effort is made to fortify the individual with sufficient endurance to fit him again into an environment of normal associates. He is taught to get up and down from a sitting position without assistance, to get in and out of bed, and otherwise take care of his personal needs. In so far as possible he is trained to do all of the normal activities of everyday life with as little assistance as possible. Thus not only is the individual made more independent but the necessity of his depending on an attendant or some member of the family is reduced.

(Georgia Warm Springs Foundation, 1940, pp. 28-29)

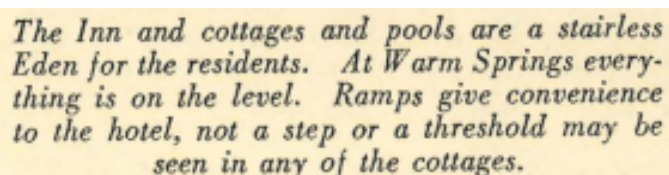
A new subject, Disabled but Independent of human assistance, emerged from Warm Springs. Not only able to stand, walk, sit, and step, but able to “do all of the activities of everyday life with as little assistance as possible” (Georgia Warm Springs Foundation, 1940, p. 28) (i.e., to Independently perform essential everyday activities). Returned from the “outside” to the Family-Home, they became a body that depended on objects, while the cost of “depending on an attendant or some member of the family is reduced” (Georgia Warm Springs Foundation, 1940, p. 29). Within this discourse, reliance on human assistance is not the right way to live. It is the nemesis of the self-governing individual, the sign of an unfavourable subject who is a cost to the health and wealth of the nation.

As an agent and instrument of care, the atmosphere and buildings of Polio Institution also needed to be active in the production of these new subjects. The aesthetic of the space, of a resort in the instance of Warm Springs, maintained the connection between familiar spaces within society and the disciplinary space. Just as designs for Mental Hospitals had employed architecture to connect or reconnect patients to the community, Rehabilitation facilities for Polio-Patients sought to maintain a connection to the “outside”. In New Zealand, King George V and Queen Mary Hospitals were also connected to the Spa Resort, while a facility designed for children was connected to an aesthetic of “home”.¹⁸⁴ In contrast to the custodial institution which should be a “permanent home” (Pomare, 1923) the “home” for those “crippled” by polio was temporary, and designed to maintain an aesthetic of the Family-Home: “Twenty-five crippled but happy and excited children left the Auckland hospital... for the Wilson Home... The aim of the board and the staff is to make it as homelike as possible and to avoid the institutional atmosphere” (“Wilson Home”, 1937, p. 10). Within a

¹⁸⁴ Indeed, while initially children with Polio were attended to in hospitals, particularly hospitals that had been built or annexed for injured soldiers, Aotearoa New Zealand’s first hospital for children with Polio was the former beach front home of benefactors (Ross, 1993). Adaptations included the addition of hydrotherapy baths (Ross, 1993).

Rehabilitation discourse, the institutional atmosphere was seen as a danger. Architecture with an aesthetic of spaces within society maintained a connection to the disciplinary network, and would assist in the production of subjects who may be returned to that society.

However, within Rehabilitation facilities, such as Warm Springs and the Wilson Home, a contradiction emerged. While a discourse of Rehabilitation producing Independent, self-governing subjects became established, the Independent subject was a complex of body-object articulations, whose “third and hardest” (Plastridge, 1931, p. 3) hurdle was to step up and down stairs. Although Rehabilitation training held the promise of such transformation, the architecture of the facility “from the very base” (Roosevelt, 1940, p. 3) was also being enlisted to treat the patients and, as such, was designed to produce Independent subjects who could not yet stand, walk, or step. Thus, the idea of architectural design for Disabled-People was born (later to be known as Disability or Accessible Design), and Warm Springs became a “Stairless Eden”:



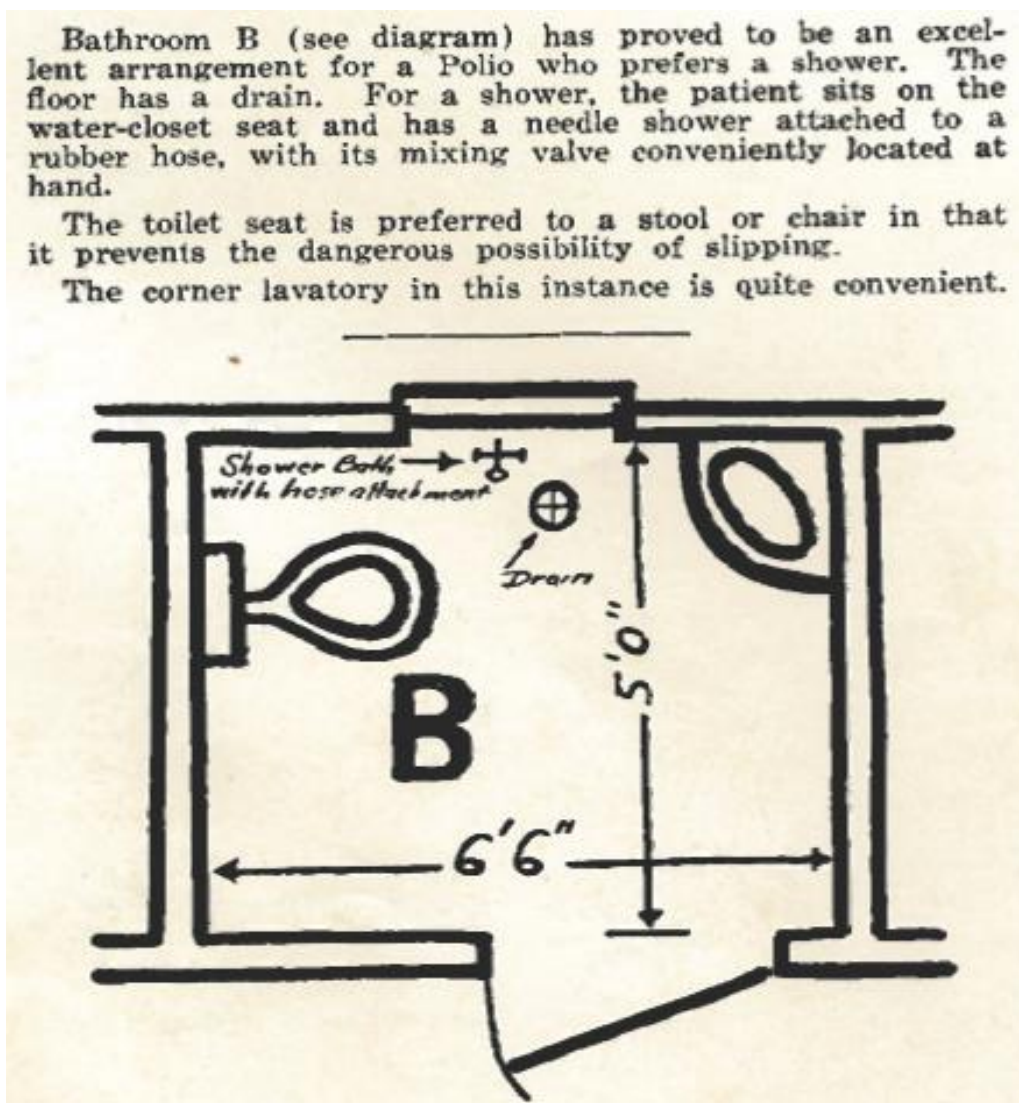
The Inn and cottages and pools are a stairless Eden for the residents. At Warm Springs everything is on the level. Ramps give convenience to the hotel, not a step or a threshold may be seen in any of the cottages.

(Donnelly, 1932, p. 6).

It is within this stairless Eden that the architectural suggestion for “bathroom B”, an “Arrangement for a Polio who Prefers a Shower”, emerged (Figure 45):

Figure 45

1931 Warm Spring's Bathroom: Arrangement for a Polio who Prefers a Shower



Note. From "Architectural suggestions," by H. J. Toombs, 1931, *The Polio Chronicle*, 1(3), p. 4. Reprinted with permission.

The Warm Springs Arrangement-for-a-Polio-who-Prefers-a-Shower was a hygiene shower. In some ways, it was a shower room; in other ways, it was a shower cell. The absence of a step to partition the shower off from the rest of the bathroom meant that the entire room became a showering room. The space was thus not dissimilar to the large shower rooms of Delabost's Ablution-System or Changing-Rooms-&-Baths-for-Miners (see Essays 1 and 2). However, as there was only one shower in the room, the entire room functioned as a cell, creating the possibility for an individual to shower alone. Furthermore, unlike the Psychopaedic-Shower-Room of the Permanent Home, the shower was within a bathroom. There was a handbasin, and a toilet seat that may be used as both a toilet and a seat. The shower room could function as a compact bathroom that might have been attached to a hotel bedroom. It was also a shower cell

with a seat, like Gerhards 1908 Rain-Bath-Compartment (see Essay 3). However, there was no step at all, not even the shrunken bath/shower tray of Gerhards Rain-Bath-Compartment. Toombs (1931) stated “the relative locations of the fixtures in a bathroom can materially add to a Polio patient’s comfort... Also, the bathroom should be sufficiently large that a wheel chair may be easily turned around” (p. 4). The materiality of the Arrangement-for-a-Polio-who-Prefers-a-Shower meant that it was comfortable and convenient for those who could not stand, walk, or step up. It could accommodate the Independent body-complex that Warm Springs aimed to produce. Furthermore, just as showers had become sufficiently comfortable and convenient for homeowners to install in private dwellings at this time (see Essay 3), the Arrangement-for-a-Polio-who-Prefers-a-Shower emerged as a shower for comfort and convenience. It was designed to suit the preferences of a self-activating, self-regulating, Independent Polio-wheelchair complex. This was a subject who would be self-governing through their preferences but whose choices were dependent on the architecture of the Rehabilitation space, which was, in turn, attached to their disease and the discourses employed to discipline it.

Architecture as a Practice of Exclusion

The Warm Springs Arrangement-for-a-Polio-who-Prefers-a-Shower connected Disabled-People who could not stand or step up to a comfortable and convenient way to invest in their hygiene. The possibility of a wheelchair-body complex being able to shower as an everyday essential activity within one’s own home seems like it may have been resolved. However, upon exiting the stairless Eden, it became apparent that the architecture of the “world” was full of steps and stairs, unfriendly to those who did not easily stand erect or struggled to step:

One of the things a person deprived of the customary use of his limbs comes to realize is how full of stairs the world is. Steps up and steps down, so many beautiful stone stairways without a sign of a hand railing to give friendly aid. Going up stairs normally means putting all the weight of the body on one foot when a step up or a step down is taken. Even people with perfectly good legs are prone to puff a bit before the top is reached and it is generally known that stair climbing puts a strain on the heart. Yet stairs everywhere prevail.

(Donnelly, 1932, p. 6)

What the stairless Eden reveals is the politics of architecture in the world outside of the Rehabilitation facility. Although it may now seem thinkable for the Arrangement-for-a-Polio-who-Prefers-a-Shower to be attached to a private dwelling as a hygiene shower, it only appears to have materialised within other institutions as a discursive object of hydrotherapy at this time (see “Treating Arthritis”, 1932, Appendix I). The possibility of such showers within private dwellings would come a considerable time later (see Essay 6).

In contrast to the Warm Springs Arrangement-for-a-Polio-who-Prefers-a-Shower, the showers of the private dwelling became visible as a space of exclusion. As I have argued in Essays 1 and 2, the private domestic shower was born from disciplinary spaces in which the body needed to be upright to be surveilled. While the bath had remained a space in which one could recline in a private dwelling; strong, upright bodies were connected to the shower. As a product of a Sanitation discourse, the Properly-Plumbed-House required that wastewater from the shower be confined since “by completely removing as speedily as possible all waste matters from the dwelling by pipes... the danger of infection arising from defective drainage and plumbing may be reduced to a minimum” (Gerhard, cited in Plunkett, 1884, p. 111). As such, the Bath, even when shrunk down to standing room only in the tray of the Rain-Bath-Compartment, must be a container, to be stepped into and out of. The confined, collective space of the Rehabilitation facility, designed “from the very base” (Roosevelt, 1940, p. 3) as a Stair Free Eden might permit a shower room that can be wheeled into and out of. However, the shower of the private dwellings remained an appendage, an attachment to a building that was not designed to be friendly to those who could not stand, walk, or step up. The shower was part of a society where “stairs everywhere

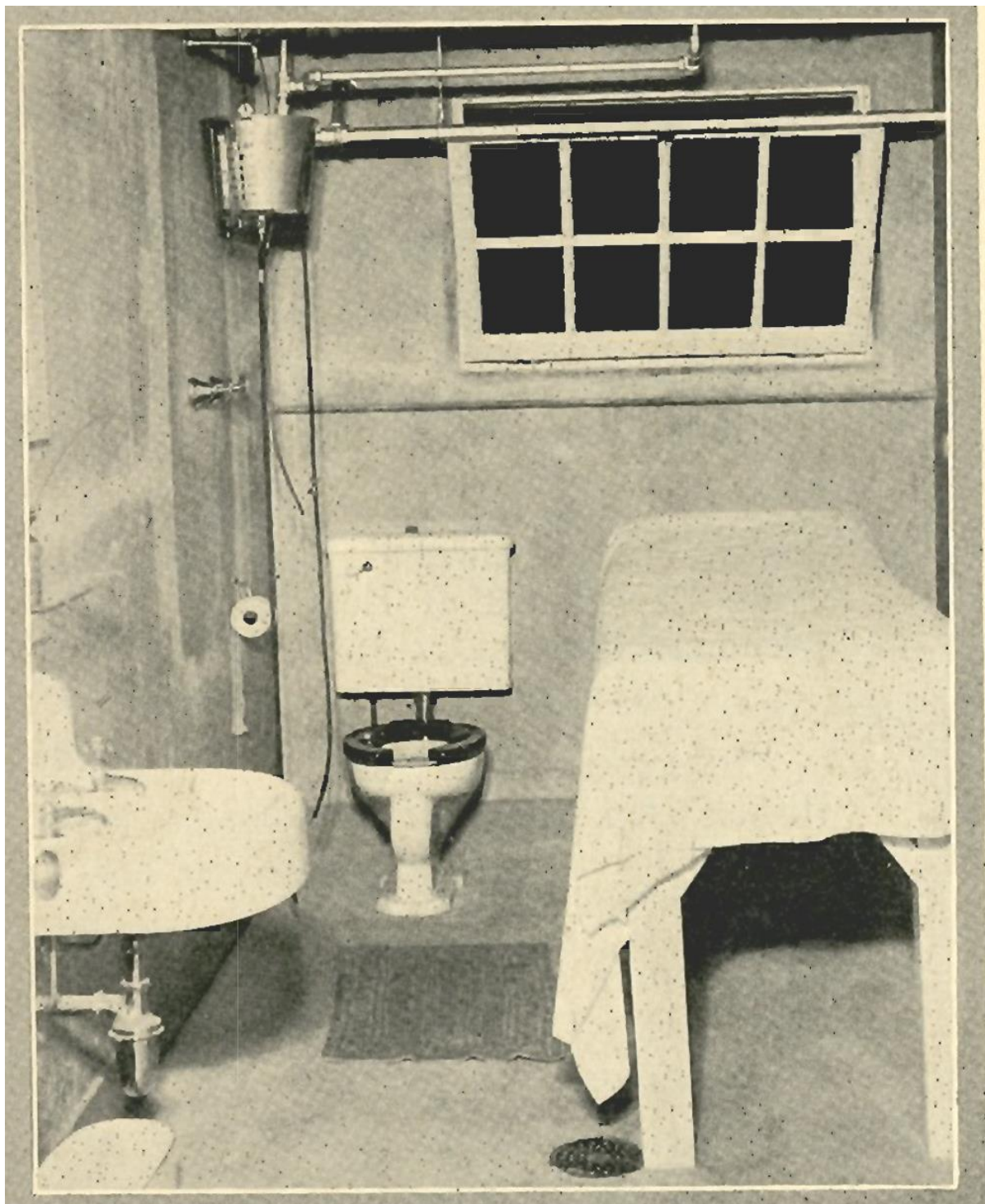
prevail” (Donnelly, 1932, p. 6). Born as a cell within which upright bodies would stand, commitments were made to this design within the private dwelling reducing the flexibility of design from this point on (Winner, 1980). The Warm Springs Arrangement-for-a-Polio-who-Prefers-a-Shower made a shower that was comfortable and convenient to those who could not stand or step up a thinkable thing. However, the failure of such shower design to escape the disciplining hospital reveals the politics of the initial design of the private shower which excluded Disabled-People and divided them from society.

Summary: Rehabilitation Showers to Produce Independent Disabled-People

Within the dispositif that emerged to reduce the cost of units of unsound physical and mental health to the nation, the Rehabilitation discourse aimed to produce Independent Disabled-People who could return to the Family-Home without depending on an attendant or family member. This discourse, employing Hydropathy, and later Hydrotherapy, connected Soldiers wounded by war, and bodies paralysed by Polio to particular collective, confined spaces. As part of the disciplinary society, these spaces had an aesthetic that maintained connections with the “inside” and aimed to return Independent subjects to society. However, these spaces were also Disciplining Hospitals, distinguished from the outside world by being designed according to the patient and their disease to act as an agent and instrument of care. Within this “Stairless Eden”, the Warm Springs Arrangement-for-a-Polio-who-Prefers-a-Shower emerged, making a shower for those who could not stand and step up a thinkable thing. Within this shower the Disabled-Person was no longer an object to be showered or surveilled by the nurse—they are a Showerer, able to turn the shower on and off at will, to attend to the pressure, temperature, and duration of the shower, and to maintain the private territory of their body.

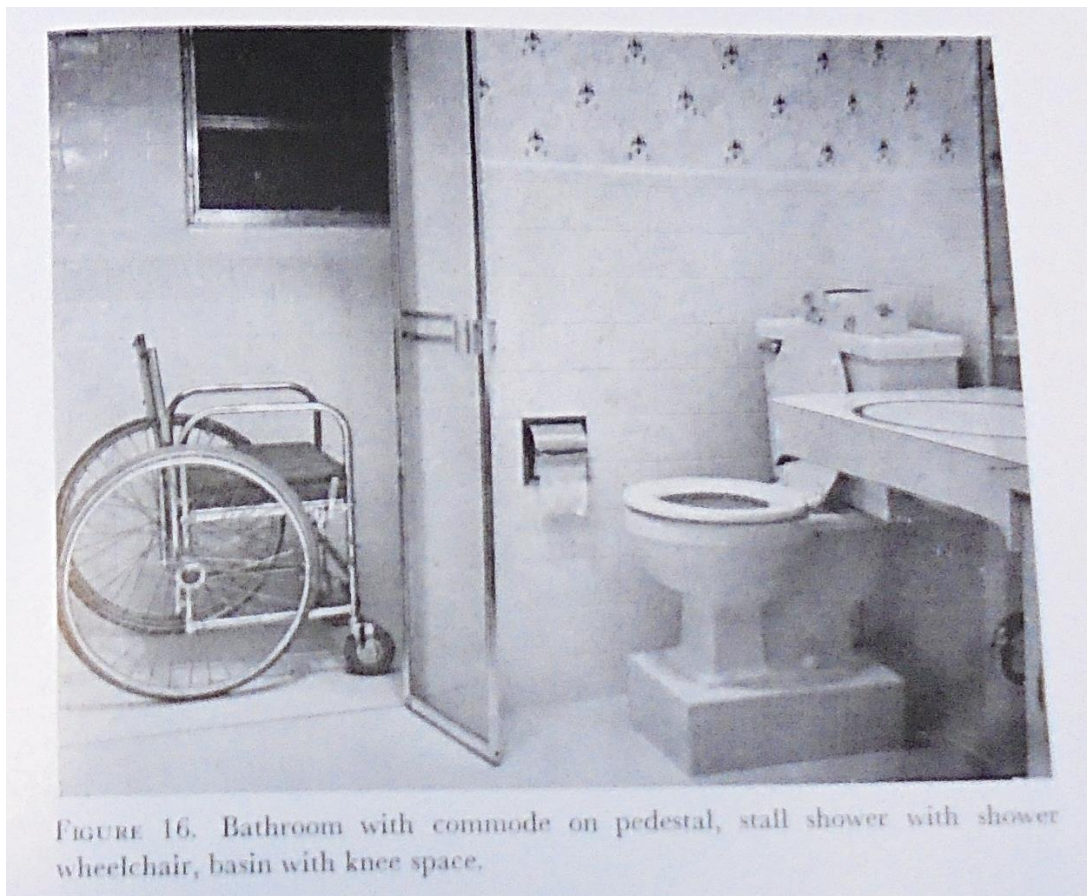
The Arrangement-for-a-Polio-who-Prefers-a-Shower revealed the politics of power established with the Hygiene Shower in the private dwelling. As a discursive object designed for the upright, walking and stepping body, the shower of the private dwelling connected the strong and desirable to the shower cell with its tray, a feature of the Properly-Plumbed-House. As such the Arrangement-for-a-Polio-who-Prefers-a-Shower, or any shower that could be access by a seated, rolling body-wheelchair complex, remained unthinkable in the private dwelling at this time. However, the Rehabilitation discourse did not end with the production of the Arrangement-for-a-Polio-who-Prefers-a-Shower. The influence of the Warm Springs “Foundation Family” (Donnelly, 1932) extended out from the Rehabilitation Facility to connect Independent

Disabled-People to the apparatus of production, and the possibility of showers made-to-order for the Disabled-Home-Owner. I discuss these discourses in the next Essay.

Appendix I**Figure 48***1932 Norman Wilson Memorial Infirmary Hydrotherapy Department*

Note. From "Treating Arthritis," 1932, *The Polio Chronicle*, 1(6), p. 10. Reprinted with permission.

Essay 6 Made-To-Order Showers for the Worker



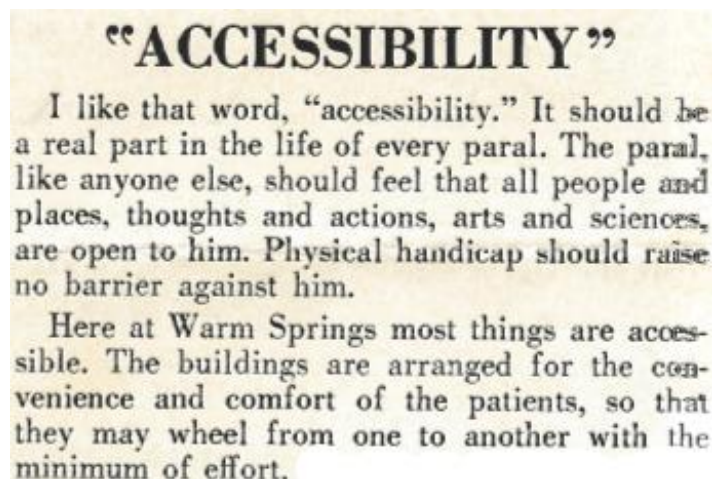
E. M. Gutman & C. R. Gutman's Made to Order Shower (1968).

In the 1968 a book titled “Wheelchair to Independence: Architectural Barriers Eliminated” (Gutman & Gutman) depicted a shower stall with shower wheelchair as a feature of a “made-to-order” house. This shower was designed for the “wheelchair-user” (Gutman & Gutman, 1968), who could wage a battle against “architectural barriers” through design within their own private dwelling. In this Essay, I analyse the emergence of showers designed for Disabled-People within private dwellings. As noted in Essays 4 and 5, government of Disabled-People in the early 1900s had moved them into collective, confined spaces, either for exclusion or transformation. The established order of things, including the private shower unit, designed for a single upright subject, excluded those who could not stand or step from much of public and private life outside of the Rehabilitation Facility. From the early to mid-1900s, discourses, subjects, and discursive objects extended out from Rehabilitation Facilities for the “Physically-Handicapped”. Various governmentalities that sought to tie the interests of Disabled-People to society were established. For some, this meant being able to attend university, gain employment, and invest in a Made-to-Order house, with a shower modified for their everyday use.

The Physically-Handicapped

As outlined in Essay 5, Rehabilitation Facilities emerged in the early 1900s for the disciplining of Disabled-People. The Warm Springs Arrangement-for-a-Polio-who-Prefers-a-Shower was designed as a therapeutic operator of a Rehabilitation discourse that produced Independent “Polios”. While such Disabled-People may have comprised of a body-object complex, they were constructed as Independent by their ability to perform essential everyday activities without human assistance. The Rehabilitation Facility was designed and constructed to be an agent and instrument in the production of this subject. The Arrangement-for-a-Polio-who-Prefers-a-Shower, a feature of a step free heterotopia, made the Hygiene Shower for Disabled-People a thinkable thing within the collective, confined space of the Rehabilitation Facility. It allowed bodies that could not remain standing or step up a step to become a Showerer, creating the possibility of Disabled-People self-governing their hygiene. This transformation to Independence was connected to Disabled-People returning to society. It meant that the Rehabilitation Facility was not a Large-Permanent-Home; rather, it was part of a network within the disciplinary society in which individuals would become responsible for themselves. However, while Warm Springs may have produced individuals who could self-govern their hygiene despite their inability to stand or step over shower tray lips, the return of such subjects to the outside world revealed the politics of architecture that was not designed for Physically-Disabled-People.

The Rehabilitation Facility was a “Stairless Eden”, designed to produce Independent subjects. However, what the Independent Disabled-Person within the Facility revealed was the problem of the architecture of the world, with its “stairs everywhere” (Donnelly, 1932). Eventually this problem would be associated with the development of legislation requiring public buildings to be accessible to Disabled-People (see Appendix D, Building Act Reform for Building Users), but the problem of “Accessibility” was initially constructed as a problem of physical-handicap rather than architecture:



(“Accessibility”, 1934, p. 3¹⁸⁵)

The idea that “The paral, like anyone else, should feel that all people and places, thoughts and actions, arts are sciences, are open to him” sounds like a rights discourse. However, at this time, rather than suggesting that society should be made Accessible, the idea of people and places being “open” was limited to the confined space of the Rehabilitation Facility. “Comfort and convenience” were restricted to the buildings of the institution, and the production of the feeling that everything is “open” rested on the patients of the facility. It was they who were responsible for bringing newcomers into the patients artificial “family” association: “If we, here at Warm Springs, could only make ourselves accessible to the other person, and interchange our worries, troubles, likes and dislikes, hopes and ideals, perhaps we could then call ourselves an ‘ideal happy family’” (“Accessibility”, 1934, p. 3). Accessibility was thus a disadvantage that collectively, Disabled-People needed to overcome.

While Warm Springs was significant in relation to the architecture of the Arrangement-for-a-Polio-who-Prefers-a-Shower, it was also a space in which Disabled-People associated with each other. In 1931, the associations that were the “ideal happy family” within the Facility were established and looked to extend their territory out into society. The Warm Springs Foundation employed a metaphor of military action to call

¹⁸⁵ “Paral.” = Paralysed

for the cooperation of “us – the trustees, the present patients, the former patients, and the friends of the Georgia Warm Springs Foundation” to join forces into “one vast national crusade against infantile paralysis” (Roosevelt, 1931, p. 1).¹⁸⁶ This crusade was to be a collective effort:

If you and I and the rest of us involved directly or indirectly in the work of the Georgia Warm Springs Foundation are to really stimulate such a crusade, we must approach it in a spirit of humility. No swaggering, self-appointed leadership is indicated. Our one objective must be to further the cause, and to that end let us not give a moment's thought to titles and credit for the work, but simply enlist as privates in what we shall hope to make a sizable and invincible army — a legion, if you please — in this crusade.

(Roosevelt, 1931, p. 1)

Endorsed by President Roosevelt, the Foundation called for a collection of privates, a “legion” or company of soldiers, avoiding “swaggering, self-appointed leadership”. At this time the National Patients Committee formed, enlisting former patients of Warm Springs to “carry on its work” (Botts, 1931, p. 4). This Committee aimed to deploy former patients to carry out “a campaign of education” to other polio patients, their families and doctors in “their own communities”:

The aim and purpose of this National Committee is to prepare, collect and disseminate among all patients, valuable information which will make it possible for these patients to actively carry on in their own communities a campaign of education for the benefit of those recently afflicted with poliomyelitis.

(Botts, 1931, p. 4)

Drawing on an additional metaphor of associations within Education Facilities, the Committee called on “Warm Springs Alumnus” to pledge themselves to the Campaign.

¹⁸⁶ The support that Disabled-Veterans were given by society, may have influenced the use of the military discourse in relation to Disabled-People. The exclusion of Disabled-People from the benefits given to Disabled Veteran's was problemised following World War I. In 1935 a sit in protest by the newly established League of the Physically Handicapped, and further protest action in 1936 regarding attitudinal barriers to employment resulted in a thesis being presented to President Roosevelt and the “New Deal” chief of the Work Projects Administration (Longmore & Goldberger, 2000). The thesis pointed out the contradiction of excluding the Physically Handicapped from “civil service” positions that war Veterans with physical disabilities could be preferred for (League of the Physically Handicapped, 1936). The protests and thesis did result in a substantial increase in the number of Physically Handicapped employed through the Administration; however, it did not result in change to the established order of excluding Disabled-People from work (Longmore & Goldberger, 2000).

They were enlisted to help finance the Warm Springs Patient Aid fund, and to “spread the gospel that physical handicap of polio does not make one a ‘cripple’” (Botts, 1931, p. 4). I return to this important point regarding the “gospel” of being a cripple being distinguished from Physical-Handicap later in this Essay; however, firstly let us consider the governmentalities revealed by the discourses employed by the Warm Springs Foundation and Committee.

The unranked or non-hierarchical collective action that both the crusade and the campaign hoped to employ combined both the ideals of Fordist self-governing individuals and democratic space in which the collective could take care of organising and governing themselves. As Ford (1922) stated in relation to governing his own factory:

A group of men, wholly intent upon getting work done, have no difficulty in seeing that the work is done. They do not get into trouble about the limits of authority, because they are not thinking of titles. If they had offices and all that, they would shortly be giving up their time to office work and to wondering why did they not have a better office than some other fellow. (p. 54)

Provided the interests of the self-governing individuals have been rightly understood to align with the collective interests, this “call to arms” could induce action through a democratic governmentality in which “citizens obey the call of society at large and are self-guided, without chains, without force, they quietly place themselves in the hands of society and mobilize themselves in society’s interests” (Cruickshank, 1996, p. 246). The national crusade employed a metaphor of military “Enlistment”¹⁸⁷ so that all patients connected to Warm Springs were claimed as the territory of the Committee. Democratic government was maintained through the “Election” of every patient: “Every patient – past and present – has been elected a member of this committee” (Botts, 1931, p. 4).¹⁸⁸ In a continuation of an Education Facility metaphor, patients were made visible to the collective through the listing of names in “Roll Calls”, published in the Polio Chronicle. Those who had made a contribution were also on various “Honor Rolls”. In 1933, a Roll of Honor was announced that would list Public Buildings “which meet a minimum requirement... of having handrails on both sides of one or more public entrances... and a ramp entrance somewhere about the building” (Donnelly, 1933, p. 3). It appears that it was somewhat more difficult to enlist buildings, and little architectural change resulted from this movement at this time (Rogers, 2009). However, the idea that Physically-Disabled-People should collectively continue the work of Rehabilitation outside of the facility did eventually become established.

¹⁸⁷ As discussed further in this Essay, the connection between war, disability, and architecture was significant in the dispositif at this time.

¹⁸⁸ Rogers (2009) gives a detailed analysis of the discourses associated with the emergence and death of a Disability Rights movement within Warm Springs, associated briefly with attempting to transform the territory of public spaces into spaces for Disabled-People.

As noted above, one of the objectives of the Warm Springs National Patients Committee crusade was to “spread the gospel that physical handicap of polio does not make one a ‘cripple’” (Botts, 1931, p. 4). The idea of Polio, or other Physical-Disability producing a Physical-Handicap (a disadvantage in a contest), rather than making one a Cripple (a bent body), was associated with a shift in the disability discourse. Handicap constructs a subject facing barriers rather than being permanently attached to the body as an object in a permanent state of unsound physical health. As self-governing subjects, Handicap became connected to disadvantages that an individual could overcome, despite the resistance of the body to be normalised. Initially the focus was on overcoming disadvantages to gaining employment:

PREPARATION *vs.* PREJUDICE

In a recent letter, a member of the crutch brigade describes his efforts to obtain a position as an accountant. He feels that he has had eminently good preparation for such a position and that he could compete with anyone. He only asks that chance—to compete—but he has met discouragement so far. The employer's reaction is the obvious one with able-bodied unemployed applying for every job. "Why experiment?"

The prejudice against employment of the handicapped is overstrong in a normal employment market, but in a period of widespread unemployment it becomes wellnigh insurmountable. What to do, then?

For those who have the necessary business ability and who can devise workable ideas, this is an excellent time to launch ventures in which they become their own employers. With recovery evidently under way, the factors external to these ventures would seem to favor success, and, given the ability to provide a service the public wants, such ventures should succeed. The handicapped person will find the public a kinder judge than the employer.

Such ventures should have modest beginnings, for getting financial backing for any pretentious scheme would prove as discouraging as the job hunt.

For those who cannot undertake the risks and responsibilities of individual ventures, this should be a time of preparation, and more preparation. It is a time to consider investment in physical recovery or educational training. It is a time to plan to meet the return of employment opportunity with the best physical and mental equipment possible.

In short, it is a time for investment by the physically handicapped unemployed. Some will invest in employment and experience; others, in treatment of their physical disabilities and in education. Given the will to do, the means for investment can be found.

("Preparation vs. Prejudice", 1934, p. 3)

Here, a particular body-object complex, described again using a military metaphor (“a member of the crutch brigade”), may have had the desire to compete for employment, but prejudice against the handicapped meant that exclusion remained. A member of the Crutch-Brigade was not part of the established order of employees, so “why experiment”?¹⁸⁹ However, rather than collective action against the prejudice of people or architecture (which would emerge later), the Physically-Handicapped were constructed as Independent subjects who could overcome barriers, “given the will to do so”. As potential members of a Fordist disciplinary society, individuals must take responsibility for their transformation into productive members of society.

Entrepreneurs with sufficient human capital (those with “the necessary business ability and who can devise workable ideas”) were encouraged to become their own employer-employee. While those “who cannot undertake the risks and responsibilities” of such entrepreneurship should remain connected to Rehabilitation (treatment), or “invest” in “education”. The will to invest in education, and access to educational facilities, would become an important part of the dispositif in which Disabled-People sought to become an asset rather than a deficit to the nation’s capital.

Initially the focus of the campaign was on spreading the gospel to the people afflicted with Polio (and their family and physicians). However, responsibility for overcoming the disadvantages associated with Physically-Handicap rested with the individual (see Figure 49):

¹⁸⁹ As noted in Essay 5, Ford had indeed experimented with success; however, it would seem that the established order outside of large factories remained, with limited employment opportunities for Disabled-People (Longmore & Goldberger, 2000).

Figure 49

"Rehabilitation Requires Study", 1931

Rehabilitation requires STUDY



You may be handicapped, but the world won't give you a "handicap" in the economic race. You have to know your stuff.

Note: From "Rehabilitation Requires Study," 1931, *The Polio Chronicle*, 3(1), p. 2. Reprinted with permission.

Although they had a disadvantage, they were part of the competition, and as self-responsible subjects they should not expect to be given any advantage. The idea of "being handicapped" by Physical-Disability, but not being "given a handicap" or some form of advantage, was important in the production of these self-governing individuals. "Having the will to do so" and "knowing your stuff" were necessary to be included in the "economic race".¹⁹⁰ Next I discuss the problem of access to Educational Facilities, which was important in the eventual connection between the Physically-Handicapped and the possibility of investing in a Made-To-Order shower in a private dwelling.

¹⁹⁰ While the "economic race" is clearly connected to the idea of competing as in a "running race", the image of a single subject could also elicit the idea that one either belongs to the "economic race", as in a population, or one does not, an idea being deployed by eugenicists at the time (see Essay 4).

Tertiary Education as Investment for the Physically-Handicapped

Educational Facilities had been connected to Disabled-People during the 1800s as a technology of discipline and, at times, exclusion from society (see Essay 4). Following World War I, State funded Education Training as a feature of Rehabilitation within established educational facilities emerged. As noted above, the early 1930s were associated with difficulties for Disabled-People obtaining employment. At this time, high levels of unemployment in the USA led to the “New Deal”, which established the Federal Emergency Relief Administration including the Emergency Educational Program (Dass, 2014). This programme included funding for state education departments to provide “Vocational Rehabilitation” (amongst other training and education programmes) to “physically handicapped persons” (Federal Works Agency, 1946, p. 92; “How We Do It”, 1933, p. 2).¹⁹¹ Educational Training came to be practiced alongside physical training (such as learning to stand and walk) to form “Vocational Rehabilitation”. Vocational Rehabilitation promised to produce skilled workers who would earn more than it would cost to train or maintain them (“How We Do It”, 1933, p. 2).¹⁹²

Fadyl (2013) has provided a comprehensive analysis of the history of Vocational Rehabilitation in Aotearoa New Zealand, which identifies key discourses connecting returned Soldiers to education, training, and vocational facilities. In relation to education, a connection between state security and employment saw the development of Training Schemes for Returned Soldiers (or “veterans”), and the idea of “reciprocal duty” of the State to provide vocational rehabilitation and of Soldiers to take it up.¹⁹³ Employing a democratic governmentality, this idea connects the interests of the individual to the collective and vice versa, providing an assurance (or insurance) that the individual’s sacrifices and interests are tied to the collective. While Rehabilitation had involved training (a “new education”, see Essay 5), the educational training associated with Vocational Rehabilitation was distinct. It was associated with established educational programmes. In Aotearoa New Zealand, the Discharged Soldier’s Settlement Act 1915 connected Veterans (not injured) to “Agricultural Instruction” (“Agricultural Instruction”, 1916, p. 6) and vocational programmes within existing “Technical Colleges” (“Southland Technical College”, 1916) such as “boot repairing, carpentry, cabinetmaking, motor engineering and business courses” (“Invalided Soldier”, 1919, p. 7). Educational training of Disabled-Veterans was

¹⁹¹ It does not appear that such practices emerged in New Zealand or in Great Britain (Adult Education Committee, 1919).

¹⁹² Fadyl (2013) provides a detailed analysis of vocational rehabilitation in relation to disabled ex-soldiers in her thesis.

¹⁹³ For example, in New Zealand the Repatriation Department paid part fees and subsidies for their training (“Vocational Training”, 1920)

established in workshops both within Rehabilitation Facilities such as those in Hanmer and Rotorua, and hospitals (e.g., “Invalided Soldier”, 1919), and then at established Technical Schools (“Local and General”, 1920, p. 4). The aim of such programmes (the responsibility of the state’s Repatriation Department) was “helping the men to help themselves” (Fanning, 1919, p. 12). This involved retraining Veterans for a life that would be of “value to the community as well as the individual” (p. 12); and, where possible, the Department employed “existing facilities” to assure the “right reabsorption of soldiers in civilian life”:

In the difficult circumstances the Repatriation Department has striven to make the best possible use of existing facilities for the right reabsorption of soldiers in civilian life. The administration is linked up with technical schools and University colleges

(Fanning, 1919, p. 12)

While separate facilities were established for Vocational Rehabilitation (see for example Fadyl [2013], “sheltered workshops”), Rehabilitation in the form of “education” also made use of established educational facilities.

In the USA, there was an expectation that the state’s involvement in Vocational Rehabilitation would not upset liberal markets (Dass, 2014).¹⁹⁴ As such, established educational facilities maintained the separation of Disabled-People from the rest of the student population, and developed auxiliary programmes rather than provide access to existing classes (Dass, 2014).¹⁹⁵ This meant that although the space of the existing Educational Facility may have been used, Physically-Handicapped-People remained separated at this time. In 1946, this separation was disrupted when a Veteran’s Hospital was converted into a College-Rehabilitation Institute,¹⁹⁶ and connected to the University of Illinois as a satellite campus (at Galesburg) (Hostetler, 1948). Eventually, the University of Illinois could be considered the birthplace of the discourse of Accessibility as architectural barriers; but, before I get to Galesburg, I discuss another USA veteran’s hospital—Halloran Hospital.¹⁹⁷ Halloran was a hospital for injured Veterans that produced early designs for showers modified for Disabled-People in private dwellings. Halloran hospital is significant because the collective action of

¹⁹⁴ In Aotearoa New Zealand there were similar concerns regarding the work of returned soldiers (Fadyl, 2013).

¹⁹⁵ It is unclear whether injured soldiers joined the non-disabled in classes in Aotearoa New Zealand. Generally, references were made to “special classes”.

¹⁹⁶ Just as Warm Springs and other rehabilitation facilities had taken over hydropathy resorts in the early 1900s.

¹⁹⁷ Halloran Hospital was initially designed as a Large-Permanent-Home for Disabled Children but was taken over by the Army in 1942 as the building was nearing completion. In 1952, the hospital was returned to the state for its original purpose (College of Staten Island, n.d.).

patients from within it created the idea of state funded “prosthetic homes” that would make it possible for Disabled-Veterans to leave the Disciplinary Hospital and be eligible to attend community Educational Facilities.

Showers in Prosthetic Homes for Paraplegic Veterans

In a liberal governmentality, private property is generally considered to be best governed with limited state involvement. It is a site of freedom for those who have acquired the material capital to design and build or otherwise purchase their own home. Indeed, a liberal governmentality generally relies on “freedom of the market, freedom to buy and sell, the free exercise of property rights” (Foucault, 1979/2008a, p. 63). However, as part of the idea of reciprocal duty, both Aotearoa New Zealand and the USA supplied property and dwellings to returned soldiers.¹⁹⁸ Following World War I, Aotearoa New Zealand Veterans could be given public money (either on loan or gifted as the Minister of Lands saw fit) to purchase land and build houses (Discharged Soldiers Settlement Act, 1915; Rehabilitation Act, 1941).¹⁹⁹ While it does not appear that the idea of housing designed for Disabled-Soldiers was circulating in Aotearoa New Zealand at this time,²⁰⁰ in the USA federal funding for half of the purchase of “special housing for wheel-chair disabled veterans” was being granted by 1948 (80 Congr. Record, 1948).²⁰¹

In 1947 an article outlining designs for Housing Units for Paraplegic Veterans, specifically “those confined to wheelchair living” (Carrere et al., 1947, p. 70), was published in the USA’s “Progressive Architecture” magazine. The designs, produced by the American Institute of Architects, had been prompted by lobbying from patients

¹⁹⁸ The New Zealand government has a fairly long history of provision of housing to soldiers; from as early as 1855 houses were provided to pensioner soldiers in Aotearoa New Zealand (Forsaith, 1855).

¹⁹⁹ Additional loans and grants for injured Soldiers were provided by the Land Board and Patriotic Society following the loss of limbs, fingers, eyes, or paralysis, which could be used for investment in a house (e.g., “loss of both legs” could be awarded a \$950 loan and \$755 grant) (“Assisting Soldiers” New Zealand Herald, 1920, p. 10).

²⁰⁰ For example, while “Provision for the Disabled”, and “Housing” are both included in the Rehabilitation Board (1950) Reports for the year ended 31st March 1950, neither subject is connected. While state involvement in the provision of dwellings specifically for Disabled-People is not evident in New Zealand at this time. Physically-Disabled-People did live in private dwellings in New Zealand (e.g., “92-Year-Old Double Amputee Carries On”, 1945) and individuals could install ramps for wheelchair access into suitable dwellings with the assistance of Servicemen’s Welfare officers (“Property Wanted”, 1948). However, within a decade a kitchen designed for training Disabled-People opened at Auckland Hospital in 1957, and it was proposed that the fittings could be copied for use at home (“Kitchen for Disabled Patients: Even the Crippled Can Cook, 1957).

²⁰¹ While housing developments were booming in the USA at this time, access to housing in the UK was limited and although there was a discourse of returning Disabled-Veterans to their traditional position in the household, charity was relied on for assistance for housing. Modifications included bathrooms with “special equipment” being provided on the ground floor (Anderson, 2020).

within Halloran Veteran's Hospital to allow them to be discharged from hospital. Patients of this hospital formed the Paralyzed Veteran's Association in 1946. The Association called for suitably designed houses that, they argued, would reduce the costs of hospitalisation,²⁰² would allow them to live "more normally" (Kersten, 1947, p. 5), have the freedom to attend college (Shrifelt, 1947), regain their masculinity, and become "self-sufficient" (Moss, 1947, p. 16). While initially the Veteran's administration was opposed to this funding as a departure from existing policy, the house was argued to be a "prosthetic home", simply an extension of funding for prosthetic limbs which was already covered (Moss, 1947; Williamson, 2020). This eventually led to the provision of federal grants for adaptive housing in 1948 (Davis, 2020).²⁰³

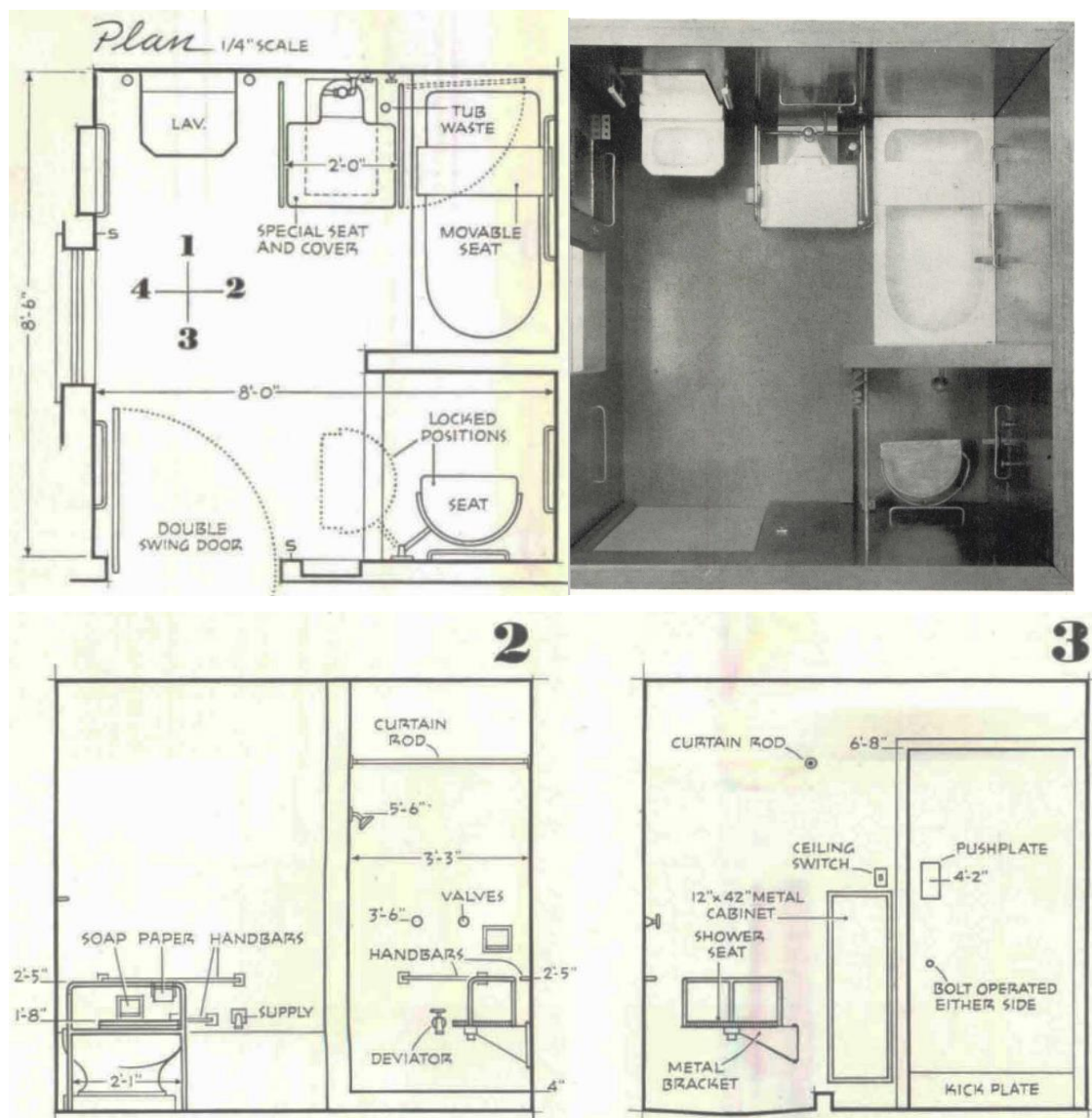
The article in *Progressive Architecture* noted that "in order to not design a "stock" house – which obviously would not suit all conditions equally well – the committee concentrated on the design of units, including bathroom, bedroom, workroom" (Carrere et al., 1947, p. 70). Distinguished from the general population who might be able to have a "stock" house, the units were an extension of the Disciplining Hospital, modifiable according to the condition of the patient and "medical advice" (Carrere et al., 1947, p. 70). The architects noted that for the bathroom "more than in other rooms, as complete independence as possible is desirable" (Carrere et al., 1947, p. 70). The patients had deemed it necessary for bathroom to be similar to the "treatment room" of the hospital (Shrifelt, 1947, p. 14). The proposed design for the bathroom unit included a double swing door; a bath with handbars and moveable bath seat; a toilet with handbars and a special seat and cover; a handbasin ("lav"); and a shower unit with a curtain, handbar, and swing out seat (see Figure 50):

²⁰² By using family members to provide care.

²⁰³ In a further connection to Ford, Paraplegic Veterans had been provided with modified Ford cars, and they argued that if the government could provide them with cars, they should provide them with accessible housing, including an accessible garage for their car (Davis, 2020; Williamson, 2019).

Figure 50

Drawings and model of a bathroom unit for Paraplegic Veterans, 1947



Note. From "Housing units for paraplegic veterans designed by a committee of the New York chapter. A.I.A." by R. M. Carrere et al., 1947, *Progressive Architecture*, XXVIII(2), pp. 70-71. Orphan work.²⁰⁴

The Paraplegic-Veteran's-Bathroom-Unit made the idea of a hygiene shower designed for a specific population of Disabled-People within a private dwelling a thinkable thing.²⁰⁵ The unit was designed for wheelchairs to move about freely; the space beneath the handbasin, for example, "must admit wheelchair arms" (Carrere et al., 1947, p. 70). Both a shower and bath were available, allowing the individual to act on their preferences and reflecting the established inclusion of the shower-bath or shower

²⁰⁴ If you believe that copyright infringement has occurred in any of this content, please contact the author.

²⁰⁵ By the mid-1950s, other Populations of Disabled-People were being connected to showers designed for their use in private dwellings. I discuss this further in Essay 7.

alongside the bath in domestic bathrooms at that time (see for example, *Progressive Architecture*, 1947, XXVIII(2), pp. 3, 78, 96).

The idea of a shower unit as a cost-effective hygiene solution within the private dwelling was established by the mid-1900s (see Essay 3). Indeed, shower units were advertised as the preferred choice for veterans in 1947 (see Appendix I).²⁰⁶ While a shower without a step was a thinkable thing by this time (e.g., the Warm Springs Arrangement-for-a-Polio-who-Prefers-a-Shower), the shower unit was a standard bathroom fixture (see for example, Massey, 1923, *Ladies' Mirror* 1(7), p. 14 in Essay 3, and Appendix I). The addition of a swing out seat and handbar made it possible for those who could move themselves from seat to seat to shower Independently. While this was a modified shower, it was only modified for a particular Disabled-Person, those who would be eligible to leave the Disciplining Hospital:

But there are some of them that will never be qualified and fitted to leave the hospital. They have to be pretty well rehabilitated physically; that is, so they can lift themselves around and take care of themselves before they should leave the hospital.

(Bradley, 1947, p. 23)

Unlike the Warm Springs Arrangement-for-a-Polio-who-Prefers-a-Shower where the shower was a room that could be wheeled into, this shower was for an individual who could “lift themselves around and take care of themselves”.

The collective action of the Paralyzed Veteran's Association established the private dwelling as territory that could be included in the state's duty to supply Disabled-Veterans with the prosthetics that they needed as a result of injuries sustained while in service. The design is attached to the Disabled-Person like an extension of the prosthetic body-object complex. The therapeutic architecture of the Disciplining Hospital thus attached itself to the person. It escaped the confines of the Rehabilitation Facility, and surfaced in rooms that came to comprise a private dwelling or Family-Home for those who were able to lift themselves around and take care of themselves. The bathroom was a unit, attached to other units, to construct a house to suit a variety of “Conditions”.²⁰⁷ These units were for the Disabled-Person who was eligible to live in the community, extending the Rehabilitation discourse out of the Facility by being Independent, and continuing to pursue their Vocational Rehabilitation (e.g., the “Workroom” unit includes space for “parallel bars”, a worktable with a sink

²⁰⁶ The realisation of Bresgen's hope in 1871 that showering Soldiers would continue to shower once they returned home.

²⁰⁷ Here the influence of Ford Factory production in the USA can be seen, in which standardised “units” could be produced, and then assembled to produce a whole. This was an approach to the production of dwellings and mass production “shower unit” at this time, not exclusively associated with Disabled-Veterans (see *Progressive Architecture*, 1947, XXVIII(2), pp. 2-3, and Appendix I).

and fluorescent lighting, and an exercise mat” [Carrere et al., 1947, p. 71]). These bathrooms and the showers within them were made possible through the idea of reciprocal duty, in which the nation owed a debt to Disabled-Veterans, and in which these Disabled-Veterans needed to align their own interests with the interests of society. Those subjects who were eligible to be freed from the Disciplining Hospital would then be eligible for funding to attend college (Shrifelt, 1947).

Showers for Paraplegic-Veterans in the Rehabilitation-College

As discussed in Essay 5, although the stairless Eden of the Rehabilitation Facility may have allowed body-object complexes to be Independent, Colleges were part of the world in which stairs everywhere prevailed. The Polio Chronicle had tasked Physically-Handicapped-People with the responsibility for investing in their education in 1934. However, the established architecture had made this task “practically impossible” for wheelchair and crutch users:

A college education for paraplegics (those who are paralyzed from the hips down) and amputees has been practically impossible in the past because of the restrictions placed on them by wheelchairs and crutches. Many colleges have attempted to accomplish education of paraplegics by conducting all classes in the same classroom, thus eliminating the necessity of travel. But it remained for the University of Illinois to solve the problem.

(“Disabled War Vets Attend Galesburg U of I”, 1948, p. 8)

Unlike other existing Educational Facilities in which auxiliary classes had been set up, the University of Illinois promoted the entire Galesburg campus as providing opportunities for “Disabled War Vets”.²⁰⁸ Following World War II, the Illinois Veterans Commission produced a newspaper illustrating how “Illinois Mobilizes for its Veterans”. As the Warm Spring National Patients Committee had employed a metaphor of war to mobilise Warm Springs alumni in the community, the Commission too sought to extend the idea of the war effort into re-establishment of Veterans into society. In Illinois, this mobilization included access for Physically-Handicapped-Veteran’s to the Galesburg campus of the University of Illinois.

²⁰⁸ Although initially there was a “press blackout” in the hope to limit the number of Disabled-Veterans enrolling, and the potential to damage “normal enrollment” (Rose, 2012).

Galesburg was promoted as being a space where all places were open to the Paraplegic-Veteran. In addition to the classrooms, units, dormitories, the campus hospital, and dental facilities (left over from its origins as a veterans' hospital), there was a gymnasium, theatre, and swimming pool, an auditorium (for meetings, dances, and "special programs"), a lodge, post office, bookstore, barber shop, dry cleaners, laundromat, chapel, sports fields, basketball and tennis courts, archery range and, nearby, a small practice golf course. These spaces were all part of "ideal living" for the "battle-scarred war heroes" ("Paraplegics go to School", 1948, p. 14). Galesburg was declared to be "a university unique in the history of education" ("Paraplegics go to School", 1948, p. 14) that would assist the Paraplegic-Veteran back to a "natural existence" (p. 14). While the Rehabilitation Facilities discussed in Essay 5 may have reflected the normality of a Resort or a Home, Galesburg was a Heterotopia Community, a space of transformation, where the disciplining space of the Rehabilitation Hospital, the College and Community merged.

This transformation of a Veteran's Hospital to a college campus meant the facilities may have been "open" for Paraplegic-Veterans to gain an education (i.e., already designed to be a somewhat stairless Eden); however, it was not a complete conversion from hospital to college, and the Rehabilitation Hospital function was maintained. Alongside the usual university facilities, a Rehabilitation Programme for the Paraplegic-Veteran-Student was established. Some students were funded by the Servicemen's Readjustment Act of 1944 (passed to provide "aid for the readjustment in civilian life of returning World War II veterans" [Servicemen's Readjustment Act]; commonly known as the GI Bill of Rights [Madaus, 2011]), and others through Public Law 16.²⁰⁹ The programme "which would make them feel part of the whole student group" (Division of Rehabilitation Education Services, 1949, p. 1), provided:

1. Maintenance of good physical health
2. Correction of physical deficiencies
3. Reeducation in motor abilities and skills
4. Development of unafflicted parts of the body
5. Physical growth, strength and agility.
6. Opportunities for emotional adjustment and stability
7. Opportunities for play (recreation and athletics)
8. Opportunities for social activities
9. Mediums of self-expression and self-administration
10. Organization of the group to meet their own needs.

(Division of Rehabilitation Education Services, 1949, p. 1),
 Alongside providing the opportunity to invest in oneself through Educational Training, the programme at Galesburg provided therapies (Physical Restoration, "emotional adjustment") and opportunities to participate in student life. It had specific objectives to

²⁰⁹ See Rose (2012) for a description and analysis of these different funding streams.

create Democratic Associations (“organization of the group to meet their own needs”) and to promote disciplinary society self-government (“self-expression and self-administration”). All these objectives formed a network of technologies to produce subjects who could be returned to “civilian life”.

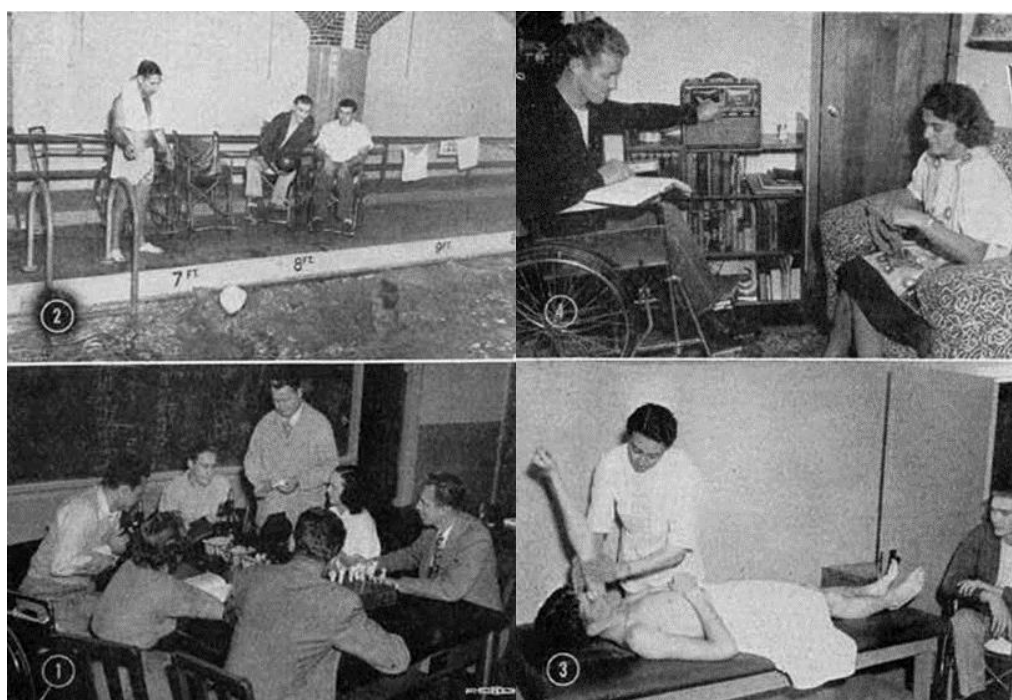
Just as Warm Springs selected specific subjects to admit to the facility (those “Polios” whose Independence could be secured), the programme at Galesburg Educational Facility was for a specific type of Disabled-Person. The “Paraplegic” Veteran needed to be able to “‘take care of their own needs’ without assistance” (Hodges, 1947, cited in Rose, 2012, p. 35). They included the “wheelchair-confined individual” and “ambulatory disabled” (Division of Rehabilitation Education Services, 1949, p. 1). While the Wheelchair-Confined and Ambulatory-Disabled may have otherwise found themselves handicapped in a world where “stairs everywhere prevail” (Donnelly, 1932, p. 6), within Galesburg campus they were showcased as easily adjusting to “college life” with the assistance of the “ideal facilities” at “U of I” (University of Illinois) (see Figure 51):

ADJUSTMENT to college life is easy for paraplegics with the ideal facilities at U of I's undergraduate division at Galesburg as shown by photos on these two pages. (1) Class in bacteriology is attended by two wheelchair vets, Ray Crigger and Joseph LoPresti. (2) Swimming class finds Crigger and Harold Scharper receiving pointers while Harris Hjelter and Donald Swift look on. (3) Soothing massage aids tired muscles. Hjelter watches Harry Neale and Frank Conci demonstrate. (4) Scharper and wife at home.

(“Disabled war vets attend Galesburg U of I”, 1948, p. 9)

Figure 51

“Disabled War Vets attend Galesburg”, 1948



In Figure 5,1 Paraplegic-Veteran-Students are seen as normalised students. They are attending classes alongside “regular” students or studying at “home” with their wife.²¹⁰ They are doing Rehabilitation activities, such as swimming and massage, although these are constructed as typical activities of the outside world (being described as “swimming classes”, “soothing massage”) rather than the therapies of the Rehabilitation Facility. Just as discipline functioned to normalise subjects, within the disciplinary society, Rehabilitation is reconstructed as activities that are part of “normal” society. They become part of the disciplinary society, an illustration of the totalising reach of Fordist discipline into restoration of the Injured-Veteran to a “natural existence”.

²¹⁰ Rose (2012) provides an interesting analysis of the gendered aspect of the Disabled-Veterans of Galesburg campus. I will discuss the connection between women, specifically housewives, and the shower in the following Essay; but it is worth noting here, that it was the male students who were made visible despite a female student attending the college.

Following the USA tradition, the Paraplegic-Veteran-Students lived on campus, furthering the functions of the Heterotopia in the lives of the Veterans. Married students were provided with units on the campus as their “home” (see Scharper above), while single Vets lived in dormitories:

Rooms for Single Vets
 Unmarried veterans live in dormitories at the University. There the rooms are so arranged that they can move about freely on wheelchairs without outside assistance. Bathrooms and shower rooms have special features to permit bathing and shaving.

(“Disabled war vets attend Galesburg U of I”, 1948, p. 14)

These rooms were “arranged” for the free mobility of Independent Students “on wheelchairs”, and despite initially providing baths, included shower rooms with “special features”.²¹¹ While these rooms were within the campus, they were designed as agents and instruments of the Rehabilitation Facility, employing architecture to produce body-object complexes that can do essential everyday activities Independently.

Paraplegic-Students Become Part of the Student Group

While the programme at Galesburg may have been established with the purpose of returning the students to “civilian life”, the idea of a programme “which would make them feel part of the whole student group” (Division of Rehabilitation Education Services, 1949, p. 1) produced effects beyond discipline of the students. Promoted in Illinois Veterans Commission newspaper (Figure 51 above), Scharper was described as the ideal Galesburg student. He participated in all classes, swimming, and special physical education programmes and had managed to “adapt himself to the school environment without being a burden to anyone” (Division of Rehabilitation Education Services, 1949, p. 9). Connected to his ability to participate in normal activities of everyday living alone was his “own superior confidence in his efforts” which importantly, is “reflected to others”:

²¹¹ Initially, modifications to the campus involved the removal of showers to install baths (Galbraith, 1950).

Probably the greatest single factor in Scharper's attendance at the school was his own personality—a personality which radiates to his fellow students. His own superior confidence in his efforts to be independent and a “regular” student is reflected to others.

(“Disabled war vets attend Galesburg U of I”, 1948, p. 9)

Scharper was portrayed as a man with “personality” and “his own superior confidence in his efforts” could “radiate” an influence on others. As noted in Essay 2, Cruickshank (1996) connected the idea of Democratic government to associations between individual and collective interests. Cruickshank argued that alongside a “science of associations” (p. 242) citizens needed to desire to act collectively. This was a matter to be governed through “‘enlightened self-interest’ or ‘interest rightly understood’” (Tocqueville, 1961 cited in Cruickshank, 1996, p. 242). Scharper is the ideal self-interested subject. He rightly understands that he may depend on his own power to overcome any disadvantage caused by his handicap. Scharper is constructed as an individual who has freed himself from dependence and abnormality. The architecture does not feature as an actor in Scharper’s success. Rather, it is his person that “radiates” this discourse of the Independent Paraplegic-Veteran-Student to his “fellow students” and his interests (to be Independent) rightly align with the interests of the “regular students”.²¹² The production of association between Paraplegic-Veteran-Students and Civilian Students was seen as one of the most “valuable” features of accommodating both within the same space:

One of the most unusual and most valuable experiences of the Division was its Re-education program for Disabled Students. This program was unique because, starting in September of 1948, in four short months it became a vital part of the school's activities. It proved valuable not only because the disabled students gained a new approach to life, but also because the rest of the students and faculty gained a new concept of the wheelchair-confined individual.

(Division of Rehabilitation Education Services, 1949, p. 1)

²¹² While Aotearoa New Zealand does not seem to have established a facility like the Galesburg hospital-college, the story of “Mr Christopher Lethbridge”, paralysed after diving into a river, had some parallels to Shaefer. He was completing the theology degree he had started prior to his injury while in hospital, attributing his success to “strong discipline of the mind” and somewhat differently, “faith in God” (“Young Man Undaunted By Limb Paralysis”, 1959, p. 15). Mr Lethbridge was engaged to be married, and was calling for the North Canterbury Hospital Board to establish a paraplegic unit. With regards to attending university, even by 1970 a wheelchair graduate was headline news, although the graduate had to be carried up and down stairs by “the boy students” and her friend had to share her notes from textbooks held on the second floor of the library (“Graduate in Wheelchair”, 1970, p. 2). In 1972, calls were being made to make colleges accessible, such as Canterbury University where the “doors into otherwise excellent facilities in showers and toilets were too narrow” (“Problems of Access”, 1972, p. 18).

The presence of Disabled-Students within Galesburg produced new subjects, both the Paraplegic-Veteran-Students and the “rest of the students and faculty”, who were transformed through their association.

Rehabilitation may have transformed permanently injured bodies into Independent subjects, but the architecture of Galesburg and the duty of society to restore such Veterans to civilian life meant the Paraplegic-Veteran-Student did not need to be excluded from society to protect the interests of the Intellectual Class as a Eugenics discourse had advocated (see Essay 4). Indeed, they were associates of the Intellectual Class. Having invested in themselves through their own efforts to escape the unfavourable state of dependence and abnormality, they could be thought of as clean, desirable members of society, despite being Paraplegic (see Figure 52).²¹³

²¹³ In Aotearoa New Zealand the idea of Disabled-Veterans as potential husbands was also seen as possible (“P.O.W.’s Romance”, 1945, p. 6). Anderson (2020) provides a detailed analysis of the connection between disability and masculinity at this time in a study of “Homes away from Home’ and ‘Happy Prisoners’: Disabled Veterans, Space, and Masculinity in Britain”, 1944-1945.

Figure 52

"Paralyzed War Vet, Being Greeted at the Door of the Administration Building by Two Members of the Administrative Staff", 1948



Note. From "Paraplegics go to School," 1948, *Illinois Mobilizes for its Veterans*, 7(3), cover & p. 14. In the public domain.

The Paraplegic-Veterans were distanced from the crippled body with its permanent dependence. They were made visible as determined, Independent, intelligent subjects, able to invest in their education and be considered an asset within society.

Alongside the idea of reciprocal duty to War Veterans, a discourse of rights was circulating in the late 1940s that disrupted distinctions between disability and health ("Constitution of the World Health Organization", 1946)²¹⁴ and promoted the idea that "all members of the human family" have "equal and inalienable rights" (United Nations, 1948, p. 2). As a product of democratic government that is associated with rights, the "GI Bill of Rights" was attached to attendance at College. While there was no legal right for Disabled-People to attend university, it was thinkable that they "should"

²¹⁴ The first Constitution of the World Health Organization (1946) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p. 2). This discourse disconnected disease from disability. It creates the possibility of being unwell without "disease or infirmity"; however, it also produces the possibility of "well-being" despite a state of "infirmity".

be allowed to participate. Galesburg College promoted the idea of Paraplegic-Veteran-Students and their “Fellow Students” becoming comrades, to “participate as college students in college activities”:

In summary, in the short time that they were here, the men in wheelchairs convinced everyone that there is a place for them in college, that they are too capable to be ignore, and that so long as there are men and women so disabled, those in education should see that they are allowed to participate as college students in college activities.

(Division of Rehabilitation Education Services, 1949, p. 1)

Within a Democratic governmentality the College became the territory of Physically-Disabled “men and women”, a space in which they “should” be granted permission to invest in themselves. However, just as the subjects emerging from Warm Springs encountered the discriminatory architecture of the world, the Disabled-Students of Galesburg still had to face a world full of stairs outside of the campus. These students may have otherwise been expected to contend with this problem as self-responsible individuals, but the closure of the Galesburg campus, which I discuss next, resulted in collective action to resist the exclusion of Disabled-People from college life beyond Galesburg.

The College gets Modified for Paraplegic Individuals

In March 1949, the origin of the Galesburg campus as a hospital was connected to its closure. Claims were made regarding the “critical need” for more hospital space for the “aged and infirm”,²¹⁵ resulting in Galesburg closing (“Galesberg Branch will Close June 30”, 1949, p. 1). The small numbers of Paraplegic-Veteran-Students who were able to use existing facilities could transfer to other Illinois University campuses, while others could complete their studies via correspondence (“Galesberg Branch will Close June 30”, 1949, p. 1). The idea of removing the College from the territory of the Disabled-Veteran’s met with resistance. Students and facility staff gathered outside the Governor’s mansion to protest the closure (Figure 53):

²¹⁵ Subjects who I will discuss further in Essay 8.

Figure 53

*1949 Protest Outside the Governor's Mansion*²¹⁶



Courtesy of Tim Nugent

Note. From *Protest outside the Governor's mansion*, by T. J. Nugent, 1949, (<https://www.disabilitymuseum.org/dhm/lib/detail.html?id=490>). In the public domain.

Despite these protests, Galesburg campus did close. Its closure highlighted the problem of other campuses' not being adapted for Paraplegic-Veteran-Students.²¹⁷

The solution initially rested on individual students who could use their own determination to "somehow" access the campus:

The only real problem is the academic one of how they will get the last two years, necessary for graduation. As you know we have no answer to this one, thus far. Sometimes, I believe determination of some of these boys will somehow get them there.

(Graffoulier, 1948b, p. 1)

The students "marched" on to the Urbana campus and, using planks as ramps, made their ability to access the campus visible and staked their claim to the campus (Brown, 2017). Following these demonstrations, the University administration agreed to a visit from one such determined "boy" (Scharper), who suggested that they could access buildings through the vehicle entrances. Just as access to work had been limited to those with "will" and "workable ideas" in the 1930s ("Preparation vs. prejudice", 1934, p. 3), the possibility of Paraplegic-Veteran-Students attending Urbana campus was a

²¹⁶ Similar protests were held regarding the closure of Halloran Hospital in 1951 ("American war invalids in wheelchairs protest against the early closure of Halloran Hospital on Park Avenue on January 19, 1951 in New York, United States", 1951).

²¹⁷ There was already an awareness of the problem, as a limited programme at Galesburg meant they could only partially complete a degree, and questions had been raised about whether or not the campus as Urbana could be adapted (Graffoulier, 1948a, p. 1). The solutions at that time was for the Paraplegic-Veteran-Students to remain at Galesburg to complete their studies (Bone, 1948, p. 1).

thinkable thing for those “determined” students who could “somehow” overcome architectural barriers (Bone, 1949).

Following Scharper’s visit, it was decided that each student should visit the main campus at Urbana to have the chance to determine what they could or could not do in relation to the buildings:

In discussing transfer procedure with some of these other veterans, it seems to me, Dr. Bone, that the best method of deciding whether they can handle the Urbana situation or not is to permit each of the boys who are interested in transferring to make a personal trip to the campus. Do you not agree? . . .

We could also decide on a day or two for these veterans to make a trip to the Urbana campus to decide for themselves what they can or cannot do in relation to the building situation.

(Graffoulier, 1949, p. 1)

As self-responsible individuals, the Paraplegic-Veteran-Students were to decide for themselves what barriers, if any, the campus might present, and then how they should overcome them. Within a short time, the students were suggesting adaptations to the existing facilities. In relation to the bathrooms, the adaptations were designed to be adjustable to suit the “individualized techniques” of the students:

Answers on the shower and toilet facilities will be hard for me to attempt to standardize as there are so many individualized techniques. It is because of this fact that I would like to suggest pipes or bars, if possible, suspended on chains which can be raised or lowered by means of snaps and the links in the chains. If these are installed, they should be suspended approximately 6 to 8 inches in front of the seats with the height adjustable.

(Blankenship, 1949, p. 1)

Another student requested rails for a shower-bath with “a stool and board” in the women’s halls of residence (Sheldon, 1949). University staff then requested widening of doorways, hanging pipes and providing stools in two family housing units (Barnes, 1949). They also requested that two other housing rooms have the wall between the toilet and shower removed, to create a shower room with a shower curtain, shower seat, and handrail (Norman, 1949). Such minor additions and subtractions were made at Urbana to convert a bathroom in a Residents Halls, in two of the Family Units, and in two other Housing Rooms. These were minor modifications for the student who can “lift himself”, made within only “certain buildings” that individual students would need to access (Bone, 1949; Graffouliere, 1949). This ensured that, just as Scharper had adapted himself to the school environment “without being a burden to anyone”, there would be minimal disruption to the established architecture.

College Showers Designed for Disabled-People

Galesburg and Warm Springs had been somewhat confined, collective spaces for particular populations. Initially, enrolment of Disabled-Students to Urbana was also restricted to Veterans. Within the year that students started to transfer from Galesburg, other Wheelchair-Confined individuals sought to access the University in the hope that it would allow them to invest in their education, become self-governing, and have the potential to gain employment:

I am confined to a wheelchair as a result of having polio as a child, but as my home is in Champaign and I now have adequate transportation to and from the campus, I thought perhaps this was an opportunity to complete my education.

The main difficulty is that I do not possess a high school diploma. I attended the Champaign public schools full time through one year of high school, and then because of so many stairs it became impossible to continue.

However, it would mean a lot to me to obtain a university degree as I need to be self-supporting and I cannot think of a better way to obtain worthwhile employment and lead a more useful life.

(Bainum, 1949, p. 1).

Fadyl (2013) discussed the “useful life” as an early rights discourse that was employed from the late 1940s in relation to Disabled-People, and that was associated with belonging to, or wanting to be employed, with work forming a central part of social life in the community. Within a dispositif in which Disabled-People had been seen as a deficit to the capital of the country, the production of Disabled-Students who were visible as a group of assets created desire in other Disabled-People to join the Students of Urbana. As Cruickshank (1996) explained, rather than any external discipline being involved in locating and concentrating such subjects into disciplinary spaces, individuals see their own interests as tied to the collective and seek out territory in which they might make a claim to the benefits of such.

In 1950, the programme had expanded beyond Disabled-Veterans to include “wheelchair students” (“quadriplegic”, “triplegic”, or “paraplegic”) and students with other disabilities (five “amputees”, two “pulmonary cases”, five “partial paralysis cases”, one “spastic (cerebral palsy)”; and “civil cases” far outnumbered veterans (Nugent, 1950, pp. 2-3). By 1954 the individualised modifications to the facilities were deemed inadequate (or were discovered not to have been done at all).²¹⁸ This had resulted in some students being unable to shower:

²¹⁸ Modifications to a shower-bath in the Girls Residence Hall had been proposed for the first female student (Sheldon, 1949). Five years later it was discovered that although doors had been removed to enabled access, rails had never been installed.

5. We were very disturbed to find out that some of our girls had taken as few as three baths in the course of the last school year because of the difficulties encountered in entering the shower-tub stall. These girls compensated by means of 'sponge baths' but this is not desirable.

(Nugent, 1954, p. 10)

As noted in Essay 3, by the middle of the 1950s frequent showering or bathing was necessary to be included as a healthy and desirable member of society. From this time, rather than individual students determining what they needed, modifications to buildings were specified by Nugent (supervisor of the Student Rehabilitation Centre). In the bathrooms this included the installation of rails, widening of doorways, and provision of additional facilities to ensure that not all “wheelchair girls” would need to be in one corridor. Having only one bathroom facility in the girls’ dorms was problematised as it meant the “wheelchair girls” were all collected together. Such an arrangement was dangerous in terms of “security” and “social integration”:

a. The assignment of all wheelchair girls to one corridor could create many security problems.

b. The assignment of all wheelchair girls to one corridor is also a very unfavorable pattern of social integration.

(Nugent, 1954, p. 11)²¹⁹

Rather than the students “somehow” getting by using their own determination, the idea of removing architectural barriers for Disabled-People to be united with the rest of the student group emerged.

In 1954, the University determined that all new buildings would provide “for the entrance and accessibility of wheelchair students” (Nugent, 1954, p.4). The idea of architecture providing “wheelchair students”, “students with other forms of physical handicapped”, and “other severely handicapped individuals” the “free and independent” use of the University was established:

²¹⁹ It is not clear from the text what the many security problems could be.

Five new ramps have been planned and approved for construction making available additional academic space and vital activity centers on campus. The rebuilding plans for Altgeld Hall will also allow for the free and independent use of the wheelchair students and students with other forms of physical handicap. The policy that all new buildings built at the University of Illinois will be planned so as to allow for the free and independent use of wheelchair and other severely handicapped individuals without additional expense or modifications is already being exercised. The new Law Building and the new Home Economics Building conform to this policy. This is also true of the plans which have been approved for two new permanent residence halls for men.

(Nugent, 1955, pp. 1-2)

The possibility of architecture providing Disabled-People with “free and independent” use of the campus was a significant shift away from individual self-responsibility to overcome handicap. Many universities from around the USA sought to replicate the new building plans of Urbana (Nugent, 1955).²²⁰ Nugent became an authority on the elimination of Architectural Barriers, and the Disabled-Students became subjects of a new science of Accessible Design (see Appendix II). The ideas of Accessibility and architectural barriers led to the establishment of Standards for making public buildings (and the showers within them) Accessible (see Appendix D – Building Act Reform for Building Users). However, I now return to private dwellings and the 1950s emergence of showers designed by and for Disabled-People.

Disabled Entrepreneurs may Escape to Freedom

As noted above, the duty of the state to Disabled-Veterans meant that some governments had involvement in Accessible Design in the private property market. In the USA funding was limited to a very specific population of Disabled-Veteran. For example, funding was granted initially only to paraplegic veterans who had lost “both bladder and bowel functions in addition to paralysis” (“Paraplegic Ruling Fought by Amvets”, 1948, p. 4). For those who were not eligible for state funding, the same ideas of self-responsibility, will power, and entrepreneurship (or “workable ideas”) that had been proposed to overcome prejudice in the workplace (see “Preparation vs. Prejudice”, 1934, p. 3 above) applied to the prejudices of architecture in the private dwelling.

²²⁰ It appears to have taken another 10 years for a discourse of Accessibility in relation to architectural barriers to have emerged in Aotearoa New Zealand (“Need to Make Buildings Accessible for Crippled”, 1966; “Architectural Barriers”, 1968).

In 1950, the USA Saturday Evening Post article “Escape for Wheelchair-Prisoners”, “courageous” and “gallant victims of crippling misfortune” could be transformed into “a cheerful and productive citizen” living and working in the world. The article proposed that this transformation could be made possible through the use of “gadgets”²²¹ designed by manufacturers, handicapped people, occupational or physical therapists, physicians, engineers, inventors and “handy men about the house” (Spencer, 1950, p. 23) to meet the individual needs of such “gallant victims” (p. 22).²²² The article shared the stories of various Disabled-People who “haven’t given up” and who, photographed with various Gadgets, were able to perform everyday essential activities Independently. Jerry (Gerald) was one such subject. Pictured in his “ingenious portable shower” the description states “polio victim Gerald Chapin invented this ingenious portable shower, which he can use while sitting in his wheelchair - and without spilling a drop” (Spencer, 1950, p. 22). Jerry is photographed in a small bathroom, to his left is a hand basin which is connected to two hose pipes. The hose connects to a large white plastic shower curtain which is strung up to a bar near the ceiling behind the young man. The curtain falls down each side of the man, then folds under and over his lower half so only his torso and head is visible. He holds a shower head over his head, his eyes are closed and his mouth is open. Another hose comes out of the bottom of the shower curtain. Jerry is sitting on a wheelchair with a box in front of it that the front of the folded shower curtain rests on. There is a toilet to the right of the man and a bath in front of that. The hose coming out of the curtain goes into the bath.

Unlike the shower with a swing out seat in the Paraplegic Veteran’s Bathroom Unit, Jerry’s Ingenious-Portable-Shower was a gadget rather than architecture. Jerry’s gadget connected him to the Properly-Plumbed-House. The water flowed out of the established handbasin, through a shower hose pipe to a hot-and-cold mixer, then over the body of Jerry as a body-wheelchair complex. Jerry was contained within an ingenious adaptation of a shower curtain propped up with a box, and then out through another pipe, into the established bath. The shower tray was replaced by the curtain, or “tent”, made from “strong waterproof cloth” that was temporarily configured to ensure that he could shower “without spilling a drop” (Spencer, 1950, p. 22). Jerry demonstrated his shower at his grandmother’s house and explained that the shower can drain into a “bucket, washtub or any other available outlet of convenient height” (Spencer, 1950, p. 63).

²²¹ See Hocking (2004) for a fascinating historical analysis of the connection between occupational therapists and gadgets (amongst other objects).

²²² See for example *Occupational Therapy & Rehabilitation*, 27(3), 1948.

Jerry was a navy veteran and, later, a Warm Springs alumnus. Like Scharper, Jerry was described as being the type of Disabled-Person who rightly understood that he may depend on his own power to overcome the disadvantage of handicap. Jerry's "refusal to take advantage of his situation" allowed him to be "popular" and a "fine influence" on his normal associates when he returned to high school to invest in his education (Spencer, 1950, p. 64). Jerry was not connected to any duty of the state that Paraplegic-Veterans may have had. Instead, like the students of Galesburg, he was a subject who could "somehow" adapt the private space of the domestic bathroom with minimal cost to ensure that he would be Independent. Like Scharper, Jerry was "ambitious", confident in his efforts, and planning to enter College where, provided stairs did not create too much of a barrier, he could continue to invest in himself (Spencer, 1950). Furthermore, Jerry was an entrepreneur, who patented his Ingenious-Portable-Shower in the hope to make it available to other Disabled-People (Figure 54):²²³

²²³ Jerry's design followed a much earlier "Portable bath or sack for washing or bathing purposes" (Herz, 1904) and continued to influence hygiene shower inventions through to 2020 (McCaffery, 2020). Interestingly, Jerry also appeared later in the Periodical "Performance, The Story of the Handicapped" (United States President's Committee on Employment of the Handicapped, 1963) in which he is photographed partially hidden behind a different form of curtain in his new profession as a puppeteer. Apparently forced to take puppet-making as the only class left to him at college (the University of Miami), due to the barrier of stairs, he was shown in 1963 to be "Pulling Strings in His Business" with his wife and young child (United States President's Committee on Employment of the Handicapped, 1963, p. 10).

Figure 54

Jerry's Ingenious Portable Shower, 1953

June 16, 1953

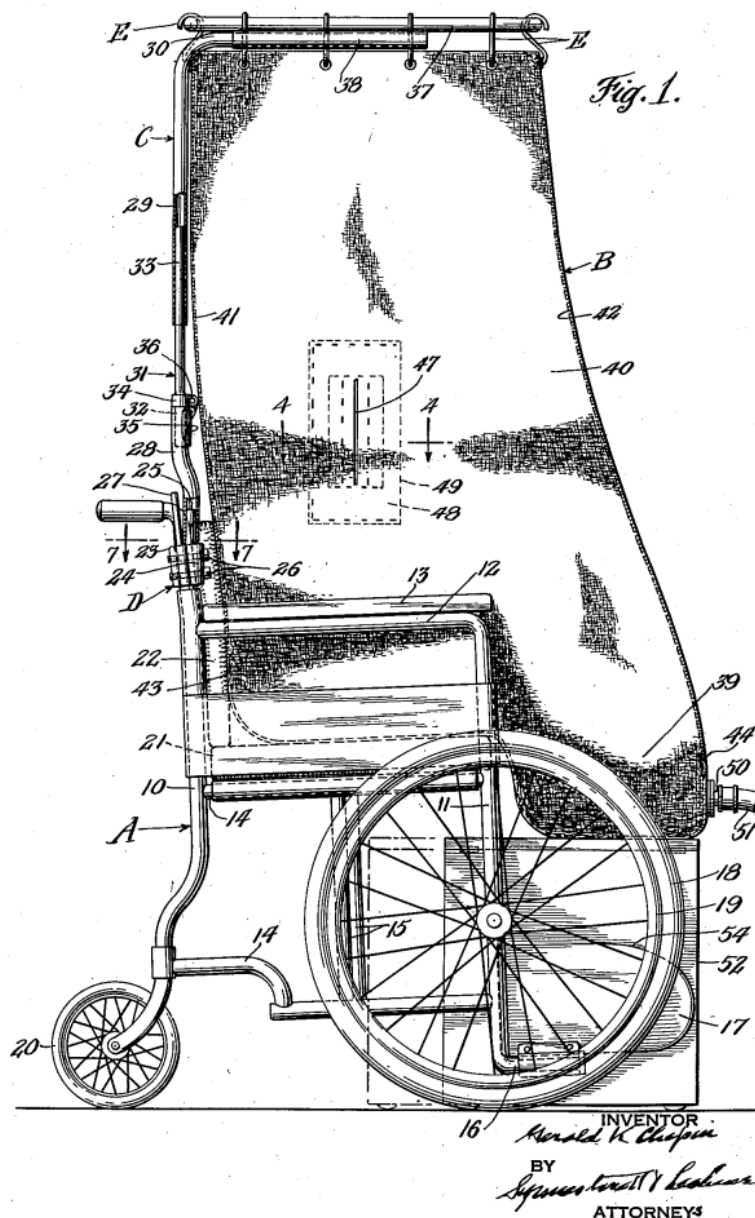
G. K. CHAPIN

2,641,770

SHOWER BATH FOR INVALIDS

Filed April 19, 1950

4 Sheets-Sheet 1



Note: From U.S. Patent No 2,641,770, by G. K. Chapin, 1953. In the public domain.

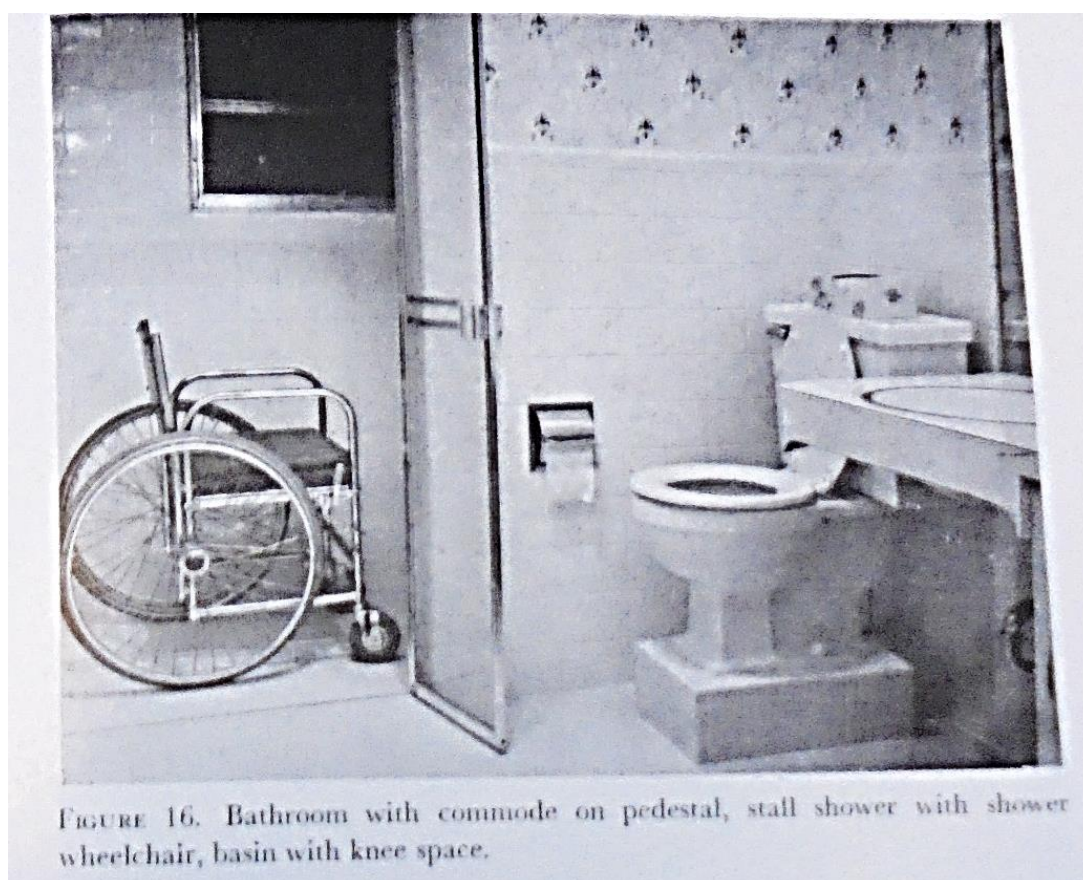
Within a dispositif in which the Crippled-Body had been somewhat divorced from Handicap (as in disadvantage in competition), a Fordist governmentality placed the power to overcome handicap within the self-responsible individual. Subjects who were seen to be able to use their will power or determination to overcome the Handicap their Physical-Disability created became agents in their own discipline. The idea of the right to attend university established the campus as part of Disabled-People's territory, and the architectural barriers of the world outside the Rehabilitation Facility became

visible. Through Rehabilitation, Education, and public building Accessibility, the possibility of Disabled-People with human capital that could be employed, for some at least, was realised (“In Annual Pay: Handicapped UI Grads Gets Nearly \$5,000”,²²⁴ 1956). As subjects with human and material capital, Disabled-Income-Earners were able to enter the liberal space of the housing market and the idea of Disabled-Person as consumers of private bathrooms, made-to-order for their use, emerged.

By 1960, modifications to an earlier 1920s “Invalid’s Toilet Chair” for use in hospitals (Appendix III) produced the “Shower Chair” designed to transport patients to the shower for bathing, in “hospitals and similar places” (Appendix IV). While the original designs did not permit Independent wheeled access to the shower, the idea of a chair designed to access the shower, and the shower designed for access to a wheelchair saw further modifications of both. This finally resulted in a domestic bathroom in which the shower could be accessed by those who are unable to stand or step (Figure 55):

Figure 55

Stall shower with shower wheelchair in the 1968 Made-to-Order house



Note. From *Wheelchair to Independence: Architectural Barriers Eliminated* (p. 29), by E. M. Gutman, & C. R. Gutman, 1968, Charles C Thomas Publisher. Reprinted with permission.

²²⁴ Well above the average income at the time.

The book “Wheelchair to Independence: Architectural Barriers Eliminated” includes showers without a step. The access is level, meaning that it may be wheeled into. These were showers for the determined Physically-Disabled-Consumer who was a member of the intellectual class: “If you are an individual, sound in mind and spirit, why permit unsuitable living quarters to serve as a veritable prison?... If architectural barriers are your nemesis, you are about to storm them with a frontal attack” (Gutman & Gutman, 1968, p. 3). Living quarters, made to suit, may provide freedom. Again, employing a military metaphor, individuals were called to wage war against architectural barriers but, this time, through investment in the property market.²²⁵ These were subjects who had acquired disability, and could invest in a Made-to-Order house that would suit the condition of their disability: “The ideal home is the made-to-order house. This is especially true after your disability strikes” (Gutman & Gutman, 1968, p. 53). Like the Disciplining Hospital, the private dwelling becomes an “individualised space environment, specific to them and modifiable according to the patient, the disease, and its evolution” (Foucault, 1978/2016, pp. 211-212) and the shower becomes an agent and instrument of care. However, unlike the collective, contained space of the hospital the “shower stall with shower wheelchair” is a shower customised for the self-governing individual who has obtained sufficient capital to be able to fight for their freedom within the property market.

Within Gutman and Gutman’s 1968 Stall-Shower-with-Shower-Wheelchair, the rationale for eliminating architectural barriers remained connected to employment. The cover of “Wheelchair to Independence” (1968) states “what a blow it is for a well-qualified applicant to be rejected for a good job merely because doorways to the office building are too narrow for his wheelchair!”. Unsuitable living quarters could be a “prison”, one of “the endless list of structural villains” that could cause you to be “trapped in your own house, or barred from it” (Gutman & Gutman, 1968, p. 3). The Stall-Shower-with-Shower-Wheelchair is a feature of the dwelling that connects the Disabled-Person to society. The dwelling becomes part of the campaign of the self-responsible Physically-Handicapped-Person, who must have the will power to overcome such barriers “because you must use a wheelchair instead of walking is a poor excuse to permit yourself to become excluded from society” (Gutman & Gutman, 1968, p. 3). The house was not to become a place to permanently dwell within; it was a space to produce Independent, determined Disabled-People who were connected to the disciplinary society and the apparatus of production.

²²⁵ Through either building their own home or modifying a rental at their own expense (Gutman & Gutman, 1968).

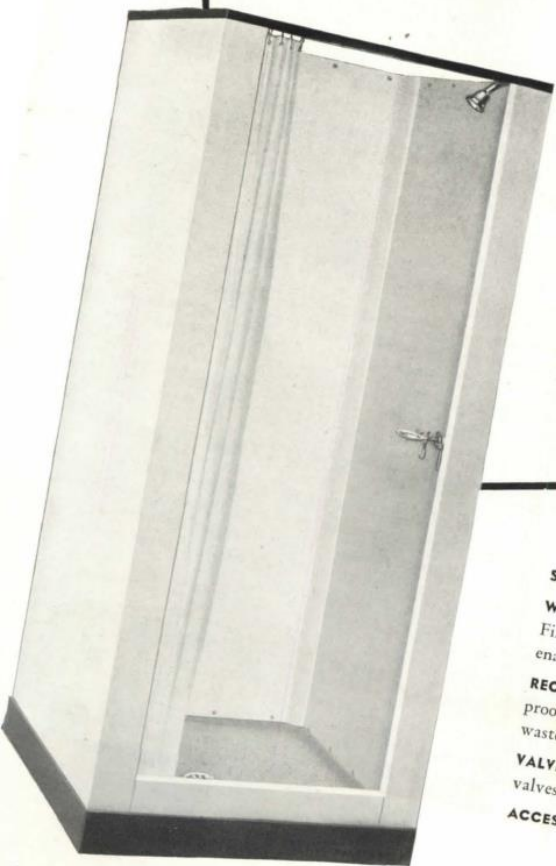
Summary: Made-To-Order Showers for Disabled-Income-Earners

In the early 1900s, Rehabilitation within the Rehabilitation Facility had functioned to produce Independent Disabled-People who could be returned to society as an asset, rather than a deficit to the nation's capital. However, the world, where stairs prevailed, presented barriers to their employment. Democratic Associations that had been established with the facility were deployed to continue the Rehabilitation Campaign, promoting the idea that physical-handicap and being a cripple should be distinguished. Physically-Handicapped-People were constructed as responsible for overcoming their handicap through willpower, entrepreneurialism, and investing in their education. While there was some state support for such education in the USA during the depression, it was the idea of reciprocal duty for injured veterans that established state support for vocational or college education.

Following World War II, the idea of support for college education as a feature of a duty of the state to veterans led to associations of Disabled-Veterans advocating for Rehabilitation spaces to be extended into private dwellings as a continuation of the idea of the prosthetics that were already supplied to them. As such, architecture that produced Independent Physically-Disabled-People surfaced in rooms that could come to comprise private dwellings. Subsequently, disciplining Rehabilitation spaces within the facilities of university campuses were designed for those who were eligible to leave the hospital. Disabled-Veterans attending college became visible, doing everyday activities and participating in ordinary spaces in society. While a discourse of Disability Rights was not yet in circulation, the idea of Human Rights and the right to attend college was available. Access to a college education was then extended to other Physically-Disabled-People. After a period of getting through "somehow" with minor building modifications, the idea of spaces within buildings designed for the free and independent use of Disabled-People emerged.

However, the established limits of government in relation to private dwellings remained, and Physically-Handicapped-People ineligible for a Paraplegic-Veteran's-Bathroom-Unit were responsible for overcoming their handicap through willpower, entrepreneurialism, and investing in their own gadgets or Made-to-Order home. The private dwelling or Family-Home with a Stall-Shower-with-Shower-Wheelchair was an extension of the Disciplining Hospital. Designed for the person and their disability, they were spaces for Independent, determined, Physically-Handicapped-People to escape the collective, contained institution to connect to society and the apparatus of production. At this point, the USA government had established some involvement in the modification of showers for Disabled-People in private dwellings. In the following

Essay, I analyse the Accident Compensation Act 1972 and the Accident Compensation Amendment Act 1973. This legislation provided the possibility for government funded housing modifications for any injured member of the population in Aotearoa New Zealand.

Appendix I**Figure 56***"Fiat skipper solves the problem for low cost housing", 1947*


FIAT Skipper

**solves the bathroom problem
for low cost housing . . .**

- Low installed cost
- Minimum floor space required
- According to surveys made at camps the majority of Veterans, both men and women, have expressed a preference for shower bathing
- Fiat Skipper showers are available



Specifications

SIZE—32x32x76.

WALLS—BONDERIZED, GALVANIZED STEEL.
Finished inside and out with white baked-on-synthetic enamel.

RECEPTOR—Semi-flat standard type Stonetex; slip-proof, leak-proof, non-absorbent. Brass drain for 2" waste connection cast integral with receptor.

VALVES—Combination hot and cold compression valves with shower head and arm.

ACCESSORIES—Curtain rod and curtain.

FIAT METAL MANUFACTURING COMPANY
Roscoe St., Chicago 13, Ill. • 21-45 Borden Ave., Long Island City 1, N.Y. • 32 S. San Gabriel Blvd., Pasadena 8, Calif.

PROGRESSIVE ARCHITECTURE

Note. From "Fiat skipper solves the problem for low cost housing," by Fiat Metal Manufacturing Company, 1947, *Progressive Architecture*, XXVIII(2), p. 102. Orphan work.²²⁶

²²⁶ If you believe that copyright infringement has occurred in any of this content, please contact the author.

Appendix II

The caption with the second photo reads “Folding seat in shower is out of way for able students, makes shower usable for paraplegics as shown by Leon Keller, Manteno (post-polio)”.

Figure 57

University of Illinois shower usable for paraplegics, 1960



Note. From “Accessible shower”
Image 0003608, by University
of Illinois, 1960. Reprinted with permission.

Figure 58

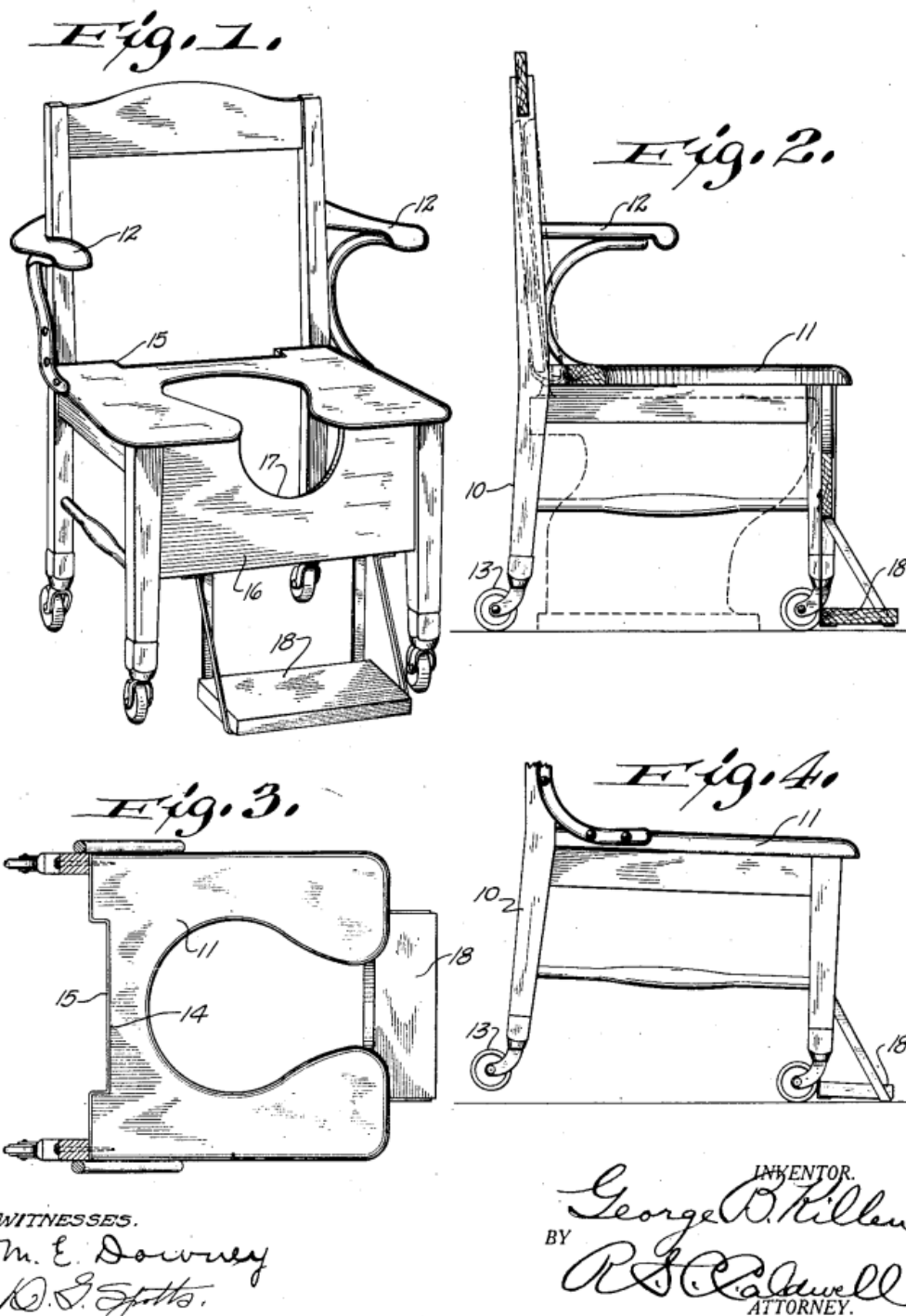
University of Illinois shower usable for paraplegics 1, 1960



Note. From “Accessible shower”
Image 0003621, by University
of Illinois, 1960. Reprinted with permission.

Appendix III**Figure 59***Invalid's Toilet Chair Patent, 1927***Aug. 9, 1927.****G. B. KILLEN****1,638,040****INVALID'S TOILET CHAIR**

Filed Nov. 12, 1926



Note. From U.S. Patent No. 1,638,040., by G. B. Killen, 1927. In the public domain

Appendix IV**Figure 60**

Shower Chair Patent, 1964

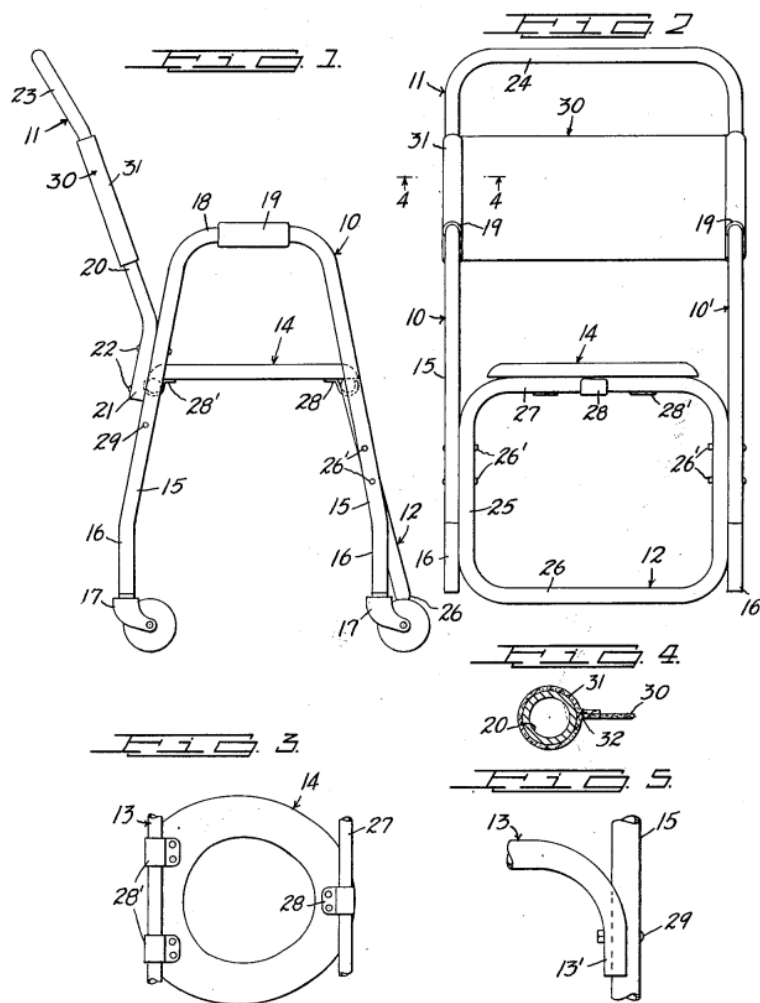
March 3, 1964

C. E. MURCOTT

3,123,398

SHOWER CHAIR

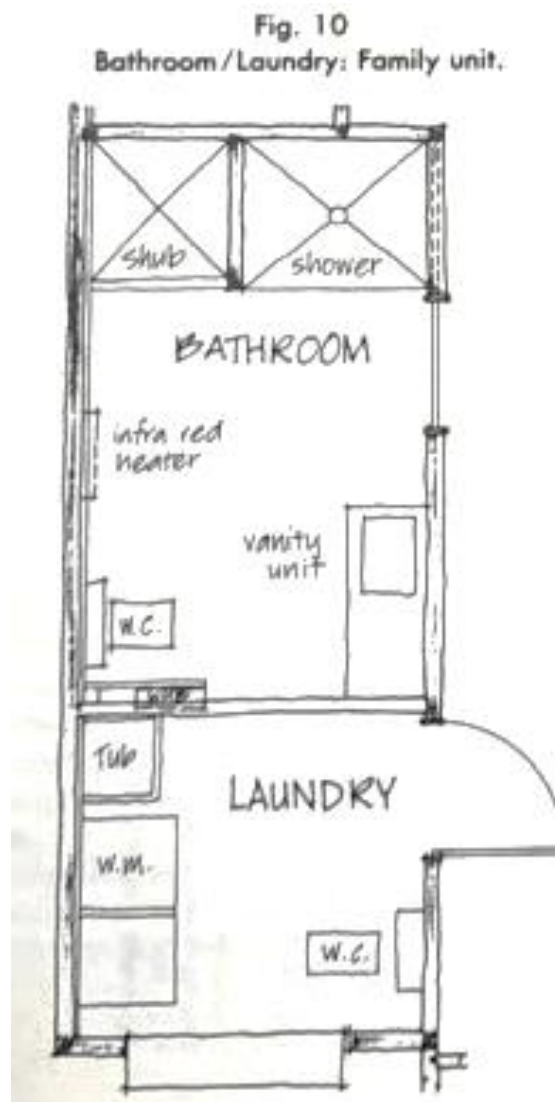
Filed Oct. 10, 1962



INVENTOR
 CHARLES E. MURCOTT
 BY
Howard E. Thompson
 ATTORNEY

Note. From U.S. Patent No 3,123,398., by C. E. Murcott, 1964. In the public domain.

Essay 7 Showers for Disabled-Housewives



P. A. Cuniffe's Family Unit Shub and Shower (1980)

In 1980, New Zealand's Accident Compensation Commission (ACC) built two housing units that contained showers "for use by paraplegics". These units, and the showers within them, were designed for people who had been disabled as a result of injury. One was a "family unit", while the other was a "single unit". The idea of state involvement in showers designed for Disabled-People had emerged in relation to the reciprocal duty to Soldiers and, in the USA, the right to participate in public spaces. The Accident Compensation Act (1972) established social insurance for anyone disabled by injury, connecting the loss of physical capital for the individual to the physical capital of the nation. The idea that the Family-Home should restore the worker constructed Housewives as a feature of the worker's home environment. As such, a loss of physical capital of the nation would be incurred should Housewives be disabled by injury. The connection between the Housewife and the Family-Home made them subjects of interest for an emerging discourse of Disability Design within private dwellings. However, shower design remained primarily for the worker, with the Housewife a feature of the environment whose interests were secondary to the restorative function of the Family-Home. Despite this, the ACC dwellings became occupied by paraplegic-housewives. While the established order put the interests of the Housewife second, accident compensation for any member of the population who sustained an injury made it possible for the state to become involved in the provision of modified showers in private dwellings for any such Disabled-Person.

Slipping in the Shower at Home and the Physical Capital of the Nation

As noted in Essay 6, governments had established some interest in the provision of houses designed for Disabled-People through the idea of reciprocal duty to Disabled-Veterans following World War II. While the Rehabilitation discourse extended to include other Disabled-People and created the possibility of such people building their own made-to-order house, a liberal governmentality maintained established limits of state involvement in the private property market. In Aotearoa New Zealand, a review of the government of personal injury in the late 1960s saw a rupture in the discourses that connected disability, work, and the health and wealth of the nation. This led to an extension in the interests of the government in the private dwellings of Disabled-People. Extending the idea of reciprocal duty to all citizens, this rupture rationalised the state's interest in the Family-Home of People-Disabled-by-Injury.

The idea of monetary compensation for injury to a body part is ancient²²⁷ and is traditionally an arrangement between the injured and a liable second party. Following this tradition, compensation for injury in Aotearoa New Zealand was, up until the early

²²⁷ For example, the mid-21st century BC Ur-Nammu code (Guyton, 1999).

1970s, obtained by making someone, such as one's employer,²²⁸ liable for the cost of injury following an accident. In 1967, a report by New Zealand's Royal Commission of Inquiry into Compensation for Personal Injury (Woodhouse et al., 1967) aimed to disrupt this tradition. The Commission argued that the existing system of private workplace insurance created additional costs for individuals and businesses and did not function in the best interests of the individual or the nation. Instead of injury being a problem for the injured and the injurer, the Commission connected injury to social insurance and state security. Just as the nation had a duty to its Disabled-Veterans (see Essay 6), they proposed that the nation owed a debt to its injured workers. The community had received the benefit of their human capital (or "productive efforts" p. 109) and, therefore, it was only fair for the community to repay this debt:

Indeed it is the feature of this inquiry that, at the outset, we are faced by a problem that no longer can be swept easily to one side if any just and coherent solution is to be found to the reasonable claims of incapacitated workers upon the community which has been prepared to accept the benefit of their work.

(Woodhouse et al., 1967, p. 34)

While the Commission connected the cost of injury to the community as an issue of reciprocal duty, the effect of this connection was to increase the role of the state in the government of the injured.

The Commission proposed that accident compensation should be connected to the effect of the injury rather than discriminating based on the cause. The cost of this loss of human capital to the nation was the same regardless of the cause. As such the value of the worker was argued to continue to exist outside of the workplace and the effect of injury are the same "if he slips and is disabled in the factory shower-room as he prepares to go home...[or] if he suffers the same accident upon his arrival at his home" (Woodhouse et al., 1967, p. 35):

²²⁸ Or a driver in the case of motor vehicle accidents.

46. It is obvious enough that a worker does not cease to be a worker as he leaves his factory at 5 o'clock. But existing processes refuse to accept his continuing status. If he slips and is disabled in the factory shower-room as he prepares to go home, he will be entitled to all the advantages of the Workers' Compensation legislation and may even succeed against his employer in a negligence action. Yet if he suffers the same accident upon his arrival at his home he will receive nothing at all, or at best the assistance provided by the Social Security Fund. From the point of view of the injured workman these inconsistent results develop from a diagnosis by causes and a disregard of their similar effects. When it is recognised that in each case it is the community which pays, the discrimination assumes an air of unreality.

(Woodhouse et al., 1967, p. 35.)

A democratic governmentality established the idea of injury being a cost to the community, a loss of the physical capital of the nation. Woodhouse et al. (1967) tied the interests of the collective to the interests of the individual and enlisted all members of the injured population into "Comprehensive Rehabilitation". Disconnecting injury related loss of human capital from the territory of injured individuals meant that anyone's injury anywhere (including the private home) was now part of the nation's government of injury.

It follows that if it is thinkable for the nation's loss of human capital to be the same whether the worker is at work or at home when they are injured, then other subjects who are not at work when they are injured might have capital too:

(c) The elderly and the young must be included on a basis which recognises their past or potential contribution to the productive effort of the nation: and the housewife because of her direct and continuing contribution to that effort.

(Woodhouse et al., 1967, p. 109)

"The Elderly"²²⁹ are connected to human capital by having been workers in the past, and "The Young" are credited with the possibility of a future contribution as workers. Although these subjects are not connected to work at the time of their accident, the idea of their human capital being connected to work at some point in time justifies the community's duty to them. "The Housewife" is also recognised for making a direct and continuing (but otherwise undefined) contribution to the "productive effort" of the nation. The Housewife appears to be somewhat of an anomaly, not clearly connected to the nation's duty to reciprocate the benefits gained from their work. So, what is the "directing and continuing" connection that the Housewife has to the apparatus of production that would explain her involvement in the dispositif? In the next section I

²²⁹ I examine discourses related to the Elderly in my next Essay.

examine the Housewife as a subject to determine how she became connected to the government of injured citizens and, thus, state funded modified showers for Disabled-People.

Family-Homes and Restoration of the Worker

Boys et al. (1984) provide a fascinating study of house design and women's roles in Britain from the 1880s to the 1970s. According to their research, prior to industrial capitalism, houses for working people were designed for both work and survival activities and accommodated people who were not related to one another. However, in the mid-1800s private dwellings in the form of "Family-Homes" emerged, connected to a discourse of preventing the transmission of disease and improving sexual morality (see Essay 3). The design of these dwellings involved reducing the number of people living within houses to distinct families (the "family cell" as Foucault would call it [Taylor, 2012]).²³⁰ These were contained, collective spaces for two parents and their children, designed to increase privacy between and within dwellings, and separating parents, boys, and girls within the dwelling. Alongside housing redesign, regulations such as banning lodgers and preventing paid laundering being done in private dwellings ensured that traditional women's paid work within their home was separated from the apparatus of production.

Boys et al. (1984) go on to explain that when entering such model Family-Homes from the street, the dwelling is designed to be a retreat from the workplace, a place for comfort and privacy, but also to display one's material and human capital. However, towards the back of the house, hidden from the public, the laborious work involved with caring for the members of the household took place. In the early 20th century, the "family wage"²³¹ became connected to the family cell and the "dependent 'full-time' housewife" was established to provide the care of the house and family of a growing middle class (Boys et al., 1984, p. 71). From this time and through to the time of New Zealand's Royal Commission of Inquiry into Compensation for Personal Injury (Woodhouse et al., 1967), housing design guides depicted the Housewife as a feature of the Family-Home. Her function was to ensure that the Family-Home was a place for comfort and rest for the male wage earner (Francis, 1984). The Housewife thus formed

²³⁰ Foucault (1979/2007) wrote about this construction of the "family" or "household" as a technology of a biopolitical governmentality: "The family is... a segment whose privilege is simply that when one wants to obtain something from the population concerning sexual behavior, demography, the birth rate, or consumption, then one has to utilize the family. The family will change from being a model to being an instrument; it will become a privileged instrument for the government of the population" (p. 141).

²³¹ The idea of the Family Wage is identified by Fraser (2003) as another feature of a Fordist governmentality.

part of the milieu that maintained the health of the working man and the wealth of the nation.

The history of housing design and government of the Family-Home is important in understanding how the Commission rationalised the inclusion of the Housewife in the government of accidents and injury. While the Elderly and Young were argued to have a historic or potential connection to work, Housewives should also be counted, since they made it “possible for the productive work to be done”:

The same considerations must apply, also, to the women in the population who as housewives make it possible for the productive work to be done. The need is for an integrated solution with comprehensive entitlement for every man and woman, and coverage in respect of every type of accident. This is the central recommendation of our Report.

(Woodhouse et al., 1967, p. 21)

Through her connection to the Family-Home of the worker, the Housewife makes her “direct and continuing contribution” to the productive efforts of the nation. While the government of injuries in the past had been connected to the duty of the employer, the person at fault, or the obligations of the nation to its Soldiers, the idea of injury creating a loss of the nation’s human capital extended this interest into the Family-Home. While the purpose of the Commission may have been to inquire into “Compensation”, their review went beyond compensation to consider the cost of personal injury to the nation. This cost, which included those with a past, future, or “direct and continuing” contribution to the nation’s productive efforts, connected all people disabled by injury to “complete rehabilitation”.²³²

Penner (2018) provides a detailed history of Housewives and Rehabilitation. She shows that from the early 1900s Housewives had been connected to an “efficient gesture” discipline via Home Economics, the science of “home-making”. While women’s traditional work within the private dwelling (such as laundry services) had earlier been disconnected from the apparatus of production, Home Economics connected the activities of Housewives to the idea of efficient work and a well-run factory. Gilbreth (1928) wrote, “Home-making is the finest job in the world” (p. vii), a job that was argued to be more interesting and satisfying through ensuring it was done without wasting energy and organised as an industrial process. Employing the idea of democratic government, Gilbreth proposed that

²³² “A total process which begins with the earliest treatment of the injury or disease. It does not end until everything has been done to achieve maximum social and economic independence” (Woodhouse et al., 1967, p. 141).

One can't remember too often that the home is a group possession. It belongs in most cases to a family—which means group ownership, group responsibilities, and group aims—if happiness is to result. We have not only “the psychology of the total situation,” but the demands of each individual in the group, adjusted to each other.

What is a home? A rest place for all of us, a work place for some of us, an opportunity to balance up what happens to us in our time outside the home and to make our twenty-four-hour day as profitable and satisfying as we can.

(p. 4)

The job of the Homemaker was to efficiently create a home for the group, a workspace for herself, and a space of restoration.

In addition to disciplining the performance of home-maker activities, Home Economics constructed the household as a site of economy:

It is profitable to look at the home as a small section or group of society and to measure each member of it as a producer and a consumer. It is usual to measure each member of society in this way and to grade him, all the way from a one hundred per cent producer to a one hundred per cent parasite. Why not look at each member of one's household in the same way? Some there, too, may be one hundred per cent producers, some one hundred per cent parasites, with the others ranging everywhere between.

(Gilbreth, 1928, p. 28)

While Gilbreth does not address the problem of disability, the economic household becomes a space of collective interests within which individuals could be calculated as units that may be an asset to, or depreciate, the capital of the collective. The interests of the individual are tied to the collective, and an inability to produce is a deficit to all.

Foucault argued that the family is a space of sovereign rule (Duschinsky & Rocha, 2012). Indeed, the model Family-Home is constructed as a space that is separated from the working man's world of production. The home is a heterotopia, a space outside of all other places where the head of the household is free from the disciplinary effects of the workplace. However, the Family also acts as a “the hinge and switch-point for the disciplines because of the way in which it can operationalise its assemblage of potent affects with economic, political and geographical ties in the

service of determinate forms of biopolitics" (Duschinsky & Rocha, 2012, p. 34). The Family-Home is thus a site within the network of the disciplinary society. Gilbreth (1928) proposed that the Housewife should be the foreman, engineer, and psychologist of the home. Included in her duties is the training of young girls and boys to independently, and efficiently, take a bath, and providing an evening bath as a remedy for her tired husband's fatigue (Gilbreth, 1928). The Housewife was responsible for producing the restorative effect of the home, alongside disciplining children as future workers and Housewives. However, rather than her job being connected to industry, she is the producer of a space for rest and happiness for the worker, and her payment is his appreciation (Glibreth, 1928). In relation to the apparatus of production she functions as a therapeutic operator, the producer and a feature of the Family-Home, an environment for the restoration of the happy, well rested worker; thus, making it possible for the productive work of the Family-Man to be done.

Rehabilitation Showers for Disabled-Housewives in the Family-Home

Just as the idea of Engineering the Cripple disciplined the bodies of Physically-Disabled-People to produce workers (see Essay 5), Rehabilitation took an interest in the activities of the Disabled-Homemaker in the middle of the 1900s. The "Manual for training the disabled homemaker" explains the danger of Disabled-Housewives within the Family-Home:

Industrialists are well aware of the effect of home life, worry, and additional responsibilities at home on the efficiency of the worker on the job. These influences are reflected in lower production and absentee-ism at a time when the wage earner will need to be at the peak of earning capacity.

A permanent disability is a continuing financial drain if the homemaker cannot carry on her usual responsibility. Domestic help or excessive outside services increase family spending and many times the cost of food and clothing increases if the homemaker is unable to shop as she did before.

(Rusk et al., 1955, p. ix)

The Housewife's "responsibilities" at this time included shopping and tasks such as meal preparation and service, cleaning, laundry, sewing, and childcare (Hossack, 1953). The failure of the home to provide happiness (by creating worry) and rest (by creating additional responsibilities) are connected to a depletion of the worker's human and material capital. This creates a deficit to the Family and the nation. Rehabilitation training could help to overcome these problems.

From the mid-1900s, Disabled-Housewives were connected to the dispositif in which the idea of Rehabilitation and Design to overcome Physical-Handicap had been

established (see Essay 6). Rusk et al. (1953) advocated for the use of Gadgets along with architectural designs as a way that all Disabled-People could continue “Living with a Disability”. Rusk et al.’s work was undertaken in co-operation with the “National Foundation for Infantile Paralysis” and the “Disabled Homemaker’s Research Fund” and had a particular interest in the aesthetic of Disabled-Women, noting that “the surest way for a doctor to know that his feminine patients are feeling better is to find them with a becoming hair-do and fresh lipstick” (p. 46). Bathing was associated with “Keep up Appearances”, “Look Your Best”, “accentuate the positive”, and Disabled-People were advised to “make sure that you don’t use your disability as a ‘crutch’ or excuse for not keeping up your personal appearance” (Rusk et al., 1953, p. 46). Just as the wider population were induced to wash (see Essay 3), Disabled-Housewives had a duty to look, smell, and be clean. Rusk et al. included bathroom design “guides and suggestions” (p. 64) for those looking to build a new home or adding a bathroom. However, like the Paraplegic-Veteran’s-Bathroom-Unit in the Prosthetic Home, their designs maintained the established shower unit. The shower was modified only by the provision of a wall hung seat, and they warned that bathrooms with a shower, but no bath, were only suited to those who can stand up (see Appendix I).

In addition to the Disabled-Person being able to take care of themselves, Rehabilitating the Housewife involved returning her to her responsibilities of ensuring that the home maintained its restorative function, to reduce the loss of the worker’s capital, and ensure the worker goes to work and is productive while they are there. As Penner (2018) explained, in the mid-1900s, studies of modified spaces to enable Disabled-Housewives to perform “Homemaking” activities were undertaken.²³³ The idea of Disabled-People being able to perform the tasks of the homemaker extended the possibilities of the modified house beyond its function as a connection to work and study outside of the Rehabilitation Facility:

Architectural implications	Even a severe physical disability need not imply loss of independence. Provided that her home is convenient the woman in a wheelchair may be able to perform her regular duties as housewife and mother.
----------------------------	--

(Goldsmith, 1963, p. 35)

The house, modified for the regular duties of the Housewife, is constructed as creating the possibility of overcoming the Disabled-Housewife’s failure to produce and maintain the Family-Home. In other words, Disability Design for the Housewife may “make it possible for the productive work to be done” (Woodhouse et al., 1967, p. 21).

Goldsmith’s (1963) “Designing for the Disabled”, published in the UK, claims to be the first manual to deal “comprehensively with the planning of private homes for

²³³ For example, “Space and Design Requirements for Wheelchair Kitchens” by McCullough and Farnham (1960) as part of the University of Illinois’ Agricultural Experiment Station.

disabled people” (p. 11). While texts such as Rusk et al.’s (1953) “Living with a Disability” and Gutman and Gutman’s (1968) “Wheelchair to Independence” offer suggestions to individuals wishing to build or modify a made-to-order home, Goldsmith provides an authoritative manual with standardized designs for the architect. Focusing on private dwellings, Goldsmith’s manual connects his designs to the activities of women:

In the majority of situations analysed in the manual it is assumed that the function is performed by a woman.

There are three principal reasons for this:

- 1 the physical abilities, mean range of reach etc. of disabled women are normally significantly inferior to those of disabled men, and they therefore determine design requirements;**
- 2 many recommendations relate to domestic activities which are normally performed by the housewife;**
- 3 among elderly people there is a significant preponderance of women.**

(Goldsmith, 1963, p. 15)

Goldsmith’s designs were produced within a dispositif in which Family-Homes were connected to Housewives. They also considered the connection between the Elderly and private dwellings (which I discuss in Essay 8) and drew on the established idea of women being weak (or “inferior”) (see Essay 3). While Disabled-People of any gender would benefit from such designs within their home, Goldsmith’s manual highlighted the idea that Designing for the Disabled could be gendered. As such, the majority of his designs were for women.

While the idea of women being connected to private dwellings would suggest that Goldsmith would design bathroom facilities for women, his shower designs maintained the established shower unit. They were designed for Disabled-People who can lift themselves around, being modified only through space outside of the shower for a wheelchair, the provision of a seat, a rail, and a ceiling eye bolt that a stirrup grip can be suspended from (Figures 61, 62, & 63):

Goldsmith noted that the height recommended for the shower seat should align with the height of a wheelchair seat which he measured as being the same for men or women. While Goldsmith did not go into detail regarding the rationale for his shower design, it is possible that the height of the shower control, auxiliary socket, and shower head had been set with women in mind.²³⁷ However, other than features such as the controller and shower head being a few inches lower, the shower was not dissimilar to the Paraplegic-Veteran's-Bathroom-Unit shower. In contrast to the bath, for which Goldsmith provides 21 diagrams, the shower, with five diagrams in total, was given little attention.

Just as Rusk et al. (1953) had suggested that the shower, established as a unit for the erect body, was only suitable for some Disabled-People (those who could stand), Goldsmith warned against providing a shower in the absence of a bath within the Family-Home:

Showers: General

The provision of a shower is suitable for some disabled people.

Those who have difficulty using a bath, including many wheelchair users, may find the use of a shower for washing easier and more practicable.

In Great Britain most people are not accustomed to showers and have a firm preference for the bath despite its problems. In family homes the shower should not as a rule be installed in place of the bath but if economics permit they may both be provided.

(Goldsmith, 1963, p. 143)

The established bath, "despite its problems", must be maintained within Family-Homes, even though "many wheelchair users, may find the use of the shower for washing easier and more practicable". "As a rule", the established order should be maintained and if the cost of Design for the Disabled was a compromise to the comfort and convenience to the collective interests of the Family, it could not be recommended. While the idea of Design for the Disabled could be used to restore Housewives to their job as homemaker, the sovereignty of the Family and their collective interests meant that even within texts advocating for Design for the Disabled within Family-Homes, the established order of the bathroom remained.

In the following section I return to analysis of the emergence within the dispositive of government funding for Disability Design within private dwellings following the Royal Commission of Inquiry into Compensation for Personal Injury (Woodhouse et al.,

²³⁷ In Goldsmith's (1963) book 3'3" is listed as the mean height of a woman's hand during seated forward reach and is also the height of the shower controller. 2'4" from seat height for vertical reach is the height of the auxiliary socket from the seat. 5'2" vertical reach for women is an inch higher than the shower head.

1967). I discuss how an established discourse of Rehabilitation for the Disabled-Housewife to reduce the cost of injury to the worker and the industrialist was connected to this funding. Finally, I analyse the production of the housing units for use by paraplegics, one of which was a Family Unit.

Accident Compensation for Housewives

As discussed in Essays 5 and 6, Rehabilitation combined with removal of architectural barriers could transform Disabled-People into Independent subjects, able to carry out essential everyday activities in the world outside the Rehabilitation Facility. Following the Royal Commission of Inquiry into Compensation for Personal Injury (Woodhouse et al., 1967), the Accident Compensation Act (1972) was passed. Although the Commission had advocated for the inclusion of the Elderly, the Young, and the Housewife, the Act initially limited government funded compensation and “complete rehabilitation” to injured workers. Like funding for the Prosthetic Home, Rehabilitation included funding for adapting private dwellings to discharge Disabled-People from the Rehabilitation Facility:

(e) Adapting or assisting with the adaptation of the home or residence of any incapacitated person who has cover in respect of the personal injury which caused his incapacity where the adaptation will enable his discharge from institutional care:

Provided that any such adaptation shall be made in consultation and co-operation with the body responsible for the institution where he is maintained:

(Accident Compensation Act, 1972, s49(2)e)

In 1973, further debate regarding amendment to the Act clarified that including Housewives, the Elderly, and the Young (non-earners) would not need to connect them to income compensation for their injuries but rather, to “complete Rehabilitation” (Isbey, 1973, p. 5121). The 1973 Accident Compensation Amendment Act thus connected Housewives to the housing adaptations to enable discharge from institutional care.

In addition to funded housing adaptations, the amendment connected non-earners to the original Act’s “Lump Sum” compensation for “non-economic loss” which included “a) The loss suffered by the person of amenities or capacity for enjoying life, including loss from disfigurement; and (b) Pain and mental suffering, including nervous shock and neurosis” (S20 [4]). As the idea of reciprocal duty had connected Injured-Soldiers to grants, loans, and suspensory loans²³⁸ for such losses that they could use to invest in a house, the Accident Compensation Act lump sum provided material capital to compensate for a human capital loss. Such loss included the freedom to

²³⁸ A payment that is dispensed with (or forgiven) over time.

achieve self-satisfaction (“amenities or capacity for enjoying life”), to appear normal (“disfigurement”), and to have sound mental health (“pain and mental suffering”). The “lump sum” was established through the idea of the worker being able to use financial compensation to establish himself in a small business or to purchase a home (Woodhouse et al., 1967) which could give himself and his family increased security. The funds were intended to establish the family man back within the family, where the family could be enlisted to support this re-establishment since “the whole family tend to involve themselves in it [the business], and in this way contribute to the support of the family unit” (Wall, 1972, p. 2997). The lump sum maintained the state’s distance from the market but enlisted the family who were seen to understand the collective benefit of re-establishing the Disabled-Family-Man in the apparatus of production.

The lump sum was connected to the Housewife through her maintenance of the family unit (or the possibility of her returning to work outside of the home), since her disability could mean that she “has lost the ability to fend for her family, and look after her home, and possibly lost the ability to get a job later on” (Moore, 1973, p. 5130). The Commission had argued for weekly compensation for injured Housewives, and while this was raised during debates regarding the amendment, it was the lump sum payment that would recognise the efforts of the Housewife and help with “preserving the family unit” (Moore, 1973) that was agreed to. The debate was silent regarding what the Housewife would invest a Lump Sum payment in. Indeed, it was subsequently argued that extending this compensation to “non-earners” in the amendment simply reinstated compensation they had been able to get prior to the 1972 Act (which had removed the possibility for the injured to sue the injurer) and was a strategy to avoid the call to supply a regular income to Housewives (Palmer, 1977). Provision of a lump sum payment would “preserve the family unit” rather than provide a personal income. This maintained the Housewife as a feature of the Family-Home, making it possible for the productive work to be done, but separated from an income.

The Accident Compensation Amendment Act (1973) significantly extended the role of the state in government of Disabled-People. State funded injury compensation extended the idea of reciprocal duty to all people who were disabled via injury. Injured Workers, Housewives, the Elderly, and the Young became enlisted into the idea of “Comprehensive Rehabilitation”. The provision of housing adaptations for discharge from the Rehabilitation Facility and a lump sum payment aimed to return the injured to family life as an entrepreneurial business owner, property investor, or Housewife. While it is unclear whether Injured Housewives used the lump sum to purchase or build a home, this funding made possible a shower with “NO sill and slope away from entry to allow wheelchair access”, built in Aotearoa New Zealand in 1974 (see Appendix II).

Being included in the Act also connected two housewives to the Accident Compensation units for use by paraplegics.

Accident Compensation Commission Shower Units for use by Paraplegics

In 1980, ACC part funded the construction of two units “for use by paraplegics” in the community. These were “rental units” built in collaboration with the state Housing Corporation of New Zealand. They were “the first of their kind” and were intended “to provide a secure base from which a person can re-establish his place in society” (Cunniffe, 1980, p. 27). Just as the Prosthetic-Home had provided Disabled-Veterans with the possibility of being discharged from the Rehabilitation Facility to be re-established in family life, work and study, the ACC units were designed to re-establish the worker:

Statistics from the Accident Compensation Commission show that the most likely cause for an accident victim to need a wheelchair is because of spinal injury. The person most likely to experience an accident of this nature is a young man in his late teens or early twenties. Such a person may be rehabilitated into the work force, and it could reasonably be anticipated that the running of the home would be the prerogative of an able-bodied member of the household. It was thus decided to plan the unit on the basis that the major activities in running the home would be carried out by an able-bodied person.

(Cunniffe, 1980, p. 24).

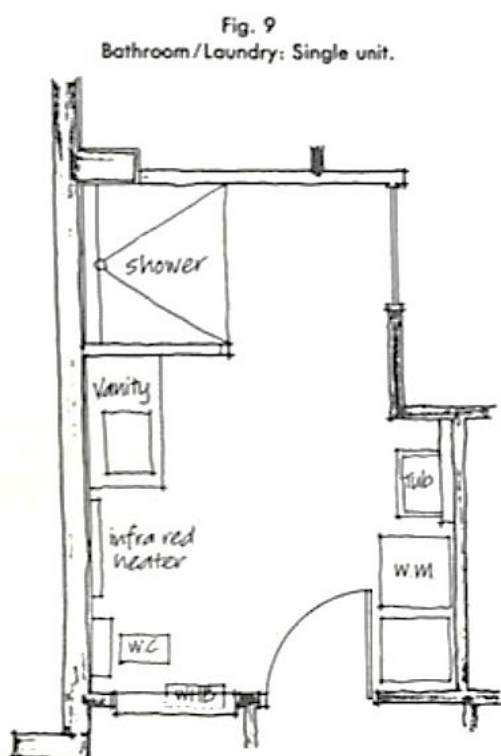
While Goldsmith (1963) had argued for gendered Disability Design in private dwellings to connect architecture to the Disabled-Woman, these units were designed for the young male paraplegic worker. As such, while the “Single Unit” was designed for a wheelchair-body complex to be Independent, the “Family Unit” was designed under the assumption that an “able-bodied” Housewife would provide childcare, cooking and kitchen activities, laundry, and general home running for the Disabled-Family-Man. She would be a member of the Family Cell, designed to support the Disabled-Person to be re-established within the Family-Home and society.

Both units (Figures 64 & 65) included a shower adapted for the Paraplegic-Worker. The Family Unit also had an adjacent shub²³⁹ “in the event of tenants having young children for whom the large shower would be most inconvenient” (Cunniffe, 1980, p. 26):

²³⁹ A small square bath.

Figure 64

ACC's 1980 Single unit for use by paraplegics

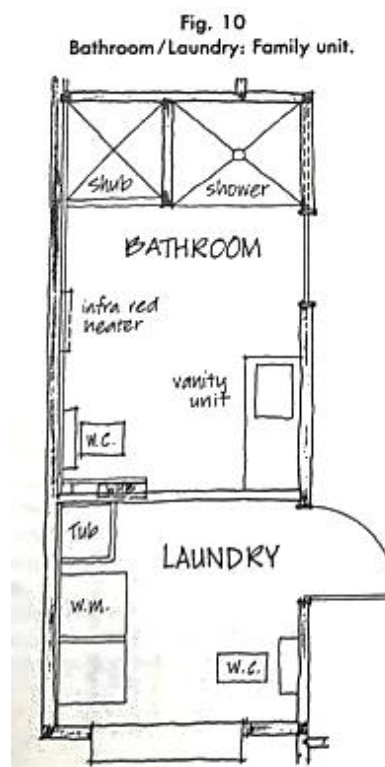


Note. From "Housing the disabled," by P. A. Cuniffe, 1980, *The New Zealand Journal of Occupational Therapy*, 31(2), p. 27.

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Figure 65

ACC's 1980 Family unit for use by paraplegics



Note. From "Housing the disabled," by P. A. Cuniffe, 1980, *The New Zealand Journal of Occupational Therapy*, 31(2), p. 27.

Reprinted with permission.

The showers were designed to have no step in, and to be accessed using a "shower/commode chair" (Cuniffe, 1980, p. 26). By 1980, the Stall-Shower-with-Shower-Wheelchair was a standard rather than Made-to-Order shower; however, these were Paraplegic-Worker-Showers presuming that the Housewife would be "able bodied".

Despite the expectations of the units' designers, a pamphlet that illustrates the units and the Disabled-People who inhabited them (Appendix III); "ironically" (New Zealand Crippled Children's Society, 1979, p. 3) found that both of the units were occupied by paraplegic women. The pamphlet provided an illustration of the work of the Disabled-Housewives²⁴⁰ as they cared for themselves and the household within the Unit and local community. They carried out Housewife responsibilities such as shopping, paying bills, meal preparation and service for the worker, heating the house,

²⁴⁰ The pamphlet does not state that both tenants were Housewives; however, they are depicted doing the *work* of Housewives.

laundry, and childcare. The pamphlet illustrated the Paraplegic-Worker-Shower next to the shub. For the Housewife, the shower ensured that she was Independent and did not interfere with the restoration function that the Household provided the worker. The children photographed were not young children, and the subject of the shub was not addressed.²⁴¹

While the Units were constructed with the idea of their being “for use by paraplegics”, the “ironic” presence of Housewives showed that the shower was designed as a Paraplegic-Worker-Shower. In regard to designing the Units for workers, Cunniffe (1980) stated:

The aptness of this decision will be one of the points to be assessed in the future. If further rental units of this type are planned, it is likely that some family units will be needed where the design brief includes the requirements of a disabled homemaker. On the available evidence, however, these will be in the minority.

(p. 24)

Despite the apparent connection between Housewives and the units, Cunniffe maintained that the Disabled Homemaker was the exception rather than the rule. They maintained that ACC funded Units for “Use by Paraplegics” should mostly continue to be designed for the Disabled-Worker. While the Accident Compensation Amendment Act (1973) had made it possible for a unit to have been designed for a Housewife, the dominant discourse of Rehabilitation being for the purpose of return to work outside of the house meant that the Family Unit was designed for the Paraplegic-Worker. With him as the subject, the Housewife was simply a feature of the Family Unit, enlisted to support the re-establishment of the Disabled-Person in society. As part of the milieu, they were presumed to be an “able-bodied member” feature of the Family-Home, part of the network that produces workers and sustains them through the restorative function of the home.

Summary: The Possibility of State Funded Housing Modifications for Disabled-People

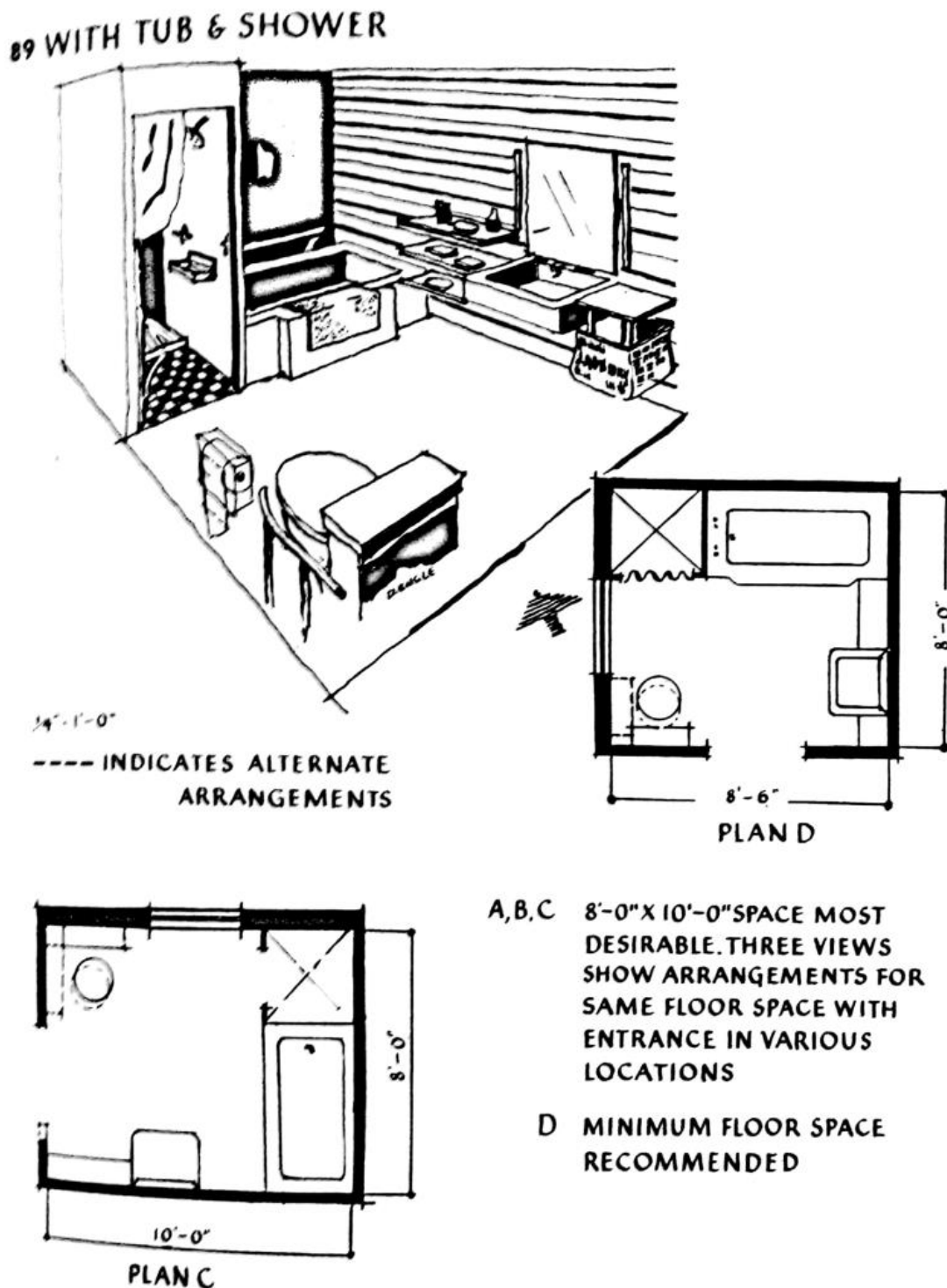
The Family-Unit Paraplegic-Worker-Shower was a discursive object born out of a dispositif in which the idea of reciprocal duty made it possible for the government to participate in the production of Family-Homes for Disabled-People. The idea that a loss of human capital through injury was a loss to the physical capital of the nation, irrespective of whether it was caused at home or work, connected all injured citizens to

²⁴¹ Even Goldsmith (1976) is silent on Design for the Disabled-Housewife in relation to bathing children.

state funded Rehabilitation and compensation. This connection aimed to reduce the cost of disability to the nation by enlisting all of the injured population into “Comprehensive Rehabilitation”. The Housewife appeared as an anomaly in her inclusion, as the other non-workers were included due to their historical or future connection to work. However, analysis of the dispositif reveals that the Housewife was connected to the apparatus of production through the idea of the Family-Home, a feature of the disciplinary society network that provided restoration to the worker. Rehabilitation, including Designing for the Disabled-Woman, emerged as a solution to the risk of Disabled-Housewives being unable to maintain this restorative function of the Family-Home.

Despite the possibility of showers being designed for the Disabled-Housewife, the ideas of sovereign rule of the Family Cell meant that even those producing Disability Design advocated for the collective interests of the Family to supersede those of the Disabled-Person. The materialisation of the Family-Unit Paraplegic-Worker-Shower showed that although Rehabilitation had been extended to the entire injured population, the primary object of Rehabilitation remained the worker. The Housewife was a feature of the worker’s environment and, as such, was not considered the subject for whom the units were designed. Despite this existing order, two “Paraplegic Housewives” inhabited the Units, and illustrated their inclusion in the territory of government funded showers modified for Disabled-People. Although the Units may have presented a barrier to the Housewife bathing small children, the Units showed the possibility of these Housewives performing their regular duties without being a loss of material or human capital for the worker.

While New Zealand’s Accident Compensation Act (1972) connected a much greater number of the population to government funded showers modified for Disabled-People than had been possible elsewhere, eligibility remained limited to those who had been injured. In the dispositif in which the problem of any unit of unsound physical or mental health was a deficit to the physical capital of the nation, further developments were needed to connect Disabled-People to modified showers. In my final Essay, I discuss the Disabled Persons Community Welfare Bill (1975) and Act (1975) which included provision for alterations to homes for other Disabled-People. This is the legislation that led directly to the Ministry of Health Housing Modification funds for which I applied for Jay, and that prompted my study.

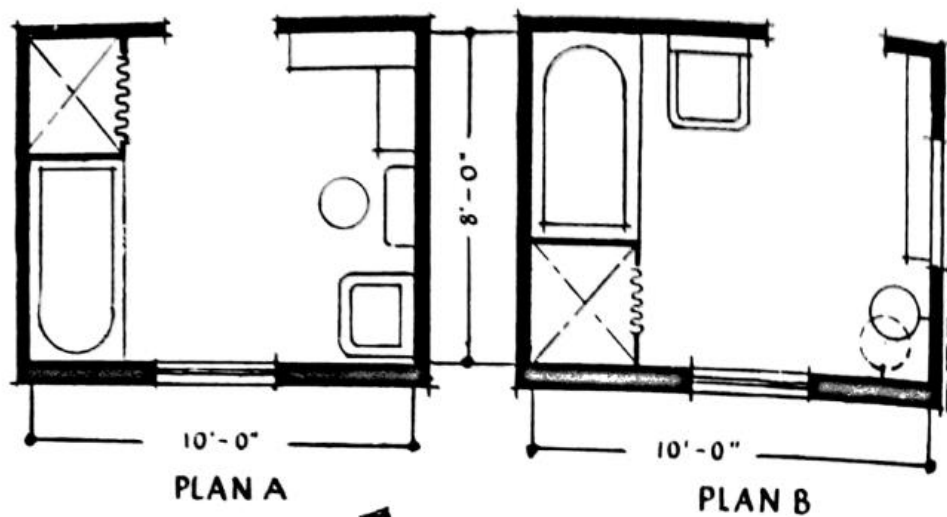
Appendix I**Figure 66***Rusk et al.'s 1953 Bathroom with Tub & Shower*

Note. From *Living with a disability* (p. 65), by H. A. Rusk et al., 1953, The Blakiston Company. Orphan work.²⁴²

²⁴² If you believe that copyright infringement has occurred in any of this content, please contact the author.

Figure 67*Rusk et al.'s 1953 Bathroom with Tub & Shower 2***90 WITH TUB & SHOWER**

1/4" = 1'-0"

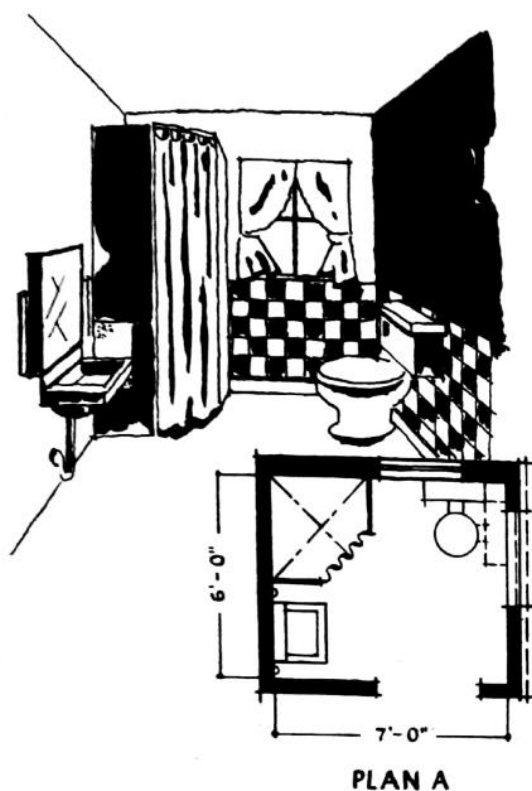


Note. From *Living with a disability* (p. 66), by H. A. Rusk et al., 1953, The Blakiston Company. Orphan work.²⁴³

²⁴³ If you believe that copyright infringement has occurred in any of this content, please contact the author.

Figure 68*Rusk et al.'s 1953 Bathroom with shower only***93 WITH SHOWER ONLY**

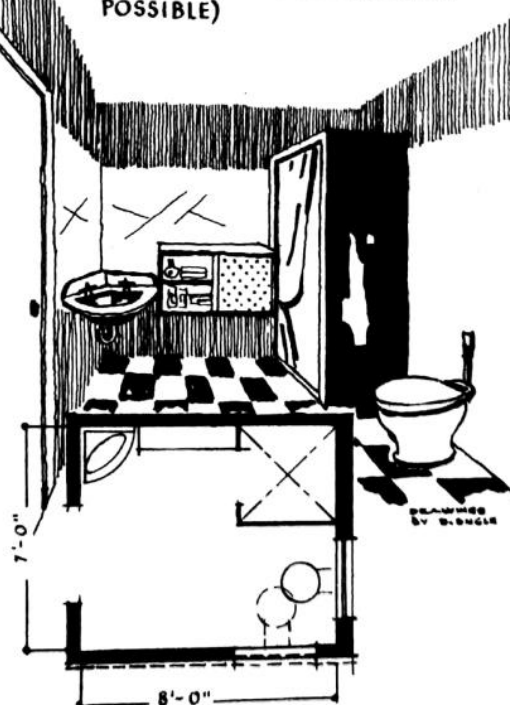
14' x 1'-0"



----- INDICATES ALTERNATE
ARRANGEMENTS

A 6'-0" X 7'-0" MINIMUM FLOOR SPACE RECOMMENDED. (SUGGESTED AS MORE SUITABLE ONLY FOR PATIENTS WHO ARE NOT ENTIRELY CONFINED TO WHEEL CHAIR, THAT IS, THEY CAN STAND UP TO GET INTO THE SHOWER. WATER CLOSET AND LAVATORY MAY BE INSTALLED IN REVERSE LOCATIONS.

B 8'-0" X 7'-0" (OR 8'-0") BOTH ARRANGEMENTS SUITABLE FOR AN 8'-0" X 7'-0" OR 8'-0" X 8'-0" FLOOR SPACE (LARGER SIZES ALWAYS MORE DESIRABLE IF POSSIBLE)



Note. From *Living with a disability* (p. 69), by H. A. Rusk et al., 1953, The Blakiston Company. Orphan work.²⁴⁴

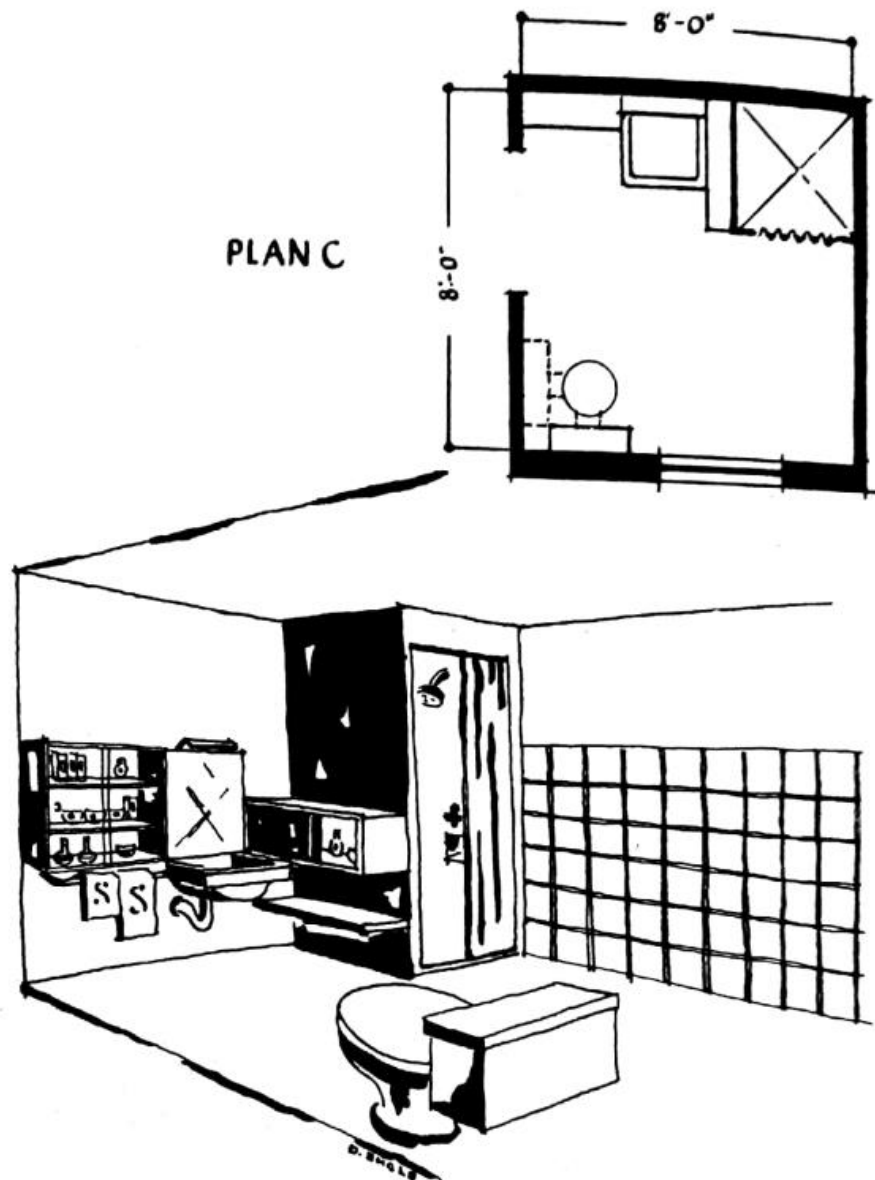
²⁴⁴ If you believe that copyright infringement has occurred in any of this content, please contact the author.

Figure 69

Rusk et al.'s 1953 Bathroom with shower only 2

94 WITH SHOWER ONLY

1/4" = 1'-0"



----- INDICATES ALTERNATE ARRANGEMENTS

Note. From *Living with a disability* (p. 70), by H. A. Rusk et al., 1953, The Blakiston Company.
Orphan work.²⁴⁵

²⁴⁵ If you believe that copyright infringement has occurred in any of this content, please contact the author.

Appendix II

Private dwelling built using an ACC lump sum payment for William Wrightson, Aotearoa New Zealand Disability Advocate (personal communication, 16/06/2015).

Figure 70

1976 Specification for Shower to be made with NO sill

BEAZLEY HOMES LIMITED	
ADDENDUM TO SPECIFICATION DATED 25/3/74	
CONTRACTOR	DES BENNETT LIMITED
OWNER'S NAME	WRIGHTSON W.W. AND D.R.
JOB No.	32/
PLAN No.	7405 Special
1. Vanity Unit to consist of top only with pipes and waste concealed to allow leg space under.	
2. Shower to be made with NO sill and slope away from entry to allow wheelchair access.	
3. Allow mirror 3'0" wide and 4'0" high over Vanity	
4. Make ramps at a fall of 1' in 12".	
5. Allow PC sum \$1000 for floor coverings.	
6. Allow PC sum \$1000 for paths and lawns, fences, driveway, clothes line and letter box.	
N.B. This client is a paraplegic and will require light switches, door handles and power points set at special heights.	

Note. From *Building Application Form* (p. 3), by W. Wrightson, 1976, Palmerston North City Corporation. In the public domain.

Appendix III**Figure 71***Pamphlet promoting the ACC Units "For use by Paraplegics", 1979*

Essay 7 Showers for Disabled-Housewives



Accident Compensation Commission Units: Moera

These new housing units are part of a government housing development at Moera near Lower Hutt. Old poor condition housing stock was demolished to provide the sites.

The location selected is very good being close to shopping and public transport; bus, train and taxi stand. The Hutt Valley is a good employment centre but also Wellington is only a short daily commuter trip away. The two units for disabled persons are part of a general purpose development. The site is level and over the road a park for kids to play in—albeit pretty rudimentary pipe equipment. New footpaths have Kerb cuts but not yet the old footpaths on the shopping route.

The shopping centre includes a library and post office. Note that the post office has a choice of heights for filling out bank slips and that entry to some shops is easier than others! Bicycles and sign boards can be foot-path obstacles too.

The two units are described as a single unit and a family unit. Design features are similar in both units except for the kitchens; the single unit kitchen is designed for a homemaker who uses a wheelchair whereas the kitchen for the family unit is a standard design for an able bodied person.

Accident Compensation Commission statistics show clearly that their clients who will use wheelchairs are much more likely to be young men—ironically enough the tenants of these units in November, 1980 are Karen Rotch and Phyllis Bartley who both use wheelchairs.

For a good article on the design of the units written by Pat Cunliffe see the *New Zealand Journal of Occupational Therapy* Volume 31, Issue 2, December, 1980.

The units are a joint venture by the Housing Corporation of New Zealand and the Accident Compensation Commission and were opened by the Governor General on 14 May, 1980.

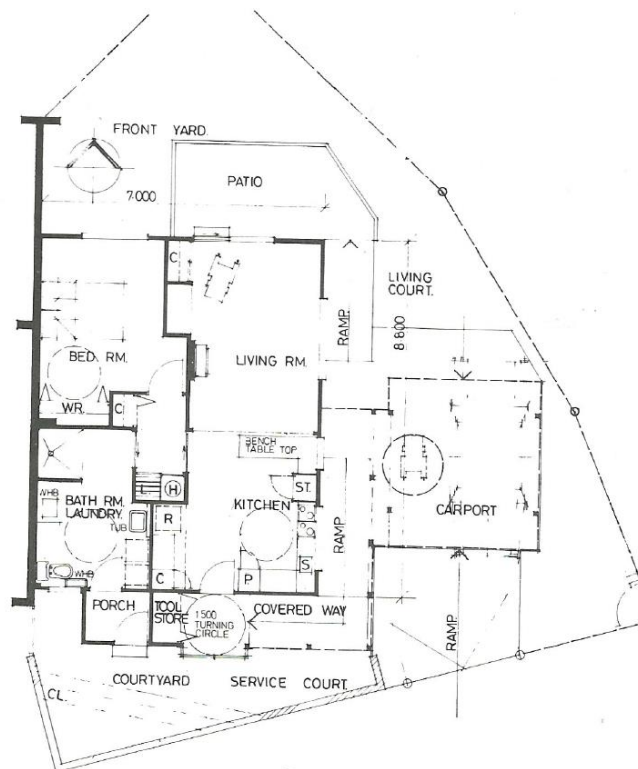
Architects: Housing Corporation, Wellington Regional Office, Walton Leigh Avenue, Porirua.

Project Architect: Tony Bartley.

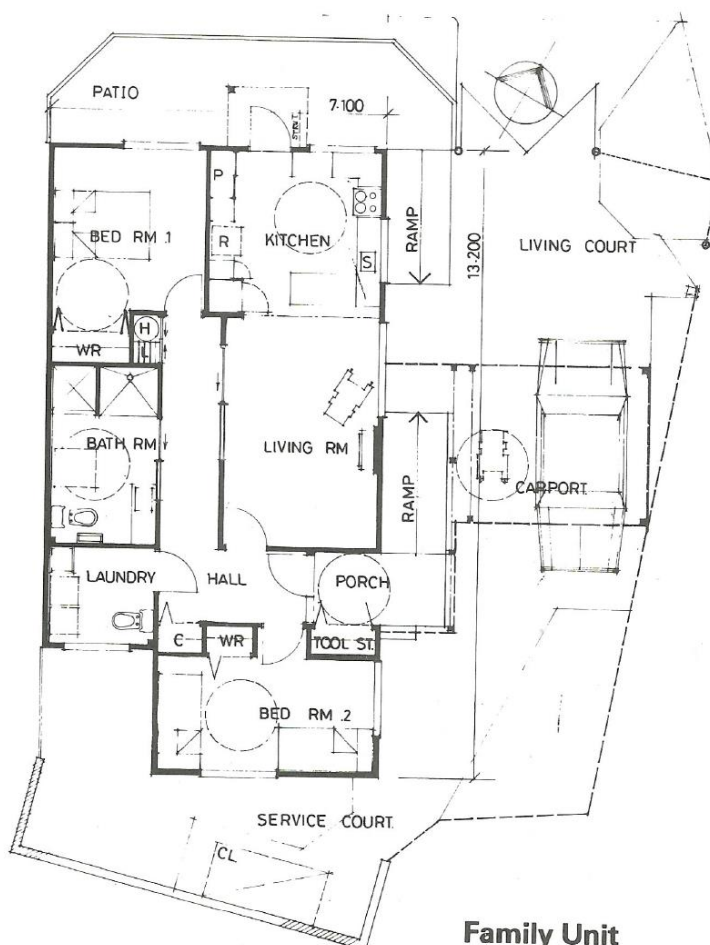
Consultants: NZ Disabilities Resource Centre, 7 Edgeware Road, Palmerston North.

Project Officer: Pat Cunliffe.

Photographer: Nick Servian, Spectrum Illustrating Co. Ltd, Wellington.

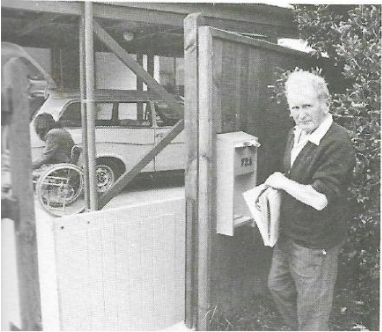
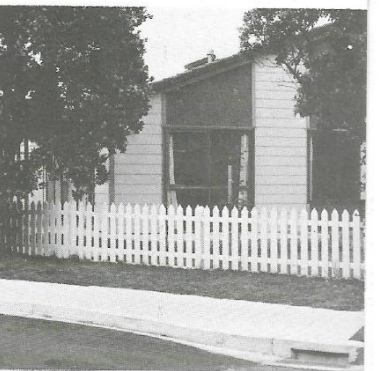
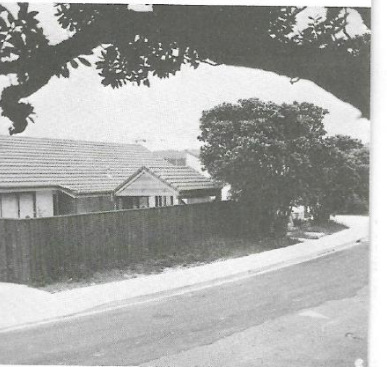


Single Unit

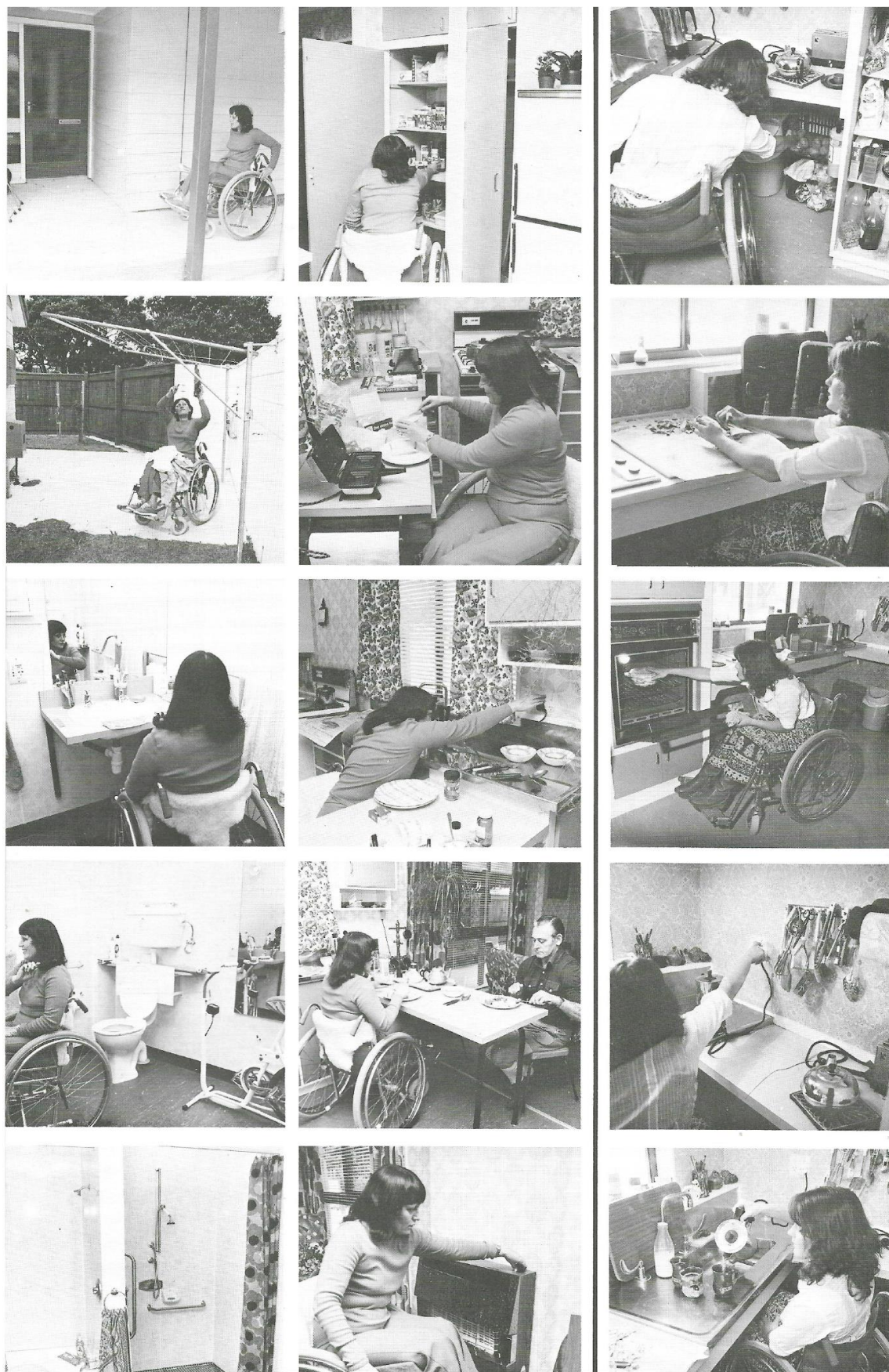


Family Unit

Continues on 9.03



Essay 7 Showers for Disabled-Housewives



Note. From *Barrier free 9.02: Housing redevelopment project*, by New Zealand Crippled Children Society Inc., 1979, New Zealand Crippled Children Society Inc. Reprinted with permission.

Essay 8 Accommodating Showers in Family-Homes



G. Booth's Wet area shower (1984).

In 1975, the Disabled Persons Community Welfare Act (DPCWA) was enacted. This Act legislated for government funded suspensory loans for “Alterations to Homes”, associated with “family care” for Disabled-People living in Family-Homes. While the Accident Compensation Act had connected the state to funding of showers modified for people disabled by injury, the DPCWA extended the possibility of such funding to other Disabled-People creating the possibility of Independence and participation in society. Although the DPCWA connected Disabled-People to Rehabilitation, the housing alteration grants were established primarily to reduce the cost of accommodating permanently Disabled-People. Established practices of accommodating the Elderly outside of the Family-Home limited their access to the funds. For those able to be supported in the Family-Home, suspensory loans made it possible to modify existing bathrooms. However, the way the funding was granted devolved risks to the Disabled-Person and their family and, ironically, limited their opportunities for mobility. In 1984, the New Zealand Disabilities Information Bureau published a brochure titled “Construction of a Wet Area Shower” (Booth). The “wet area” shower was designed to be a “wheel in”, “accessible” shower, produced through the modification of a private dwelling’s bathroom. While funding connected Disabled-People to such modified showers funded by the MOH, I argue that it produced Permanent-Family-Homes that contribute to the grim picture of housing Disabled-People in Aotearoa New Zealand.

Socially and Financially Independent Disabled-People

The DPCWA connected Disabled-People to government funding for their “Community Welfare”. The Act defined the people it was concerned with as:

“Disabled person” means any person who suffers from physical or mental disablement to such a degree that he is seriously limited in the extent to which he can engage in the activities, pursuits, and processes of everyday life:

(DPCWA, 1975, p. 926)

The DPCWA emerged from a dispositif in which the State’s interest in units of unsound physical and mental health had been maintained. The DPCWA was established two years after the Accident Compensation Amendment had extended government funded rehabilitation and lump sum compensation to all members of the population who were disabled through injury. This legislation had made government funded housing adaptations (including a modified shower) to enable discharge from a Rehabilitation Facility, or through purchasing a Made-to-Order house with a lump sum payment, a thinkable thing. The DPCWA extended the Rehabilitation discourse to the rest of the

Disabled population, and aimed to produce “Financially Independent” subjects, able to work and invest in their own Made-to-Order dwelling.²⁴⁶

While the DPCWA might appear to have had some similarities to the Accident Compensation Act (1972), it did not employ the ideas of compensation or reciprocal duty, and there was no lump sum payment that could be used to install a Made-to-Order shower. Funding for a modified shower was included in Part II of the DPCWA: “Promotion of Community Welfare of Disabled Persons”, which provided “Assistance to Families and Persons” including “Grants for alterations for homes”:

14. Grants for alterations to homes—(1) Subject to the provisions of subsection (2) of this section, the Director-General may, in his discretion, grant in respect of any disabled person financial assistance by way of a suspensory loan for the purpose of carrying out essential alterations to a home in order—

- (a) To accommodate a wheelchair, walking frame, or other appliance that is necessary for the general welfare of that disabled person; or
- (b) To provide handrails, handgrips, or similar aids for the assistance of the disabled person in or about that home; or
- (c) In order to provide such alterations to plumbing, electrical fittings, and kitchen facilities as, in the opinion of the Director-General, are necessary having regard to the person’s disability.

(DPCWA, 1975, p. 935)

Only 2-years prior, ACC legislation had connected the state the modified shower of the private dwelling through a Rehabilitation discourse and the production of Socially and Financially Independent Subjects (even if the alterations were for “those who made the productive work possible”). However, I argue in this Essay that the discursive construction of what housing alterations were for in the context of ‘community welfare’ in the DPCWA (and earlier Bill) was very different to the production of Independent Disabled-People in the Accident Compensation Act.

Subsection 1 of Section 14 of the DPCWA granted housing alterations to “accommodate” a wheelchair, walking frame, or other “appliance” that was necessary for a Disabled-Person’s “general welfare”. Subsections 1b and 1c go further than to “accommodate”, providing the possibility of aids and alterations that may provide

²⁴⁶ Aims of the Act included “(a) To assist and encourage disabled persons to become socially and financially independent; (b) To promote schemes providing for the assessment, work experience, training, sheltered employment, and other suitable activities of disabled persons... (e) To foster close working relationships, and (as appropriate) consult, with... professions concerned with rehabilitation and training of disabled persons and their placement in employment; (f) to co-operate with the Accident Compensation Commission in so far as its responsibilities relate to the promotion of the rehabilitation of persons who suffer personal injury by accident” (DPCWA, 1975, p. 928).

“assistance” or be in some other regard “necessary” in relation to the “person’s disability”. While such aids and assistance may function to produce Independent Disabled-People, as they did in the Prosthetic-Home, these points were not included in the original Disabled Persons Community Welfare Bill (1975). Originally, alterations for homes were only intended to “accommodate” the objects of a body-object complex:

14. Grants for alterations to homes—(1) Subject to the provisions of subsection (2) of this section, the Director- 35
General may, in his discretion, grant in respect of any disabled person financial assistance by way of a suspensory loan for the purpose of carrying out essential alterations to a home to accommodate a wheelchair, walking frame, or other appliance that is necessary for the general welfare of that 40
disabled person.

(Disabled Persons Community Welfare Bill, 1975)

Several submissions regarding the Bill recommended the inclusion of additional rooms (Jack, 1975), plumbing, electrical fittings, and kitchen adaptations (New Zealand Society of Physiotherapists, 1975). One such submission noted:

Alterations may be required not only to accommodate the items listed but also consequent upon their use e.g. relocation of rooms from upstairs to downstairs, alterations to kitchen & laundry, plumbing or electrical fittings. Such alterations could prevent the need to employ domestic help.

(Wellington Hospital Board, 1975, p. 2)

This submission noted that alterations were not only needed to make space for appliances; rather were required for such appliances to be used, thus creating Independent body-object complexes. The submission highlighted the connection between the house and the Housewife as discussed in Essay 7, noting that housing alterations could allow a Disabled-Person to perform the Housewife’s work or, rather, saving the worker or nation from having to pay for such work to be done. While a Rehabilitation discourse was available at the time the DPCWA was enacted, it seems that the production of an Independent subject was an afterthought. So, what were the discourses that connected the idea of “accommodating” a Disabled-Person and their “appliance” in a private home? If they were not to produce Independent subjects, what were they for?

The Right to Live in the Community, or a Duty to the Disabled?

From the 1950s, a discourse of rights was employed to resist a Eugenics discourse and to advocate for handicapped children to remain within their Family-Home (“Children’s Welfare”, 1950). Burt’s (2013) discourse analysis of disability in Aotearoa New Zealand explains how, as early as the 1930s, families resisted the discourse of

exclusion, resulting in the founding of the Intellectually Handicapped Children's Parents' Association. Burt proposed that such resistance drew on a Human Rights discourse and, certainly, from as early as the 1950s, the idea of rights was employed to advocate for "handicapped children" to remain within the Family-Home to become "self supporting and so become an asset to the community" ("Children's Welfare", 1950, p. 5). Alongside rights, the discipline of Rehabilitation was becoming established, extending the idea of Disabled-People having the potential to be an asset to the nation. By the time the Disabled Persons Community Welfare Bill (1975) was drafted, the idea that Disabled-People needed to be separated from the population due to the danger posed by their defective genes had diminished and a discourse of transformation into an asset that early rights advocates had proposed had materialised through Rehabilitation.

The parent advocacy group (The New Zealand Society for the Intellectually Handicapped [NZSIHI]) that had originally argued against the Eugenics discourse that moved children into Large-Permanent-Homes continued to draw on a rights discourse in their submission regarding the Bill:

THE RIGHTS OF THE RETARDED AND THE COMMUNITY WELFARE SERVICES NEEDED

4. The philosophy and purpose of the Society is the implementation of the rights of the intellectually handicapped which it is recognised today is to the benefit of the community to see implemented. The attainment of these rights to live within the community if possible, to become part of the community and to make a contribution in a work situation, even if a sheltered one, is a right that can be established not only on ethical, religious and humanistic grounds but is sound on basic economic and sociological grounds. Given adequate supporting services the intellectually handicapped can live within his family and make a contribution to society; and given adequate supporting services the need for expensive institution care can be reduced and family stress, breakdown and disruption avoided.

(NZSIHI, 1975, p. 1)

The submission argued that "ethical, religious and humanistic grounds" established a Right for the intellectually handicapped to live in the community, and the submission went on to link such rights to the authority of the United Nations. However, the United Nations had not established an inalienable Right for Disabled-People to live in their

Family-Home at this time and the possibility of Institutional living remained.²⁴⁷ Drawing on a democratic governmentality, a discourse of rights connected the interests of the Intellectually-Disabled living in the Family-Home and the Community. Living in the Family-Home was connected to the ability to work or “make a contribution to society” while the Large-Permanent-Home was constructed as a danger to the Family (producing “stress, breakdown, and disruption”) and the nation (“expensive institution care”).

The NZSIHI did not comment on the proposed Grants for Alterations to Homes; although, it did state that the shift away from nursing care (associated with Large-Permanent-Homes) to “social welfare” in the community was appreciated (NZSIHI, 1975, p. 5). It appears that the Bill and subsequent Act aligned with the rights discourse that families drew on in relation to the Intellectually Handicapped, however the legislation and parliamentary debates regarding the DPCWA were silent regarding the right to live in a Family-Home. While the provision of housing alterations aligns with a discourse of such rights, living within the Family-Home was a possibility but not a certainty for Disabled-People at this time. Indeed, rather than employing democratic power in which collective interests are promoted and territory is claimed, the DPCWA grants that could fund a modified shower were at the discretion of the Director-General and established on the condition of “the person’s disability”.²⁴⁸ The alterations were to address the problems with accommodating an appliance or aid attached to a body-object complex within their Family-Home. This is quite different to recognition of the

²⁴⁷ In their submission, the NZSIHI connected this idea of the right to live with family to the various authorities. This included the United Nations (1959) and their Declarations of the Rights of the Child “Principle 6: The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and, in any case, in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother” and of the Rights of Mentally Retarded Persons (1971) “Principle 4. Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life”. Both of these declarations maintain the possibility of institutional living. By the end of 1975 “the Rights of Disabled Persons” extended this right to remain in the family home to all Disabled-People (United Nations 1975); however, the possibility of exclusion from the Family-Home remained at this time “Principle 9. Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative or recreational activities. No disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than that required by his or her condition or by the improvement which he or she may derive therefrom. If the stay of a disabled person in a specialized establishment is indispensable, the environment and living conditions therein shall be as close as possible to those of the normal life of a person of his or her age”.

²⁴⁸ There are sections of the DPCWA that address the idea of accessible territory for Disabled-People which I discuss later in this essay. One of these requires new buildings or buildings undergoing major reconstruction to provide access for “disabled persons”. However, this section specifically excludes private dwellings (see Appendix D). The other requires collective, confined homes (for 5 or more Disabled-People) to be altered at the Director-General’s notification.

need to address architectural barriers that excluded Disabled-People from Family-Homes. Indeed, I argue below that the way in which the funding was implemented meant that rather than rights of Disabled-People being recognised, they were diminished.

As an alternative to rights, perhaps it was recognition of the nation's duty to Disabled-People that rationalised the extension of housing alteration grants from those who were injured, to those who were otherwise disabled? The Commission into Personal Injury Compensation (Woodhouse et al., 1967) considered the idea of extending their ideas regarding accident compensation to those disabled by "sickness and disease". While they recognised the contradiction in excluding insurance against loss of capital for some Disabled-People, they employed several explanations to justify excluding them from compensation:

17. Sickness and Disease—It may be asked how incapacity arising from sickness and disease can be left aside. In logic there is no answer. A man overcome by ill health is no more able to work and no less afflicted than his neighbour hit by a car. In the industrial field certain diseases are included already. But logic on this occasion must give way to other considerations. First, it might be thought unwise to attempt one massive leap when two considered steps can be taken. Second, the urgent need is to co-ordinate the unrelated systems at present working in the injury field. Third, there is a virtual absence of the statistical signposting which alone can demonstrate the feasibility of the further move. And finally, the proposals now put forward for injury leave the way entirely open for sickness to follow whenever the relevant decision is taken.

(Woodhouse et al., 1967, p. 26)

Woodhouse et al. (1967) suggested that including all Disabled-People in compensation was dangerous at that time. An unknown, but potentially large number of people disabled by sickness could risk the interests of the injured being met. Unlike the injured, who had a history of documented legal action and hospitalisation (discussed further below), those disabled by illness were undisciplined, diffusely distributed through society, hidden in Large-Permanent-Homes or in the privacy of Family-Homes. While it was possible to apply the same idea of disease or injury thus creating a cost to the community through loss of personal capital, the problem of the "virtual absence of the statistical signposting which alone can demonstrate the feasibility of the further move" maintained the dichotomy between the ill (i.e., who were not able to make someone else liable for their illness) and the injured.

Just as the DPCWA did not draw on a rights discourse, nor did it draw on the idea of Reciprocal Duty. While the Act did connect Disabled-People to Rehabilitation, compensation for a loss of human capital was excluded. Rather than a Lump Sum with

which the person could invest in property, the DPCWA provided funding in the form of Suspensory Loans. In the next section I analyse the interests of the state in maintaining Disabled-People in Family-Homes and argue that home alteration funding in the form of Suspensory Loans was employed to devolve responsibility to the Family to reduce the cost of disability to the State.

Family Care in Family-Homes

As noted above, while the DPCWA (1975) connected home alterations to the production of Independent subjects, I argue that the original discourse of “accommodation” established in the Disabled Persons Community Welfare Bill (1975) and maintained by the DPCWA (1975) was, instead, associated with the idea of reducing “social problems” for those caring for “socially dependent” subjects. Rather than housing alterations being connected to the duty of the state or the community to compensate for the cost of disability, or the objective of producing Independent subjects who could compete in the property market, they were part of a discourse of economical rationing, aiming to reduce the cost of accommodating Disabled-People.

Part II of the DPCWA was comprised of a range of strategies to provide “Assistance to Families and Persons”, including housing alterations. The idea of saving money by avoiding “expensive institution care” was discussed in relation to support for families:

**The Government
recognises that the burden of caring for
severely handicapped children places great
physical and mental strain on parents or
guardians, who are saving the State the
considerable expense of caring for those
children in State institutions.**

(King, 1975a, p. 5142)

The discursive construction of care for Disabled-People as a burden, which created problems for families, or “social problems”, justified the State’s involvement in the families of Disabled-People. Aim “B” of the Bill (which would become Aim C of the final Act) was:

**(b) To promote the general well-being, recreational
opportunities, and welfare in the community of
disabled persons by assisting individuals, families,
and sections of the community to overcome social
problems associated with physical or mental
handicap:**

(Disabled Persons Community Welfare Bill, 1975, p. 4)

Aligning with the Fordist disciplinary society’s practice of conscripting individuals to act as agents of social control, assistance in the form of “Family care” (S11 of the Bill and

Act) involved providing counselling services to families to “assist them to overcome social and other problems associated with caring for a disabled person” (DPCWA, 1975, p. 933).²⁴⁹ While Rehabilitation had sought to remove the cost of human assistance by collecting Disabled-People together to discipline them into Independent subjects, Family-Care returned the problem of such assistance to families. Discipline functioned to maintain human assistance provided by the family, deploying counselling to ensure that those providing care would overcome the “problems associated with caring for a disabled person” (DPCWA, 1975, p. 933). Thus, the DPWCA directed discipline towards the family to produce self-managing subjects who were responsible for maintaining Disabled-People in the Family-Home.

While a Rehabilitation shower may produce the Independent Disabled-Person, house alterations within the DPCWA were to “accommodate” a Disabled-Person within the Family-Home. Rather than disciplining the Disabled-Person, such alterations created an environment, or biopolitical milieu, in which a greater proportion of the population could be maintained within the “normal” Family structure. Employing a Fordist governmentality, the Family-Home is seen as part of the nation’s network, a space where family members who had rightly understood their responsibility for caring for a Disabled-Person and for accommodatng Disabled-People that could save the nation the “considerable expense” of Large-Permanent-Homes. While it might seem overly critical to see “accommodation” as economic rationalisation, I demonstrate next that the discourses connected to funding or not funding alterations devolved risk and responsibility for providing accommodation for Disabled-People away from the State and to the Family.

A Period of Benefit Sufficient to Justify the Expense

As noted above, while the Accident Compensation Act (1972) had provided payments for home alterations to enable discharge from a Rehabilitation Facility,²⁵⁰ and lump sums that could be used to invest in shower alterations, the DPCWA (1975) granted Disabled-People, or the “person who has the care of the disabled person” a “suspensory loan” (p. 935). A suspensory loan is a payment that is dispensed with (or

²⁴⁹ As noted in my methodology chapter, Fraser (2003) explained that a “major feature” of the Fordist disciplinary society was the proliferation of social work, psychotherapy, and psychology services to enlist subjects as agents of discourse. In addition to counselling, Families who were in receipt of a “family benefit” could be provided with 4-weeks of state funded “relief” from care of a Disabled-Person and reimbursed for costs involved with “acting as an attendant” to a Disabled-Person receiving medical treatment or vocational training. Disabled-People could also receive counselling to “realise and enjoy their potential”.

²⁵⁰ The DPCWA similarly could provide funding for alterations to a home where a “disabled person resides or intends to reside” (S14[2]), suggesting that the grant could be used to provide accommodation for the purpose of discharge from a Rehabilitation Facility.

forgiven) over time. Granting the loan was reliant on the Disabled-Person being “expected to enjoy the benefit of the alterations to the home for a period sufficient to justify the amount of expenditure involved”:

(3) The Director-General shall not make a grant to any person under this section unless he is satisfied that the disabled person can be expected to enjoy the benefit of the alterations to the home for a period sufficient to justify the amount of the expenditure involved, having regard to—

- (a) The nature of the interest in the land on which the home is situated of the disabled person or of the person with whom he resides; and
- (b) The permanency, by reason of any blood or marriage relationship or friendship or other circumstances, of any link between the disabled person and any person who may be caring for him in the home.

(DPCWA, 1975, p. 935)²⁵¹

The DPCWA (1975) attached funding to permanence of both the land, and the family or friends who cared for the Disabled-Person. This is a discourse of economic rationality, in which the housing alterations are seen as an investment weighed against the permanence of the material capital (or the “nature of the interest in the land”) and social capital (“person who may be caring for him in the home”) of the Disabled-Person or their family. Eligibility for funding a modified shower thus came to rely on established connections to property and personal relationships.

The idea of the state making a partial investment in “private” accommodation for Disabled-People to reduce costs was established in Aotearoa New Zealand from 1950, when a policy of subsidising private hospitals had been in place “on the grounds that ‘every private hospital bed is one less bed which the Government has to pay for and maintain’” (Department of Health, 1974, p. 52). This idea of partial investment to reduce the cost of Disabled-People to the state was retained in the government’s Department of Health’s (1974) proposal for “A Health Service for New Zealand”, which advised that health funded aids and services “for the continued care of the physically handicapped” should ‘minimize the dependence of the disabled or handicapped’” (p. 111), particularly on hospitals. The calculations for what constituted a “sufficient period” to “justify the amount of expenditure involved” is not stated in the DPCWA (1975); however, housing alteration grants of up to NZ\$5,000 were made from 1978-1983, and then from 1984 up to NZ\$8,000 after the Act was amended to include the addition of a bedroom (Department of Social Welfare, 1978-1988; Disabled Persons Community Welfare Amendment Act, 1984). The loan abated over a period of 5-years, and subsequent

²⁵¹ The Loan was available initially only to people who owned their home, or who lived in social housing (Disabled Persons Community Welfare Bill, 1975), but was then extended to tenants in private property (DPCWA, 1975).

loans could be made once those 5-years had passed (Palmer & Smith, 2002). Thus, 5-years was considered a sufficient period for NZ\$5,000 of expenditure (or NZ\$1,000 per annum) for housing alterations in 1975. While the DPCWA provided funding of up to NZ\$5,000 for alterations of Family-Homes, in 1975 government funded “beds” (which covered accommodation and care costs) in collective, confined spaces were subsidised for NZ\$9,000 in “old people’s homes” and NZ\$12,000 in “geriatric hospitals” plus partial or full costs of capital costs and “approved improvements”²⁵² (Department of Statistics, 1975, s5A), and “[NZ]\$8,000 a bed” for the “intellectually handicapped” (King, 1975b, p. 4426).²⁵³

Rather than funding the alterations outright or giving a lump sum that the Disabled-Person could invest in the property market, these loans were a partial investment in a “private” bed within the Family-Home that the Government did not otherwise have to pay for or maintain. The danger that the investment from the state might not “justify the amount of expenditure involved” was reduced by making the payment a suspensory loan. The loan could be “recovered” if the person did not “enjoy the benefits” of the payment for 5-years (e.g., if the Disabled-Person moved house to access more specialised care or died before the 5-years were complete [Tollemache, 1992]); thus devolving the risk and responsibility of the investment to the Disabled-Person and their family. Grants for alterations to accommodate Disabled-People were governed at a distance, hinting at an emerging neoliberal governmentality in which social services are deregulated by “shifting them onto the market or by devolving them onto the family” (Fraser, 2003, p. 166). I discuss the DPCWA grants in relation to the modified shower that became associated with them further below; however, first I discuss a population who were governed in a way that meant the nature of their dwelling and who was or was not caring for them in their home might not “justify the amount of expenditure involved”, excluding them from a loan for a modified shower.

²⁵² In addition to “Assistance to Families and Persons” the DPCWA provided “financial assistance” to voluntary and charitable organisations for the cost of “establishing, adding to, improving, or providing essential alterations to a home for the general welfare and residential care in the community of disabled persons” (S17a).

²⁵³ Alongside funding of “private beds” the state continued to build and maintain Large-Permanent-Homes for Disabled-People. The DPCWA employed this idea of partial state funding for “private” Permanent Homes, providing financial assistance for the costs of “establishing, adding to, improving, or providing essential alterations” of Voluntary and Charitable organisation group homes. The legislation also increased policing of such homes, requiring them to be registered and being subject to state-imposed standards. Through the Hospitals Act 1957, the State continued to be involved in building collective, confined dwellings for Disabled-People, subsidising the capital costs of buildings constructed by religious and voluntary organisations accommodating Intellectually Disabled children, “elderly people and others whom it is considered are in need”, and funding hospital board beds (Department of Statistics, 1975). Institutions for “Mentally disordered persons” were funded through the Mental Health Act (1969).

The Danger of Aging Family Homes and Their Aging Owners

Although there was an established history of the Elderly dwelling in Large-Permanent-Homes, in the early 1900s, pensions meant that it became possible for poor Elderly without family support to maintain themselves in private homes (Sullivan & Stace, 2020; Tennant, 1983). However, throughout the 1900s, a discourse of the dangers of failing to maintain their body or their dwelling could risk the Elderly being removed from their own home. I argue that this possibility, well established by the time the DPCWA (1975) was enacted, meant that the Disabled-Elderly were a population at risk of being excluded from government funding for modified showers.

As noted in Essay 3, concerns regarding health and hygienic dwellings emerged in the 1800s, and a degree of state authority over private dwellings to prevent the spread of contagions was well established by the 1900s. A sanitation public health discourse that connected private dwellings to the health and wealth of the nation extended the state's biopolitical interest in the population's environment into private property and the problems of overcrowding and the flow of water.²⁵⁴ In Aotearoa New Zealand, the Housing Survey Act 1935 granted the State authority to conduct a national survey of dwellings which included recording the age of the inhabitants (4[c]) and the "number of people who are detrimentally affected by existing housing conditions" (3 [1c]) such as the improperly plumbed house. Local councils were tasked with carrying out the Housing Survey and committees formed by Councils for this purpose raised concerns about the "deplorable housing conditions" of "Old Age Pensioners" ("Better Housing Sought", 1937, p. 12). They called for State intervention to remove pensioners and the poor from their "deplorable" private homes, and to provide dwellings for them ("Better Housing Sought", 1937, p. 12).

The State's stock-take of dwellings found a number of houses considered injurious to their inhabitants' health. Subsequently, the Housing Improvement Act 1945

²⁵⁴ Although I am attempting to avoid colonising practices by speaking for Māori on the effects of colonisation, it would be neglectful not to refer to practices that targeted Māori dwellings during the 1800s. Traditional dwellings (Raupo whare and "substandard dwellings") were demolished in the name of health (Raupo Houses Act, 1842), while Crown policy aimed to move Māori toward individual property ownership for the purpose of "entire amalgamation of all Her Majesty's subjects in New Zealand into one united people" (Fitzgerald, 1862, as cited in Williams, 2001, p. 26). Native schools aimed to educate the students on the importance of private property (Williams, 2001) and the 1900 Māori Council's Act attempted to disrupt collective living; "It is this communal life, this non-subdivision of land, and the communal titles which force them into idleness, carelessness and neglect... [The Act] will put a stop to this communal life which is so disastrous to their well-being" (Seddon, 1900 as cited in Williams, 2001, p. 35). Subsequently, housing sanitation reforms carried out by the "Health Officer to the Māoris" aimed for "a complete revolution in their socialistic, communistic and private life" (Pomare, 1908, as cited in Williams, 2001, p. 37). The 1918-1919 influenza epidemic resulted in the gaze of health authorities fixing on the homes of Māori, as the death rate for Māori was seven times that of the general population, with the condition of the houses that Māori lived in taking much of the blame (Wanhalla, 2006).

and Housing Improvement Regulations 1947 were passed which required dwellings to meet particular Standards to ensure the health of the inhabitants and the population. These required private dwellings to have a bathroom that “shall contain an approved bath or shower with an adequate supply of wholesome water. These regulations required that adequate means of heating water shall be provided” (S9[2]) and gave the State the power to evict occupiers, demolish houses, and fine owners as a charge against the land where the building was situated. While it was possible for anyone’s house to be “deplorable”, “insanitary” houses were a particular concern for the Elderly-Disabled at this time:

We have many aged couples in Christchurch living in insanitary conditions. I have before me a report presented to the Christchurch City Council which deals with a man of sixty-seven and his wife of eighty-one years of age living at New Brighton. The man is partially crippled and uses crutches. The woman is senile and blind. For the past seventeen years they have been living in a very dilapidated house that is only fit for demolition, and they are incapable of looking after themselves. They live in dirty surroundings, and their home is filthy. Aged and infirm people living in such grossly insanitary conditions should be helped.

(Howard, 1956, p. 2687)

Aging as a discursive construct connected with disability and an inability to care for oneself or one’s home was established (Adams et al., 1957; Affleck, 1948; Hunt, 1956; Rusk, 1951; Vivrett, 1957a; Warren, 1957) and could justify state intervention in where and how the Elderly could live. As such, the Health Act (1956)²⁵⁵ gave the state the power to remove anyone who was “aged, infirm, incurable or destitute” (s126) from an “insanitary” dwelling and detain them in a hospital or hospital board institution.

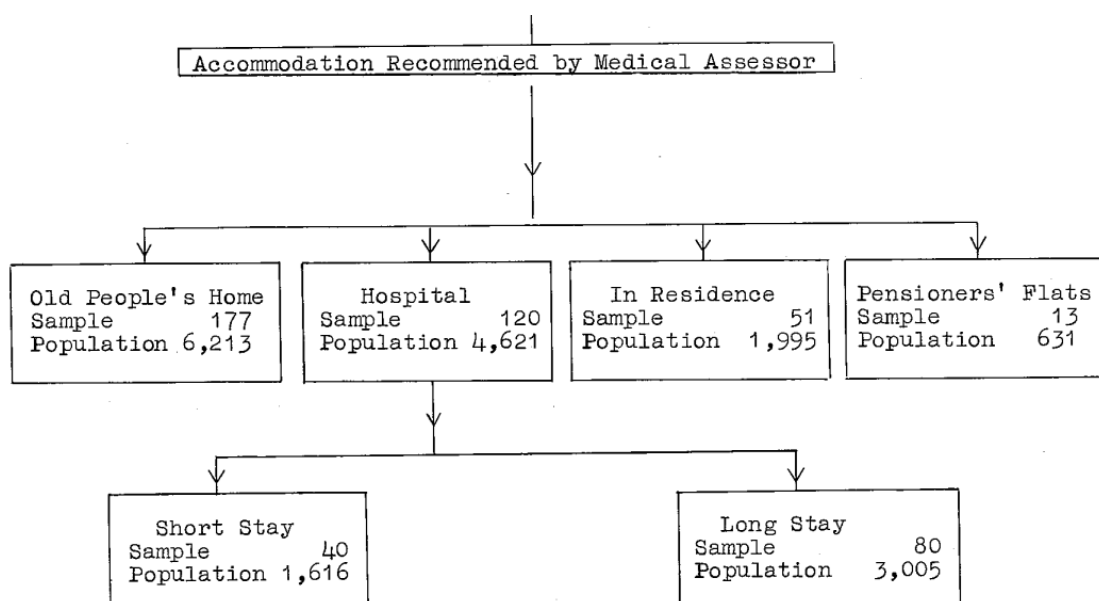
The State’s continued interest in the lives of the Elderly in their private dwellings led to reviews and associated reports in the early 1960s (“Elderly Persons Accommodation Needs in New Zealand, 1962” [Department of Health, 1963]) and mid-1970s (Salmond, 1976). The reviews aimed to assess the medical, social, and housing needs of the subjects, associated with the idea of various forms of accommodation designed for various categories of Elderly (Board of Health, 1967). The reviews

²⁵⁵ The Health Act specified the conditions that could make a dwelling injurious to health. This included building dampness; air space, floor space, lighting, “accumulations or deposits” that might attract vermin, smoke, conditions that could give rise to the breeding of insects, and the keeping of animals.

categorised the Elderly into various forms of accommodation by assessing the condition of the house and person (their “functional activity” and “pathology”). Assessment of the person aimed to identify Disabled-Elderly who would then be referred for a medical assessment and final classification regarding where they should live (see Figure 72).²⁵⁶

Figure 72

1963, Elderly Persons Accommodation Recommended by Medical Assessor



Note. From *Elderly persons accommodation needs in New Zealand, 1962* (p. 20), by Department of Health, 1963, Ministry of Health. Reprinted with permission

In 1962, those who needed care and oversight were categorised for “Old People’s Home”; however, the 1976 survey found that the “slightly disabled” and “partially sighted” could remain living on their own, and even those who were “mentally” or “severely” disabled could remain in the community if they could be cared for by a spouse (typically a husband cared for by his wife). While Short Stay in hospital connected the Elderly to Rehabilitation,²⁵⁷ the need for assistance with essential everyday activities and the use of aids such as a walker or wheelchair continued to be associated with being categorised as needing to be institutionalised in an Old-People’s-Home:

²⁵⁶ Both the person and the home could indicate disability - those “Dirty in person and surroundings” or “neglected” appearance, signalled the inhabitant having “mental state” issues (see also Vivrett, 1957a).

²⁵⁷ Rehabilitation for the Elderly aimed specifically to “free badly needed hospital beds” (Department of Health, 1969, p. 55) and focused on Independent Mobility and Self-Care (in particular eating and hygiene tasks) (Adams et al., 1957; Affleck, 1948; Bain, 1951; Hunt, 1956; Rusk, 1951; Vivrett, 1957a).

4. Recommend for care in a residential home only those people who need help with bathing, dressing, toilet and meals, but who are able to get about with a walking aid or in a wheelchair; those using appliances they can manage without nursing assistance; and those with temporary or continuing confusion of mind but who do not need psychiatric nursing care.

(Salmond, 1976, p. 16)

In addition to dependence on a walking aid, wheelchair, or other appliance, justifying the Elderly being removed from their own homes, the surveys assessed the condition of the house to categorise where the Elderly should live. Evaluation of the "Condition of Houses" included sanitation and "state of repair", the adequacy of facilities for food preparation, toileting, bathing, and sleeping, and the presence of stairs or "large premises and grounds difficult to upkeep and beyond the capabilities of the aged to maintain" (Department of Health, 1963, p 16).²⁵⁸ Thus, in addition to being dilapidated, insanitary, or lacking facilities, a dwelling that was too "large" could make it "unsuitable" for the inhabitant. A small number of dwellings that were deemed unsuitable in terms of "disrepair or lack of reasonable cooking, heating and sanitation arrangements" (Department of Health, 1963, p. 16) were identified in both surveys. If the house was assessed as "unsuitable" and deemed irreparable, but the inhabitants were not classified as needing Hospital care or a Welfare Home, Pensioners' Flats were recommended (2.62% and 6% of the population surveyed in 1962 and 1976 respectively).

For the Elderly, the idea of the danger of aging making their dwelling unsuitable, provided the possibility of being removed from their home. In relation to the DPCWA (1975), where eligibility depended on the Disabled-Person being able to "enjoy the benefit of the alterations to the home for a period sufficient to justify the amount of the expenditure involved" (DPCWA, S14[3]), eligibility of the Disabled-Elderly could be called into question. While the Disabled-Elderly were thought to need a Large-Permanent-Old-People's-Home in the first review, by 1976 the possibility of the Disabled-Elderly living in a Pensioner-Flat had emerged. Next, I discuss showers connected to Pensioner-Flats to explore how these dwellings connected or disconnected Disabled-Elderly to/from the government's funding of showers modified for Disabled-People.

²⁵⁸ It was not only being subject to the survey that could mean that health authorities could determine that an Elderly person be hospitalised. Health Inspectors implementing the Health Act could remove Elderly people "dirty in person and surroundings" from their own home: "I received many complaints from the neighbouring householders concerning the conditions of this 'dirty old woman' ... The dwelling was in an advanced state of decay... There was no water supply and the sanitary fittings were all broken or completely unusable... I managed to co-opt the assistance of Drs Newton and Barker who were associated with the geriatric hospital at Green Lane at the time, and in spite of the pressure on beds they were kind enough to stretch a point and receive the old lady into one of the wards (Forley [Auckland Health Inspector], 1969, A1 2).

Pensioner-Flat-Showers for Little-Old-Ladies

From the time of the first review of the condition of housing in New Zealand, a discourse of being “aged” leading to a house becoming unsuitable due to it being too large, insanitary, or falling into disrepair was connected to the idea of small dwellings being built specifically for the Elderly:

Week by week has been brought under my notice the providing of self-contained dwellings for old people who want small houses with one bedroom, one living room, scullery, etc., and sanitary conveniences. Such schemes are in operation at Home and the happiness of the old people when their rent is not more than 7s 6d per week shows that their erection is very necessary.

(“Housing Schemes”, 1935, p. 13)²⁵⁹

The idea of the need to house the Elderly in small dwellings, owned by the State or local council, and designed for their use, emerged following the first housing survey in the 1930s (“Better Housing Sought”, 1937; “Flats for Pensioners”, 1940; “Homes for Pensioners”, 1937; Housing Schemes, 1935; “Housing Scheme Criticised”, 1937; “Pensioner Flats for Auckland, 1938”; Pensioners’ Needs, 1937). In 1938, the State’s Housing Construction Division built 1081 Pensioner Flats (Salmond, 1976). In the 1950s, the State changed its involvement to partial funding through the provision of subsidies to welfare organisations and local councils (Cooke et al., 1971; Salmond, 1976).

Moving the Elderly into social housing that had been newly constructed (and Properly Plumbed) addressed the problem of poor Elderly living in houses in a “deplorable” state. However, Pensioner-Flats were not just new, they were specifically small dwellings. They were designed primarily to accommodate a single person (up to 1 in 10 dwellings for a couple was recommended [Department of Health, 1972]). While “Large” dwellings were a danger in relation to the Elderly being unable to maintain them, Elderly occupying large Family-Homes was also a concern for the property market:

²⁵⁹ “Home” here refers to England.

The evidence showed that there are many elderly people, in a rather better financial position, who do not qualify for a pensioner flat or a similar owner-occupier flat and yet may well have difficulty in financing the purchase or lease of a flat on the open market. Not uncommonly these people occupy family homes, now too big for them, thus aggravating the wasteful use of existing housing stock.

(Cooke et al., 1971, pp. 51-52)

Thus, the condition of being Elderly was connected to living in a dwelling designed for the Elderly. If they were to dwell in the community, this should be a small dwelling for the benefit of the nation.

In 1972 the Department of Health produced architectural "design notes" titled, The Design of Pensioner Housing. The foreword noted:

The objectives of those who provide housing for the aged can be summarized as "providing a safe, efficient and comfortable environment in the light of the known frailties and disabilities common to the elderly".

(Kennedy, cited in Department of Health, 1972, para. 1)

The Design Notes advocated for low-cost dwellings that do not use "excessive space" by employing an economic rationality stating, "the community's resources of money, building skills and welfare services must be employed in the most effective way" (Department of Health, 1972, p. 1) and noting that rents must be low for living standards (warmth, food, clothing, and some pleasures) to be maintained on a pensioner income. Furthermore:

Excess space or over-elaborate equipment will not necessarily make life easier for a frail old person who may find the extra physical and mental effort called for is a burden. Thoughtful rather than costly design is the real solution.

(Department of Health, 1972, p. 2)

The Pensioner House was thus "efficient", distinguishable from the large Family-Home that wasted the space and resources of both the nation and the Elderly themselves.

In addition to being small, Design for the Disabled was connected to Pensioner housing. As described above, Goldsmith (1963) had noted his attention to the "significant preponderance of women" (p. 15) among elderly people, and had included the anthropometrics of women aged 60+ in his designs (see Appendix I). A discourse of Injury Prevention to reduce disability and maintain Independence was connected to such design. The Design Notes state that "expanded Rehabilitation and support services, are extending the ability of old people to maintain a more independent way of

life" (Department of Health, 1972, p. 1). The "trend" of Independence connected the Elderly to such specialised design:

This trend means that there is an increasing need for specialised housing, design orientated to safety, and to minimising the effects of the disabilities of old age. Specialised housing can allow the added years to be enjoyed and can defer the time when independence may have to be surrendered.'

These notes discuss the design implications of old people's special needs and disabilities. They do not cover the specialised design requirements of persons confined to wheelchairs; information on these is available in various publications. Specific planning layouts have not been given. These are considered to be the responsibility of designers of individual schemes.

(Department of Health, 1972, p. 1)

Despite "this trend" of design that might minimise disability, the designs specifically excluded "persons confined to a wheelchair". Rather than being for a body-wheelchair complex, the designs are for "a little old lady":²⁶⁰

Women particularly were studied in the survey because the majority of pensioners are women, and their smaller size determines the more restrictive requirements. The typical pensioner is, in fact, a little old lady.

(Department of Health, 1972, p. 5)

Pensioner Houses were designed to be a little house for A-Little-Old-Lady who may have "disabilities of old age", had limited resources, did not use a wheelchair, but who may remain Independent and able to enjoy years of life through efficient, safe, Disability Design.

A discourse of Disability Design for the Pensioner was connected to Independence, as with other populations (see Essays 5, 6, & 8); however, Injury Prevention was particularly connected to the Elderly. In the Design Notes the idea of "design orientated to safety" drew on the findings of a 1966 review of hospital admissions due to accidents in which the number of people admitted to hospital for domestic injuries outnumbered any other cause of injury (Findlay, 1970).²⁶¹ Falls caused more than half of the injuries, with older women being most likely to be hospitalised following a fall. For A-Little-Old-Lady, such falls, caused by design failures, were dangerous in terms of injuring the body and causing them to occupy a hospital bed, and could threaten their "preferred way of life":

²⁶⁰ The authors of the Design Notes acknowledge Goldsmith's (1967) "Designing for the Disabled" which also stated that the private home designs were for women because "among elderly people there is a significant preponderance of women" (p. 15). Both of the housing reviews also found that the vast majority of community dwelling elderly were women, although Salmond (1976) found that the most disabled-elderly people were men being cared for by their wife.

²⁶¹ This was a follow up study from a similar one conducted in 1957 which similarly found that increasing age was associated with falls, and that "nearly one public hospital bed in each twenty occupied by females is occupied by a female who sustained a domestic fall" (Foster, 1960, p. 4).

Considerable variations in the broader aspects of planning are possible but it should not be forgotten that even one essential detail, ill-adapted for its purpose, can quite seriously add to the risks and frustrations of old age, or can spell the end of a preferred way of life.

(Department of Health, 1972, p. 38)

For the Elderly, disability from injury was a danger that could take away Independence and the years of life that may be enjoyed. Although Woodhouse et al. (1967) included the Elderly in a discourse of reciprocal duty due to their historic connection to the apparatus of production, injury here was not connected to compensation or Rehabilitation; rather categorised as needing a specially designed dwelling, or risking being moved into an institution.

At the time the Design Notes were published, showerhead mixers designed to maintain temperature control within Aotearoa New Zealand's dwellings with unequal pressure had been developed in the late 1960s (Felton Industries Ltd, 2021) and were being installed in "Special Value", "Budget" and "Single Unit" homes ("The Home your Heart is Set On must be Here!", 1975, p. 13). The Design Notes advocated for the installation of showers with particular safety features, stating that they could be provided instead of baths to prolong Independence:

Showers

Showers are often provided in lieu of baths; these can be used by persons who could not safely bath without supervision.

Shower compartments should not be less than 3 ft. x 3 ft. This allows room for handgrips and space for a chair or stool to be placed within the compartment.

Non-slip flooring is necessary.

Reliable control of water temperature is essential if accidents are to be avoided and if old people are to have confidence in using showers. Many are incapable of rapid reaction to excessively hot or cold water. Balanced water pressures and temperature control incorporating an anti-scald device are needed.

The recommended shower outlet is a "telephone" shower handpiece on a flexible lead. This permits use by either a standing or seated user or by a district nurse or other attendant on occasion.

Controls should be easily accessible from outside as well as inside the compartment.

(Department of Health, 1972, p. 21)

The Design Notes thank Goldsmith for permission to reproduce data from his manual; however, the Pensioner-Flat-Shower proposed is smaller than Goldsmith's 1967²⁶²

²⁶² In Goldsmith's second edition of *Designing for the Disabled* the shower design from the 1963 edition was retained (see Essay 7), although it was renamed "Small shower cubicle". That shower was 2'6 x 2'9; however, Goldsmith noted that "the dimensions of the shower cubicle should be minimum 3' 6" (1.07 m) in the direction of the shower stream and 3' 0" (91 cm) in the

minimum designs. The Design Notes suggest a chair or stool as an optional addition rather than being built in, and the controller should be “easily accessible from outside”, rather than on the far wall as suggested by Goldsmith. The shower is distinguished from Goldsmith’s shower for wheelchair users, as the “kerb” or step that Goldsmith states “must not be provided” to allow wheelchair access into a shower is not mentioned.

The Pensioner-Flat-Shower was designed to prevent injury and promote Independence for A-Little-Old-Lady who could walk and step without assistance. Human assistance from outside the shower was made possible for subjects who had “occasional” need for an attendant. Thus, these were not showers for Elderly-wheelchair complexes or Disabled-Elderly who depended on assistance with showering. Indeed, the 1976 review in which Salmond found that some Disabled-Elderly could live outside of institutions noted that “one in three was assessed as being unsuitable...some, obviously built on the cheap in the days of limited subsidy, were small and poorly designed” (p. 47). These small dwellings were designed within a dispositif in which biopolitical disablism allowed the Elderly to be categorised and moved out of the Family-Home to reduce the cost of their failure to upkeep a dwelling or to occupy a home that a Family Cell could make use of. The Pensioner-Flat was designed for the Elderly to live Independently, separated from family or friends who may have been able to care for them in the home. While the small dwelling might prevent injury, increase Independence, and otherwise reduce the cost of the Elderly to the physical capital of the nation, they also excluded Elderly who relied on a wheelchair, both through such subjects being categorised as “needing” to live in a “geriatric institution”, and through an economic rationality that produced small dwellings. Next, I briefly discuss showers for the Elderly within the “Long-Stay Geriatric” institutions before returning to government funded modified showers in private dwellings. These showers were designed for Disabled-Elderly who needed assistance in the shower and provide insight into the features of the 1985 “Wet Area Shower” (Booth) that would come to be established as the ideal shower for Disabled-People.

Long-Stay-Geriatric-Patient-Wheelchair-Shower

In 1974, a report was published by HDEU on “Bathing Facilities for Long-Stay Geriatric Patients”. This was a report on the “first stage of a comprehensive study... of

transverse direction... it is impossible to bend over comfortably in an enclosure 2’ 6” (76 cm) square” (p. 131, 1967). In the 1967 edition, larger shower units were also recommended, a minimum of 3’ 6” x 3’ 0” for a “comfortable” shower unit, and up to 3’ 0” x 4’ 9” for a shower unit with an integrated bench seat. Although Goldsmith noted that “some wheelchair users have a special wheelchair to use when taking a shower” (p. 131), there are no designs for such a shower in his manual.

the functional requirements of the various aspects of geriatric care" (HDEU, 1974, p. 1). The authors noted in their opening paragraphs that

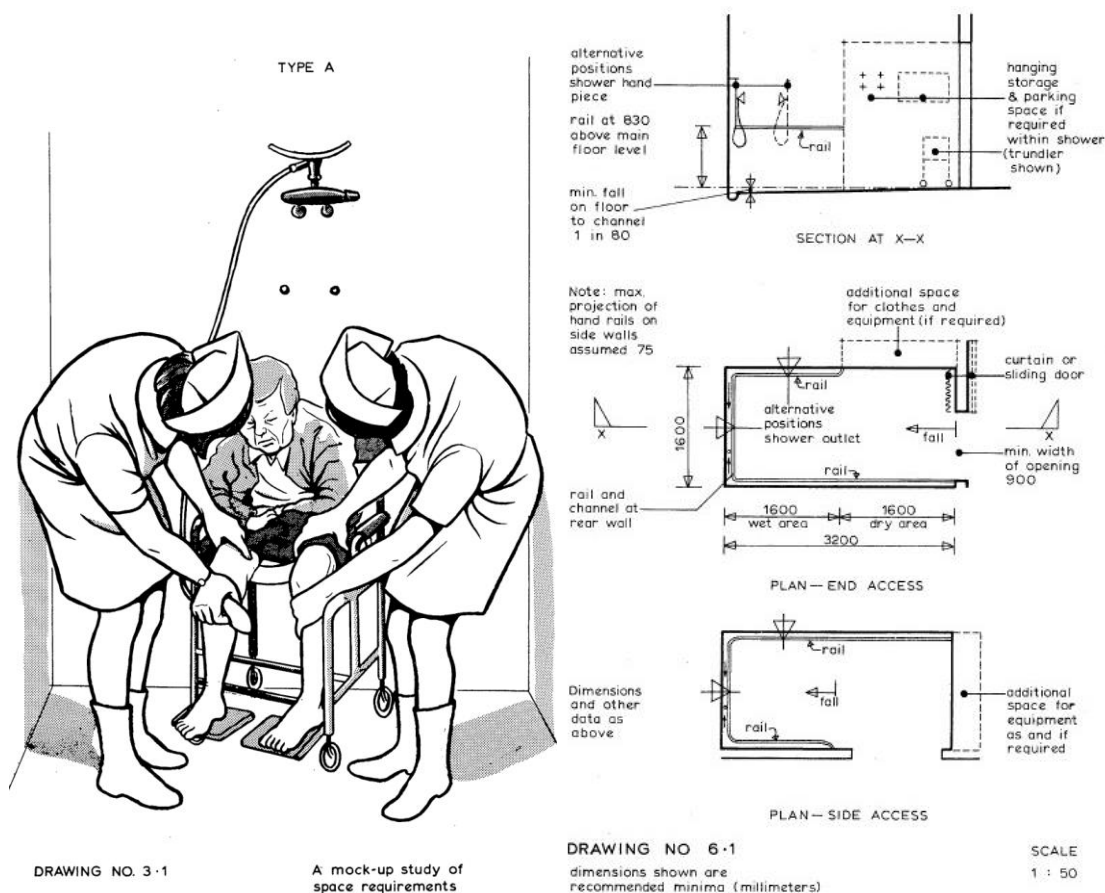
This report represents the first stage of a comprehensive study which the Hospital Design and Evaluation Unit hopes to make of functional requirements of the various aspects of geriatric care.

Although a great deal of research has already been done in this field, it cannot necessarily be assumed that the situation remains static, or can be applied in toto to the New Zealand scene. Indeed, a preliminary survey suggests that there are differences. To take one example relevant to this report, there appears to be a much greater acceptability of the use of the shower by both staff and patients alike.

(HDEU, 1974, para 1-2)

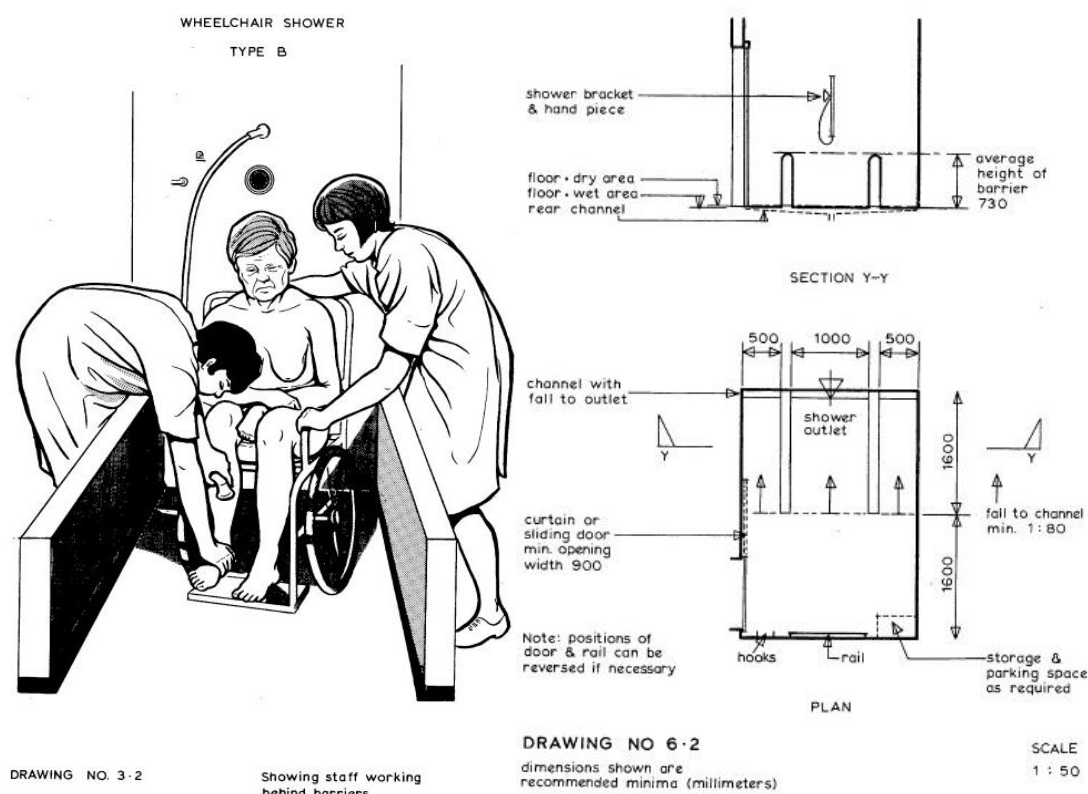
As noted in Essay 4, the HDEU were concerned with the lack of privacy between patients that bathrooms in Large-Permanent-Homes provided. The Long-Stay Geriatric report also criticised "production line" bathing which left patients "waiting in a state of undress" (s 3.6) and situations where "patients' privacy is seriously infringed not to mention the embarrassment to any passers-by" (s 3.11). In contrast to the Psychopaedic-Shower-Room, with shower units and space for a shower trolley, this study concluded that "the well designed wheelchair shower has many advantages in the long-stay geriatric setting" (s 5.3). Advantages they suggested included the design being suited to most patients; ease to transport patients into; economical; easy to use; and safe in terms of preventing cross infection, falls, and burns. While it was proposed that the patients generally preferred a bath, they were able to "adjust to its use quite readily" (s 5.3a).

The Long-Stay-Geriatric-Patient-Wheelchair-Shower was designed for attendants to shower an Elderly-wheelchair complex (Figures 73 & 74):

Figure 73*Long Stay Geriatric Patients Wheelchair Shower Type A, 1974*

Note. From *Bathing facilities for long-stay geriatric patients: part 1 of a study of planning requirements for geriatric patients* (Drawing No 3.1) by Hospital Design and Evaluation Unit, 1974, Department of Health. Reprinted with permission.

(Images are enlarged in Appendix II)

Figure 74*Long Stay Geriatric Patients Wheelchair Shower Type B*

Note. From *Bathing facilities for long-stay geriatric patients: part 1 of a study of planning requirements for geriatric patients* (Drawing No 3.2) by Hospital Design and Evaluation Unit, 1974, Department of Health. Reprinted with permission.

(Images are enlarged in Appendix III)

The study concluded that although baths were well established in Long-Stay Geriatric facilities, and a number of staff had a preference for their use, the well-designed Wheelchair Shower would provide “optimum working conditions for the nurses and comfort and safety for the patients” (para 6.1.1).²⁶³ In contrast to the compact Pensioner-Flat-Shower for Elderly who need “occasional” assistance, the Long-Stay-Geriatric-Patient-Wheelchair-Shower was designed as a workspace (“optimum working conditions”) for the Nurse and their Patient.

While the bath had been the hygiene tool of choice in Geriatric Facilities, the HDEU employed a discourse of the bath being a danger to Nursing staff in terms of back strain and being inefficient as three Nurses were often needed to lift the patient in and out of the bath. In contrast:

²⁶³ It was not only the HDEU who advocated for showers in Large, Permanent Homes for the elderly. Even designers who maintained that the bath was best in the private dwelling recommended showers for institutions including Vivrette (1957b) and Goldsmith (1967).

(c) The wheelchair shower is economical of staff time in aggregate and of staff effort in lifting etc.

(HDEU, 1974, s 5.3)

For the Patient, the shower was something to be adjusted to. While Patients' perspectives were not included in the study, the authors observed that:

Patients appear to adjust to its use quite readily and often come to realise that the leisurely and relaxing bath they may have preferred in their own homes is hardly practicable in hospital.

(HDEU, 1974, s 5.3a)

It seems that although the Patients might have preferred a bath, through the use of the shower they would become a docile body, subjected to the interests of the institution.

The Long-Stay-Geriatric-Patient-Wheelchair-Shower was an object of a Hygiene discourse in which applying warm water to the skin maintained the health of the individual and the population. However, they were quite different to the hygiene showers of the private dwelling (see Essay 3), the Prosthetic Home Paraplegic-Veteran's-Bathroom-Unit, the Made-To-Order Stall-Shower-with-Shower-Wheelchair (Essay 6), the Paraplegic-Worker-Shower (Essay 7), or the Pensioner-Flat-Shower. Indeed, they appear in some ways more similar to the disciplining hydropathic douches established 100 years earlier and discussed in Essay 1. For example, in the drawings, the Nurses hold the patient in place on the chair, although it was a discourse of safety that justified controlling the patient rather than being "fixt" or bound to the chair to break the obstinate will:

Our Comment:

Some patients may be more easily controlled in the bath than the shower but with a safety belt on a shower chair there should be little difference. With the latter safeguard we feel there is less risk of accident in the shower provided the patient can sit comfortably for the required length of time.

(HDEU, 1974, s 4.5)

The Long-Stay-Geriatric-Patient-Wheelchair-Shower also involved an attendant controlling the temperature and application of the water. Rather than a forceful, lengthy application of cold water, the shower was "economical of staff time" and "both staff and patients should have absolute confidence in the control of water temperature" (s.

6.1.5.5). Indeed, undesirable features of showers that the Nurses noted included “Patients dislike water falling from a height, forceful spray, and they feel cold quickly after a shower” (4.3). Thus, the shower was not employed to shock, instead it was something that the patients can “get used to” (4.3) as part of a warm water hygiene shower discourse. The “shower hand piece” allowed the Nurses to direct water to parts of the body rather than the water falling over the body. It is a discourse of thorough washing of the skin and hair, rather than the hydropathic effects of water on parts of the body’s unseen interior, that rationalises the attendant’s attention to the body parts. Indeed, the Nurses advocated for the hydropathic and hydrotherapy effects of the bath rather than the shower on stimulating circulation, preventing pressure sores, exercising limbs and providing benefits to arthritic patients. However, the HDEU disputed that baths provided such effects, and limited the discourse to hygiene and economical, comfortable, and safe washing of the skin and hair.

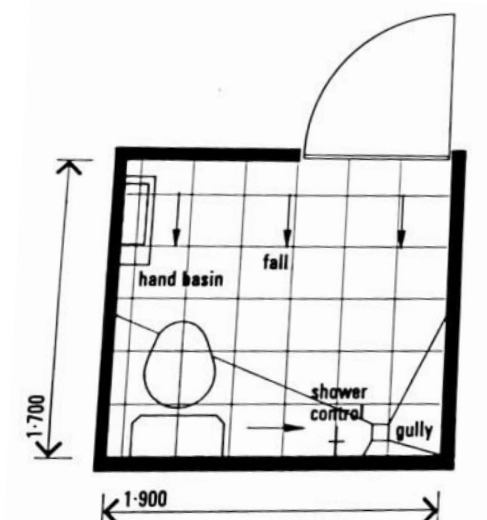
In contrast to the Pensioner-Flat-Shower, the Long-Stay-Geriatric-Patient-Wheelchair-Shower was a shower that accommodated a wheelchair and an attendant (or attendants). While the discourse that established Pensioner-Flats moved the Elderly out of Family-Homes, the showers within the flats excluded those who needed a shower that could accommodate a wheelchair or who needed more than “occasional” assistance. Such needs meant the Elderly were recategorized as a Long-Stay-Geriatric-Patient, where the Wheelchair-Shower could accommodate their body, a wheelchair, and their Nurses. Within the Long-Stay-Geriatric-Patient-Wheelchair-Shower, the Elderly person becomes a feature of the Nurse’s workspace, a docile body that must be washed as part of a hygiene discourse to manage population health within the contained, collective space of the institution. While the Wheelchair-Shower was at this time connected to Disabled-Elderly living in institutions, Booth’s “Construction of a Wet Area Shower” (1984) suggests that by the mid-1980s it was thinkable that showers that could similarly accommodate wheelchairs and an attendant could be built in private dwellings. Next, I discuss these showers that could accommodate a wheelchair and the people who were caring for Disabled-People in their own home.

The Wet-Area-Shower

By the mid-1970s, shower rooms within private dwellings Designed for the Disabled rather than being Made-To-Order were seen as a possibility (Figure 75):

Figure 75

Goldsmith's Designing for the Disabled Shower/wc compartment, 1976



54.86 Shower/wc compartment (1:50)

Note. From *Designing for the disabled* (3rd ed., p. 305) by S. Goldsmith, 1976, Royal Institute of British Architects. Orphan work.²⁶⁴

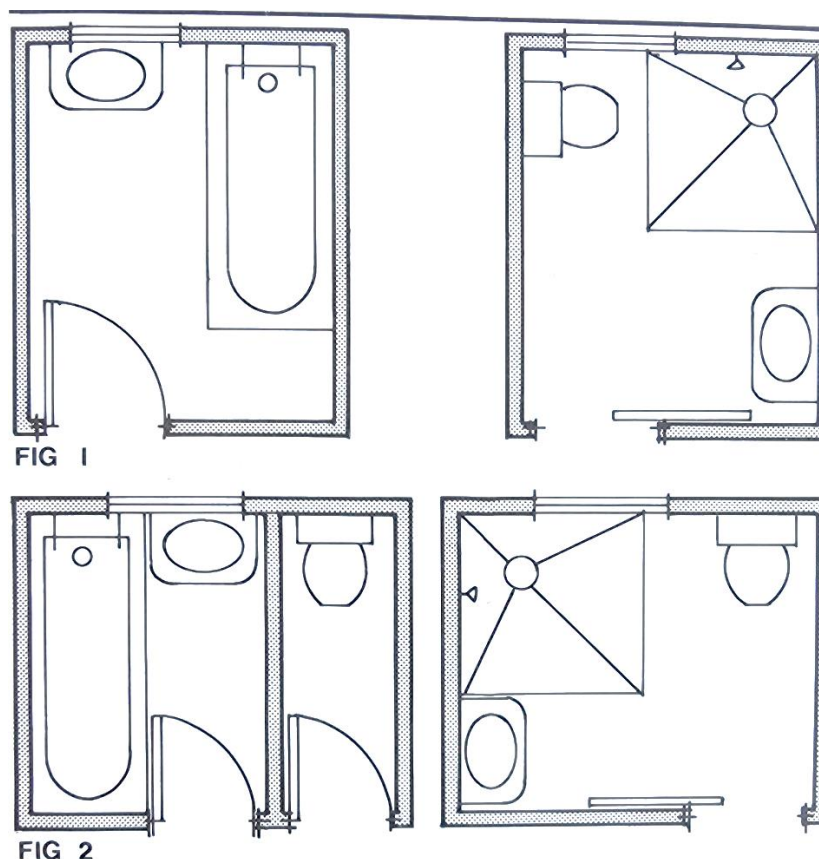
Goldsmith (1976), still generally opposed to showers in British bathrooms, maintained that “because of the problem of providing a shower in the bathroom, it may be preferred in family housing to install the shower in the wc compartment separate from the bathroom” (p. 305). Within the toilet (water closet) room the shower is no longer a unit; rather, it is an area of floor space with a shower head over it and a sloping floor that leads to a gully. This “shower/wc compartment” is very like the Toombs’ (1931) Arrangement-for-a-Polio-who-Prefers-a-Shower in Warm Springs (see Essay 5) although slightly larger (3.32m² vs 2.97 m²) and with detail regarding the Fall-of-Water. However, this was a shower room within a Family-Home. The bath that originally caught the water in the earliest domestic shower-baths had shrunk further vertically to eliminate the step and expanded horizontally to become the entire floor of the room. While it was designed for an individual to shower, with a single shower head, the cell that had originally separated the Showeree or Showerer from the population within prisons, army barracks, and then private dwellings had also expanded to become a room of a house. The expansion of the shower walls to create a shower room created the possibility of the domestic shower being a collective space for a Disabled-Person, their appliance, and the person who may be caring for them in the home.

²⁶⁴ If you believe that copyright infringement has occurred in any of this content, please contact the author.

In 1984, the New Zealand Disability Information Bureau prepared a pamphlet detailing the “Construction of a wet area shower” by Graham Booth, Builder. The pamphlet stated that “one of the best ways of providing an accessible bathroom with a minimum of alteration is to incorporate a “wet area” (or “wheel in”) shower” (p. 2). While Goldsmith’s design involved expanding the toilet room to include a shower, the Wet-Area-Shower (Figure 76) was a feature of an Accessible bathroom whereby “replacing the bath with a wet area shower often also gives space for a toilet as well” (p. 2):

Figure 76

Booth’s Wet Area Shower Design, 1984



In figure 2, toilet and bath are in separate rooms with both doors too small for easy wheelchair access. Both rooms are also too small for a wheelchair to manoeuvre. Removal of the partition and provision of one large door is necessary.

Note. From *Construction of a Wet Area Shower* (p. 3), by G. Booth [illustrations by L. Windsor], 1984, New Zealand Disabilities Information Bureau. Reprinted with permission.

The idea of “accessible” facilities was well established by the 1980s. Accessible design for public spaces emerged with the American Standard Specifications for “Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped” (1961). Drawing on the discourse of Accessibility established in Illinois University (see Essay 6), this standard and those that followed aimed to include Disability Design in

collective spaces, excluding private property (see Appendix IV).²⁶⁵ Originally, New Zealand's Code of Practice for Design for Access by Handicapped Persons (the Standards Association of New Zealand, 1971 [NZS4121:1971]) followed the American example and did not include shower facilities. However, by the 1980s, these standards were including shower design (American National Standards Institute, 1980; Standards Association of New Zealand, 1985 [NZS4121:1985]) and required their inclusion in holiday accommodation, public sports and swimming facilities, and factories that provided showers (NZS4121:1985).²⁶⁶

A discourse of places being "accessible to, and usable by people who have disabilities" (NZS4121:1985, p. 4) was connected to the DPCWA (1975)²⁶⁷ and drew on democratic power, stating that "disabled people are part of the community, and barriers which prevent them from participating in the social and economic life of that community must be eliminated" (p. 4). Accessible Design remained attached to Physical Handicap as it was established in Illinois University and included "those bound to wheelchairs" (Nugent, n.d., p. 1), "The wheelchair bound" (Standards Association of New Zealand, 1971) and those with "The inability to walk, Walking difficulties, Reliance on walking aids" (NZS4121:1985, p. 8) (see Appendix IV). However, a discourse of Accessible design for a wider population was emerging in the 1980s, and the problem of architectural barriers was connected to "the very young and the elderly" (NZS4121:1985, p. 4), making accessible design "more convenient for the public at large... [and] more economically viable" (NZS4121:1985, p. 4).

The NZS4121:1985 depicted a shower design that was a shower cell for those who could move from seat to seat with little change from the 1960 Illinois University shower (see Appendix II Essay 6). The NZS4121:1985 also included a "combined toilet and shower" room which is nearly identical in form to Booth's shower design for private dwellings (see Appendix V). Both showers were a 1200x1200 corner of a "combined toilet and shower" room or modified "bathroom" (see Appendix VI). A shower curtain

²⁶⁵ The Building Act 1991 further diminished the reach of Accessible design. While the DPCWA (1975) had required Accessible design in any "home" for five or more disabled people, the Building Act only identified "(j) Hotels, motels, hostels, halls of residence, holiday cabins, groups of pensioner flats, boarding-houses, guest houses, and other premises providing accommodation for the public: "(k) Hospitals, whether public or private, nursing homes, and old people's homes: [and] "Area health board premises and facilities" (p. 2068). In 1998 a decision was sought regarding whether a local council could require a "home" being built by a Housing New Zealand subsidiary to accommodate 10 intellectually disabled people to meet accessibility standards (Building Industry Authority, 1998). The argument was that the home's purpose was to enable "usual community living patterns" and that it would be used as a "private home" (p. 2). The authority concluded that the "home" was a private residence and could not be required to meet the NZS4121 standards.

²⁶⁶ See Penner (2013) for further discussion regarding the "Inclusive Bathroom".

²⁶⁷ Section 25 brought the NZS4121 into legislation requiring new and refurbished buildings to be made accessible, although the power to grant exemptions was also permitted (see Appendix D Building Act reform for Building Users).

hung just inside the area of the shower made up two of the four walls of both showers; the drain position, the height of the shower controller, and the sliding shower head were the same for both and rails were to be included. The Wet-Area-Shower was now established as the ideal shower for Disabled-People, in private or public spaces. The Disabled-Person was now the Showerer, in a shower that accepted them despite an inability to stand or step up (see Figure 77).

Figure 77

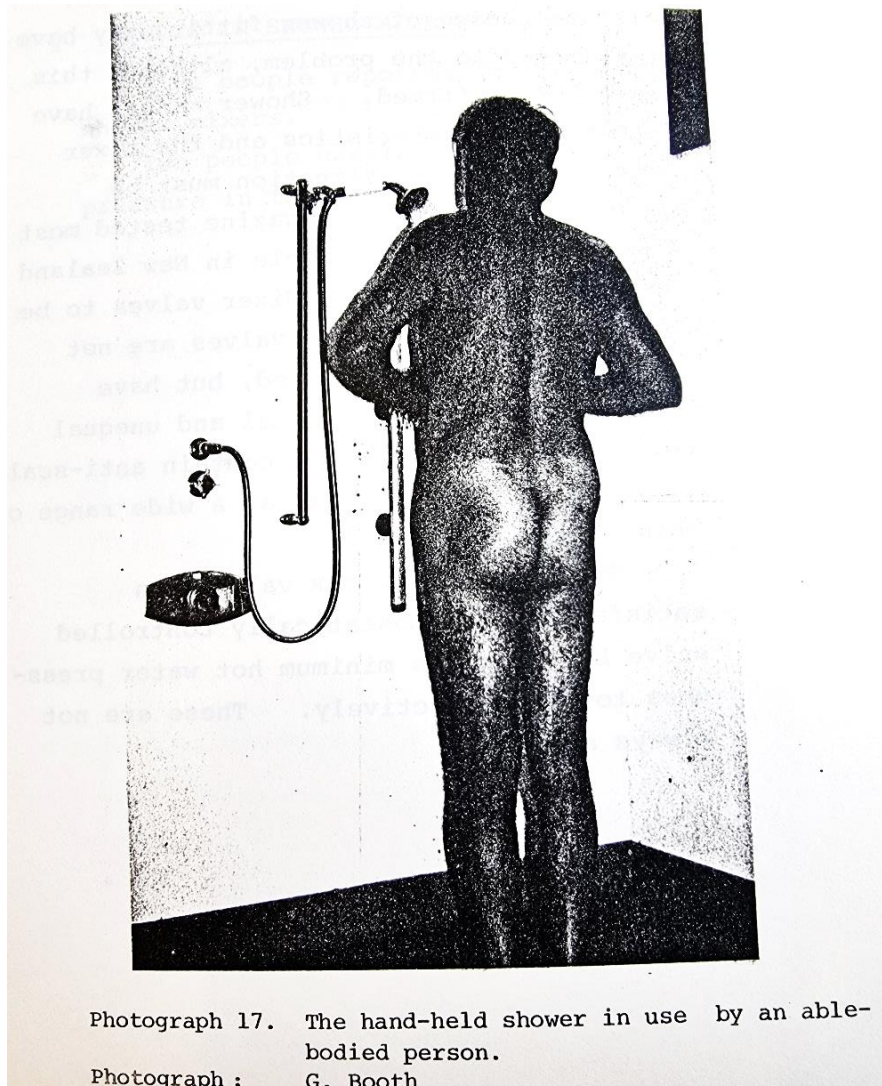
Paul Curry in a Wet-Area-Shower



Note. From *The Bathroom: Special Needs*, (1986), *New Zealand Home and Plumbing*, p. 59. Orphan work.²⁶⁸

However, installation of the Wet-Area-Shower within the Family-Home meant it also needed to be usable by the household (Figure 78):

²⁶⁸ If you believe that copyright infringement has occurred in any of this content, please contact the author.

Figure 78*Pope's Hand-Held Shower in Use by an Able-Bodied Person, 1982*

Note. From *House alterations for disabled people: Common errors and how to avoid them* (p. 66), by C. Pope [photograph by G. Booth], 1982, Victoria University, Wellington, New Zealand. Reprinted with permission.

The wet area shower would later come to be connected to a discourse of safer showers that are “*universally usable*” (Wrightson & Pope, 1989, p. 12, emphasis in original), and remains unchanged in the MOH Housing Modification manual used today (Appendix VII). However, though the Wet-Area-Shower was deemed universally usable, the small Pensioner-Flat, with a shower space of 0.9144 by 0.9144 could not accommodate this shower, further distancing the Little-Old-Lady from the possibility of living within their own home as a body-wheelchair complex.

While these shower rooms could provide space for an attendant (as they did in the collective, contained spaces for the Psychopaedic and Elderly patient), Goldsmith (1976), Booth (1984), and the NZS4121:1985 do not offer any commentary on

showering with an attendant. Although not mentioned in these documents, the problem of shower cubicles providing little space for an attendant was part of the discourse regarding the advantages of wet area showers by this time (Pope, 1982) and the 1996 “completely revised” edition of the “Construction of a Wet Area Shower” states that the shower design (which was unchanged) “provides space for an assistant to stand on two sides of the shower” (p. 5). Thus, the shower within the private dwelling became a collective space and the ideal shower for those whose securities in property and social support might make them eligible for a DPCWA home alteration grant. While the Wet-Area shower might have been a “universally usable” shower, promoting freedom of movement for Disabled-People, the practices associated with the funding of the shower limited freedom of movement for some.

Wet-Area Shower Funding and The Right to Move

The DPCWA (1975) was named a “Welfare Act”; however, it emerged at a time when the so called “welfare state” was “contracting” (Bryder & Tennant, 1998) and welfare was described as only providing a “basic income for subsistence” (Woodhouse, et al., 1967, p. 33).²⁶⁹ Neoliberalism was transforming from theory to practice at this time (Wilson, 2019), changing the discourse of welfare from distribution of wealth to ensuring a “vital minimum” for those who could not live in the community without assistance.²⁷⁰ Although the production of Independent subjects was added to the rationale for alterations to homes in the DPCWA following submissions, the grants were established in a dispositif where an economic rationality justified the state’s partial funding of private accommodation for Disabled-People. As noted above, provision of the grant as a suspensory loan meant the Disabled-Person or their family took on the risk of the period being “insufficient” and the responsibility for managing the social

²⁶⁹ Welfare at this time included a basic income (less than a third of the minimum wage for a 40-hour week at the time [Ministry for Culture and Heritage, 2021]) for “Solo parents” (Women not supported by worker’s income, or men whose wives have been admitted to an asylum [Social Security Amendment Act, 1973]) who were providing “care and attention” to an incapacitated relative (Social Security Amendment Act, 1973). A disability allowance of \$8 a week (about \$90 in today’s currency) was then introduced for those already receiving an income-tested benefit (Social Security Amendment Act, 1975).

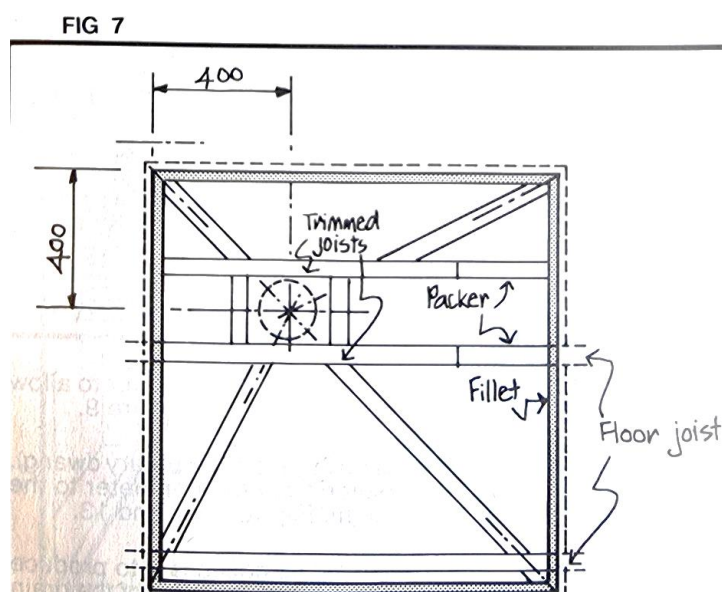
²⁷⁰ Foucault (1979/2008c) explained “A social policy with the objective of even a relative equalization, even a relative evening out, can only be anti-economic. Social policy cannot have equality as its objective. On the contrary, it must let inequality function... The only thing one can do is deduct from the highest incomes a part that would in any case be devoted to consumption, or, let’s say, to over-consumption, and transfer this part of over-consumption to those who find themselves in a state of under-consumption due to permanent disability or unforeseen events. But nothing more. So you can see that social transfers are of a very limited character. Broadly speaking it is not a matter of maintaining purchasing power but merely of ensuring a vital minimum for those who, either permanently or temporarily, would not be able to ensure their own existence. It involves only the marginal transfer from a maximum to a minimum; it is absolutely not the establishment of or regulation around an average” (p. 143).

problems associated with a socially dependent Disabled-Person. Such transference of risk was another feature of the approaching neoliberal governmentality.²⁷¹

Booth's (1984) Construction of a Wet-Area-Shower may be distinguished from Goldsmith's (1976) and the NZS4121:1985 showers in that it detailed alterations to an existing bathroom. This is a wet area shower that made use of someone's existing walls, floor joists and hot water supply. The bath was removed, the floor was pulled up to expose the joists, which were then trimmed to accommodate the shower floor (Figure 79):

Figure 79

Booth's Wet Area Shower Floor Detail, 1984



Note. From *Construction of a Wet Area Shower* (p. 8), by G. Booth [illustrations by L. Windsor], 1984, New Zealand Disabilities Information Bureau. Reprinted with permission.

This Wet-Area-Shower was a shower that required the Disabled-Person and their Family to have a bathroom with sufficient space to accommodate the shower; the Pensioner-Flat containing a shower 3" by 3" was insufficient. It was also a shower that required the Disabled-Person and their Family to possess a bathroom that they could secure for the next 5-years, and in which the state could make a partial investment in the accommodation of a wheelchair. It was an economical shower in a space of private property. Entering the sovereign space of the family, in private property that had

²⁷¹ "Social policy will have to be a policy which, instead of transferring one part of income to another part, will use as its instrument the most generalized capitalization possible for all the social classes, the instrument of individual and mutual insurance, and, in short, the instrument of private property... It involves an individualization of social policy and individualization through social policy, instead of collectivization and socialization by and in social policy. In short, it does not involve providing individuals with a social cover for risks, but according everyone a sort of economic space within which they can take on and confront risks" (Foucault, 1979/2008c, p. 144).

previously been beyond the limits of liberal government aroused concerns regarding the risk that removing the bath may devalue the property, or compete with family preference for a bath (Pope, 1982). In addition to the risk of loss of capital, installation of the shower exposed previously hidden aspects of the house, and the risk of anything being found to be substandard and needing repair would come to be passed on to the property owner (Equipment Management Services, 1995). The funding thus creates an economic space in which such risks of accommodating a wheelchair in a shower is devolved to the Disabled-Person, their family, and the property owner.

In the early 1990s, Grants for Housing Alterations underwent significant change as part of broader purchase-provider health system reforms²⁷² in which Part II of the DPCWA was eventually repealed, and State funded alterations to homes became connected to the need to “ration the allocation of assistance” (Shipley, 1995, p. 3). Funding was changed so that Disabled-People who needed modifications over NZ\$20,000 would have to meet their needs “through refinancing or relocation rather than through suspensory loans” (Shipley, 1991). In 1995 funding for housing alterations was shifted from the Department of Social Welfare to the MOH and income and asset testing for grants over NZ\$7900 was introduced (Shipley, 1996). At this time, funding became a grant rather than a loan that abated over 5-years (Palmer & Smith, 2002). The associated change in the “Terms and Conditions” of funding meant that rather than Disabled-People and their families being committed to a 5-year period that would justify the expense involved, they were “not entitled to access another grant for the same or similar modification, unless extenuating circumstances [where there has been a change in the person’s disability] can be demonstrated” (Enable New Zealand, 2001, section C). This meant that “clients do not now have a perceived automatic right to move home every 5 years” (Palmer & Smith, 2002, p. 2) and the interest in the property and those who may care for the Showeree were expected to be permanent.

I examine this problem of the Permanent-Home in depth in my Discussion chapter; however, I will mention here that Foucault (1979/2008a) explained that the freedom to move about is important for the subject of a neoliberal governmentality: “Migration is an investment; the migrant is an investor. He is an entrepreneur of himself who incurs expenses by investing to obtain some kind of improvement” (p. 230). While the Wet-Area shower supplied freedom of movement to Disabled-People within their bathroom, the funding attached the shower to a one-off grant that limited their “right” to move to another home. As such, they were excluded from the opportunity to move, and to gain the benefits of movement as investment in themselves in the competition for capital. While this might appear to be a contradiction in the dominance of a neoliberal

²⁷² See Prince et al. (2006) for an analysis of these reforms.

governmentality in Aotearoa New Zealand during the mid-1990s, Christiaens (2019) explained that although neoliberal regimes may generally see humans as heterogenous human capital (Dilts, 2011), populations may be excluded from neoliberal life through abandonment:

There are cases where neoliberal regimes of practices do not apply entrepreneurial norms on populations... but suspend the application of entrepreneurial norms in order to abandon populations deemed unproductive for further economic growth. In these instances, resistance is less likely and takes the form of an existential absolutization of inexistence. (Christiaens, 2019, p. 111)

While the funding does provide the possibility of Disabled-People being productive, the MOH's investment in the accommodation of Disabled-People is also disconnected from the idea of social and financial Independence. Although public spaces in which people might work and shop are connected to a discourse of Accessibility, Family-Homes have remained outside of the territory of the collective interests of Disabled-People. Individualisation of funding has afforded an economic space within which Disabled-People and their families could take on the risk of modifying their home; however with this funding, the possibility of moving, of further establishing territory in private dwellings, becomes limited. Disability Design within private dwellings remains abnormal and scarce. The modified dwelling thus contains the person and those who might care for them in a Permanent Family-Home.

Summary: Permanent Homes to Reduce the Cost of Dependent Citizens

The DPCWA (1975) established government funding for home alterations to accommodate Disabled-People who relied on a wheelchair, walking aid, or other appliance, and who were not disabled from an injury. The Wet-Area-Shower was designed as a shower for a family member who relied on a wheelchair, and could be installed in the bathroom of an existing Family-Home. It was Accessible and universally usable, allowing body-wheelchair, body-walker, the very young, the Elderly and the able bodied to have the freedom to get in and out of a shower without standing, stepping, or moving from seat to seat, and to shower Independently or with assistance. However, it was a shower that required space; and in a dispositif in which the Little-Old-Lady was moved out of the Family-Home, into small Pensioner Flats, the possibility of continuing to live outside of an institution as a body-wheelchair complex was limited for this population.

While the materiality of the Wet-Area-Shower was attached to a discourse of Accessibility, both within the Family-Home and the community, the Grants for Alterations to Homes attached the dwelling to the individual Disabled-Person and their carer. The alterations were part of dispositif in which state partial funding of private

“beds” for Disabled-People and the Elderly aimed to reduce their reliance on hospital beds and, thus, their depreciation to the physical capital of the nation. The funding was established to accommodate Disabled-People within their Family-Home and relied on a degree of permanence in the Disabled-Person’s material and social capital to maintain the accommodation. Initially investment from the state was every 5-years, but from the mid-1990s (when funding was transferred to the MOH) it was intended to be one off. Thus, the grants afforded those who could not invest in a Made-to-Order shower with an economic space in which they could take on the risk of accommodating a Disabled-Person for a period of time that would justify the expense. While initially this was a limited period of time, changes in the 1990s removed the “automatic right” to move house.

While freedom of movement is seen as essential in the government of homo œconomicus in a neoliberal governmentality, the MOH’s funding for wet-area showers restricts such movement. Private Property has been excluded from the legislation that could have made it Accessible or universally usable to Disabled-People. MOH funded modified showers are thus part of a dispositif in which Disabled-People may be abandoned from the neoliberal project. They are afforded the risk of modifying their Permanent-Family-Home, where they may be maintained at a vital minimum.

Appendix I

Figure 80

Goldsmith's Designing for the Disabled anthropometrics women, age range 18-60, and age 60 plus, 1963

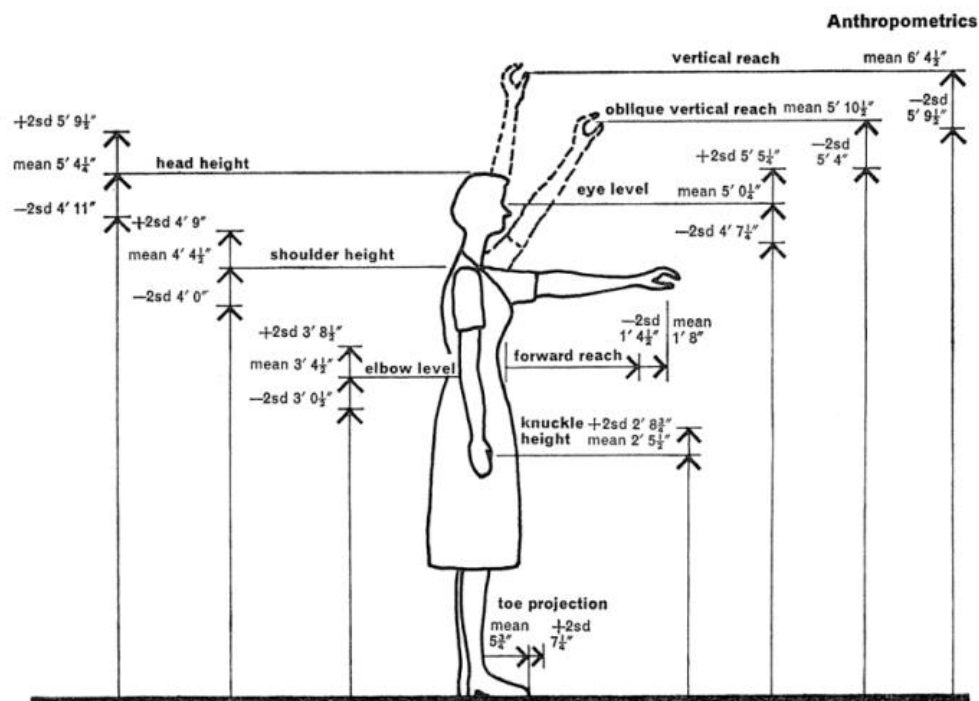


diagram 10.2 Anthropometrics: Ambulant women, age range 18-60

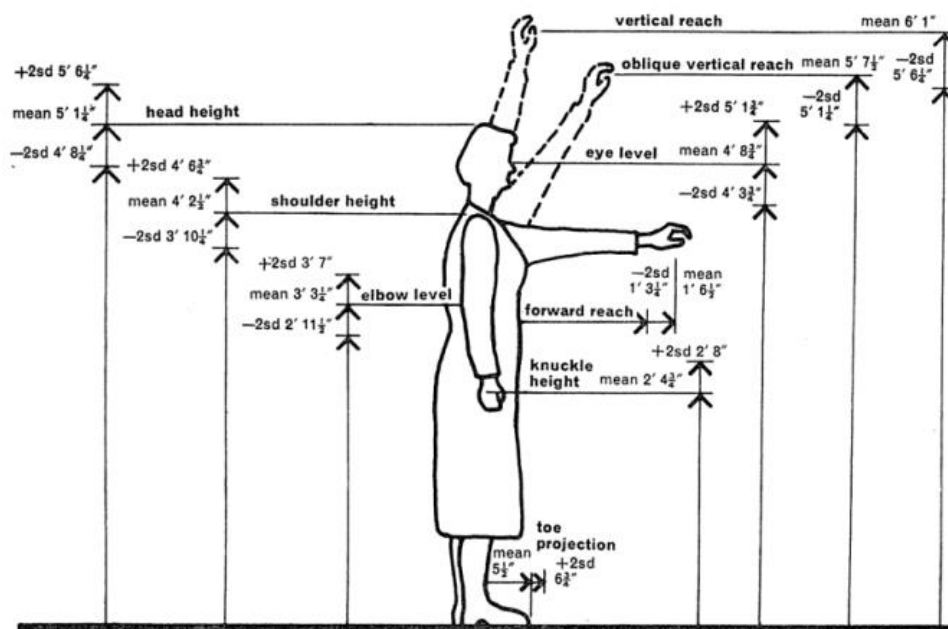


diagram 10.3 Anthropometrics: Ambulant women, age 60 plus

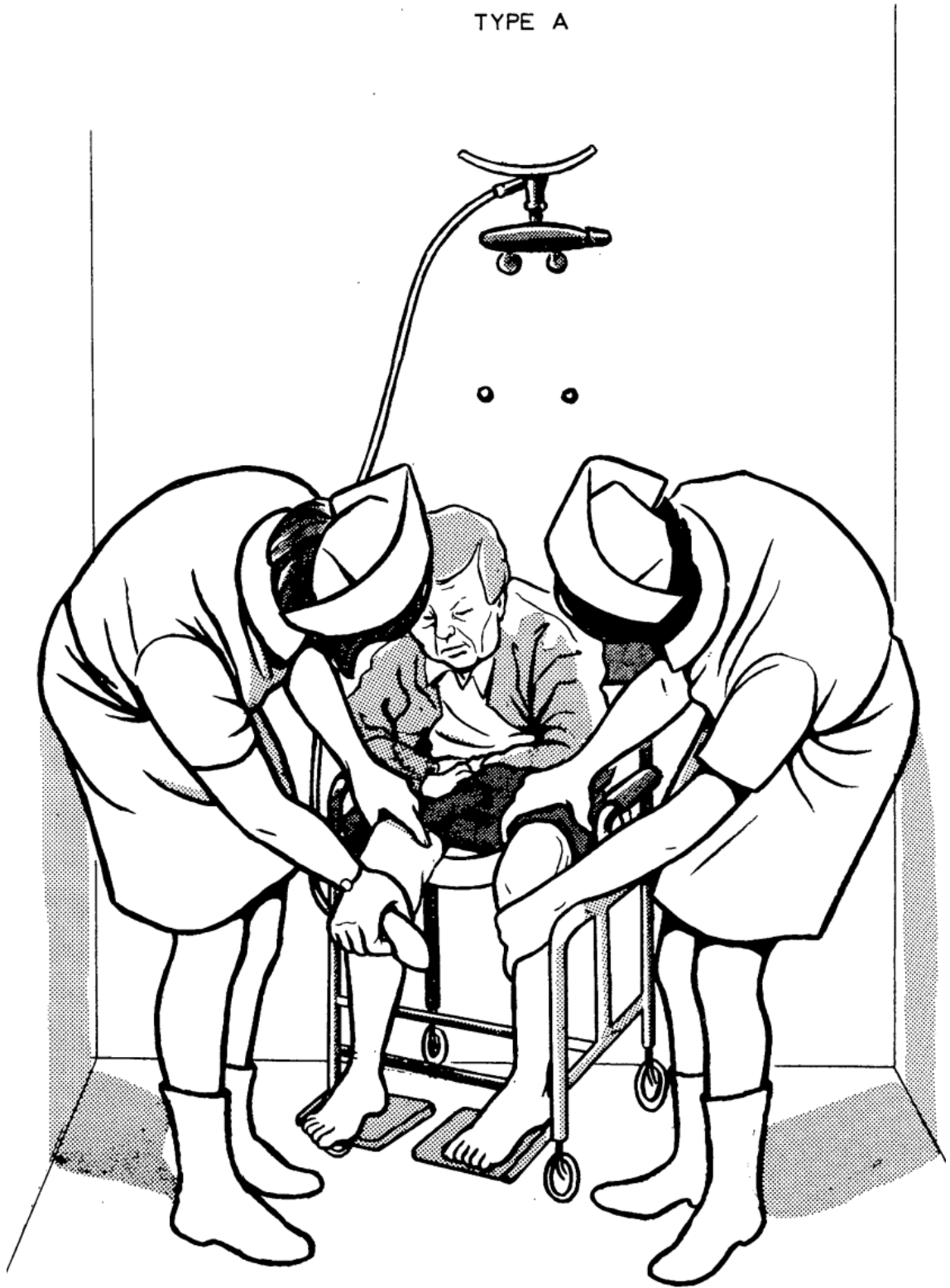
Note: From *Designing for the disabled* (p. 17) by S. Goldsmith, 1963, Royal Institute of British Architects. Orphan work.²⁷³

²⁷³ If you believe that copyright infringement has occurred in any of this content, please contact the author.

Appendix II

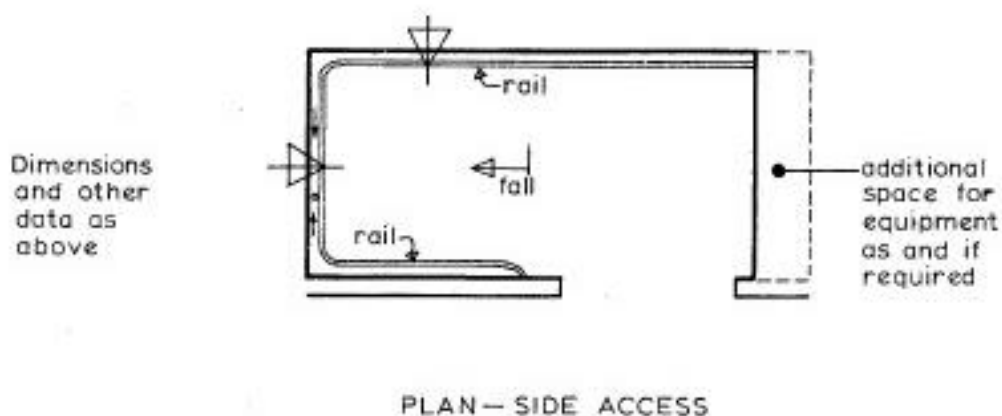
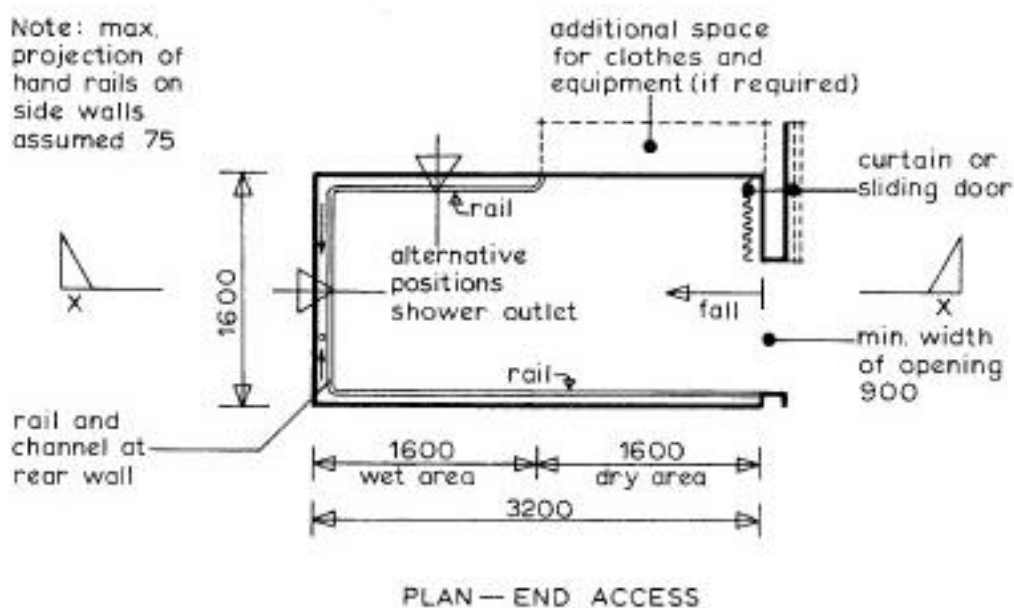
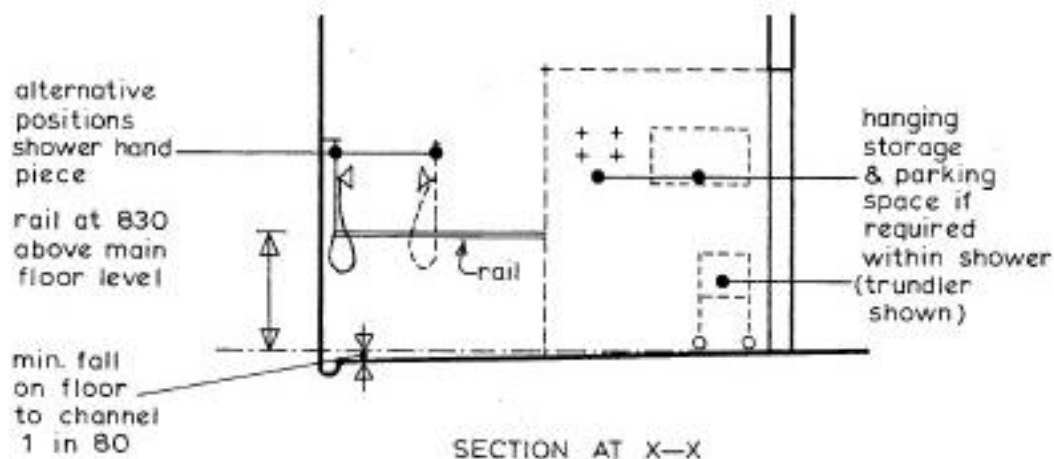
WHEELCHAIR SHOWER

TYPE A



DRAWING NO. 3 · 1

**A mock-up study of
space requirements**



DRAWING NO 6-1

dimensions shown are
recommended minima (millimeters)

SCALE

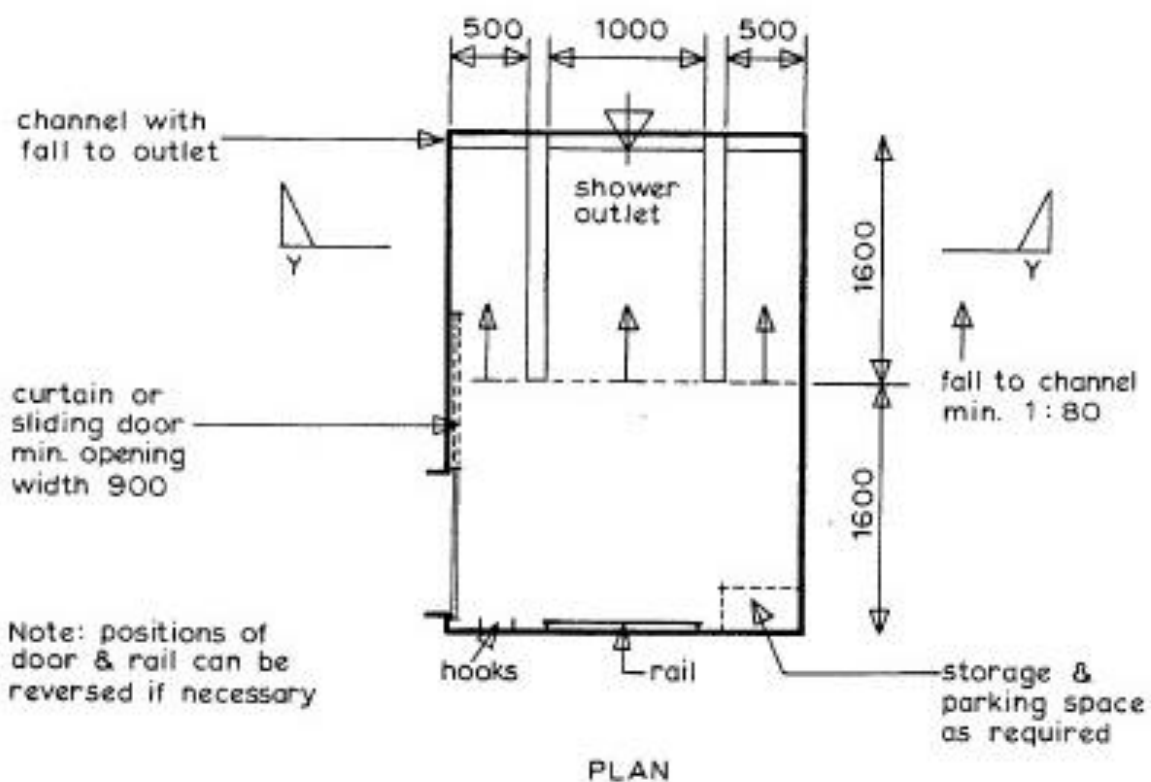
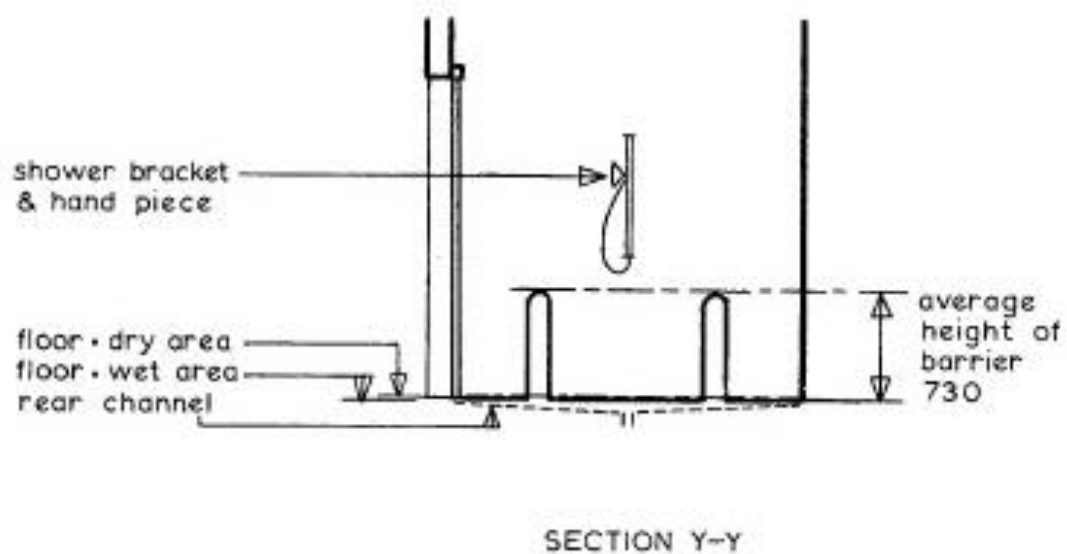
1 : 50

(H.D.E.U., 1974)

Appendix III

DRAWING NO. 3-2

Showing staff working
behind barriers

**DRAWING NO 6.2**

dimensions shown are
recommended minima (millimeters)

SCALE
1 : 50

(H.D.E.U., 1974)

Appendix IV**B. With whom are we concerned?**

1. Non-ambulatory -- those individuals who for all practical purposes are bound to wheelchairs regardless of cause or manifestation.
2. Semi-ambulatory -- those individuals who walk with difficulty or insecurity such as braces and/or crutches, amputees, arthritics, spastics, pulmonary and cardiac, etc.
3. Sight handicapped -- those individuals who are totally blind or those whose sight is impaired to the extent that ambulation in public areas is insecure and hazardous.
4. Incoordinates -- those individuals with incoordinate movements or palsy from cerebral injury, spinal injury, or peripheral nerve injury.
5. Hearing handicapped -- those individuals who are deaf or have a hearing handicap to the extent that they might be insecure in major public areas, industry, etc. regarding warning signals, etc.
6. Aging -- those manifestations of the aging processes that significantly reduce mobility, flexibility, coordination, and perceptiveness but are not accounted for in the afore mentioned groups.

(These are the basic groups with which we must be concerned, each having specific needs or requirements different from the others while at the same time having many common resolves or solutions by specification. Each of these groups includes many disabilities by name, cause, and manifestation.)

(American Standard Association, Ca. 1961)

- (b) *Sensory disabilities.* People with sensory disabilities are those who, as a consequence of blindness, deafness, impaired sight or impaired hearing, may be restricted or inconvenienced in their use of buildings because of the lack of suitable facilities. The categories "sensory disabilities" and "locomotive and manipulative disabilities" are not mutually exclusive. Many disabled people, particularly among the elderly, are included in both categories.
- (c) *Locomotive and manipulative disabilities.* People with locomotive disabilities are those with disabilities which affect mobility, that is, impairment of the trunk, lower limbs, or the trunk and lower limbs. People with manipulative disabilities are those with impaired function in one or both upper limbs, and who as a consequence may be restricted in their use of buildings because of the lack of suitable facilities, for example, conveniently designed and located switches, controls and door handles.
- (d) *The ambulant disabled.* Ambulant disabled people are those who are able, either with or without personal assistance, to walk on the level and negotiate suitable graded steps provided that convenient handrails are available.
- (e) *The wheelchair bound.* The wheelchair bound are those people who are unable to walk, either with or without assistance, and who, except when using mechanized transport depend on a wheelchair for mobility. While being unable to walk, a minority of people in this group are not strictly chairbound, inasmuch as they are able to stand on their feet while transferring to and from a wheelchair.

(New Zealand Standards, 1971, p. 11)

DISABLED PERSONS. Persons with such disabilities as:

The inability to walk
 Walking difficulties
 Reliance on walking aids
 Sight disabilities
 Hearing disabilities
 Lack of co-ordination
 Reaching disabilities
 Manipulation disabilities
 Lack of stamina
 Difficulties in interpreting and reacting to sensory information
 Extremes of physical size

(NZS4121:1985, p. 8)

Appendix V**Figure 81**

NZS4121:1985 Shower cubicle

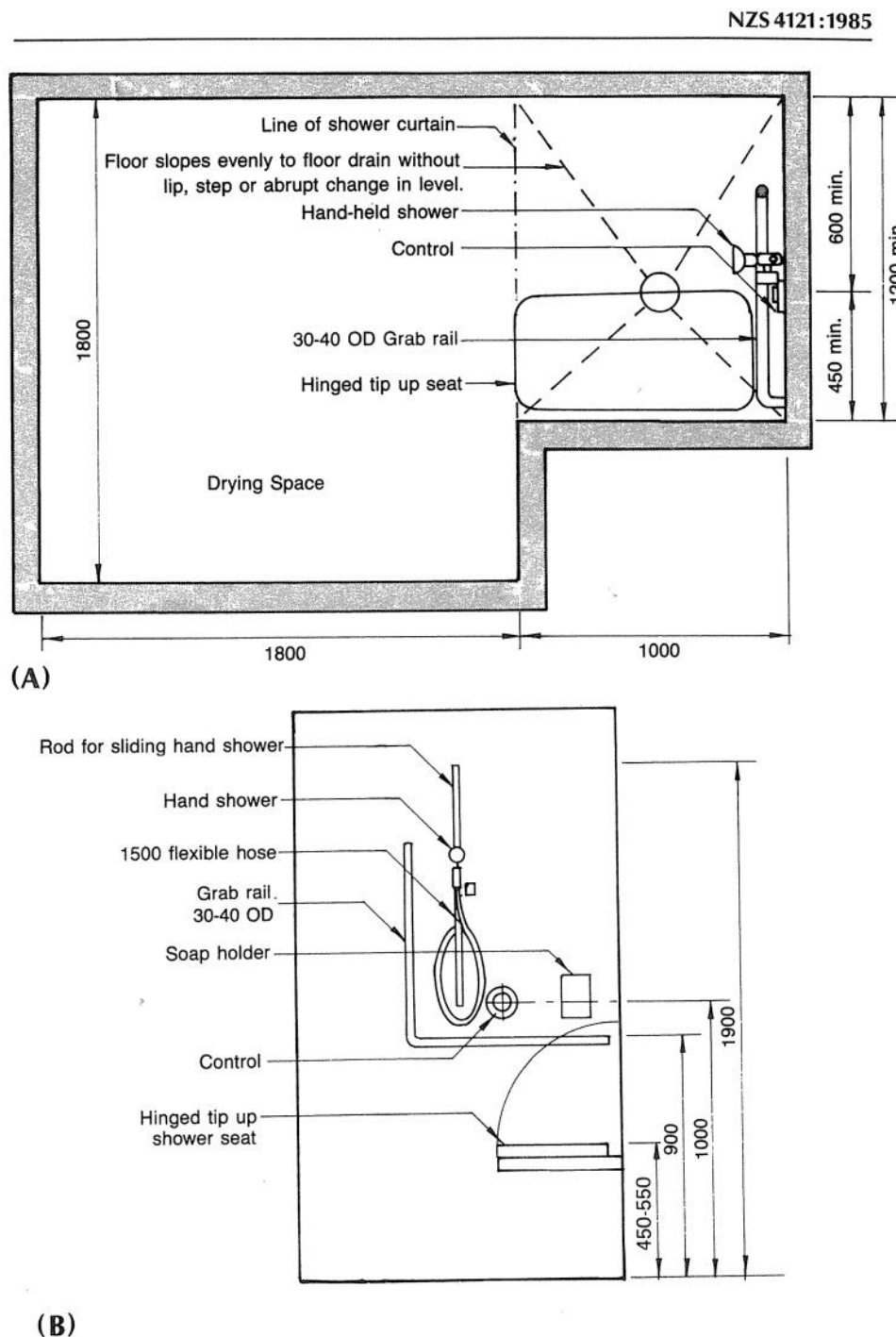


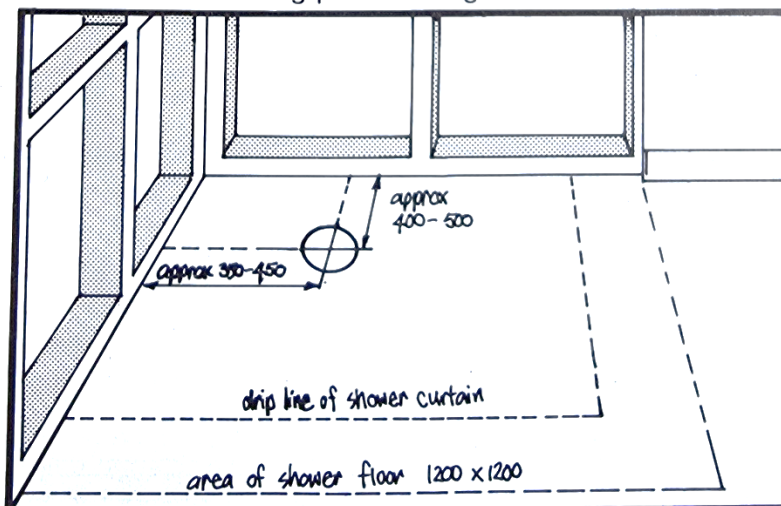
Fig. 20
 SHOWER CUBICLE

Note. From NZS4121 Code of practice for design for access and use of buildings and facilities by disabled persons (p. 25) by Standards Association of New Zealand, 1985. Copyright in NZS 4121:1985 is owned by the Crown and administered by the New Zealand Standards Executive. Reproduced with permission from Standards New Zealand, on behalf of New Zealand Standards Executive, under copyright licence LN001461.

Figure 82*Booth's Wet Area Shower Set Out, 1984*

Setting out the shower

1. The area of the floor to be reconstructed will need to be about 1200 x 1400 mm but can be more, e.g. the full length of the bath that has been removed, (minimum about 1200mm x 1200mm).
2. Shower Controls, Sliding Shower rose etc. will need to be positioned to suit the proposed sitting or standing positions of the users:
About 1000mm from the floor is a convenient height for the controls for a sitting position.
For standing use it is preferable to be able to direct the rose at least partially towards a wall rather than at the shower curtain.
3. Plan to have the curtain at least 200mm inside the perimeter of the sloping area. A curtained area of 1000 x 1200mm is usually convenient; if any larger the curtain cannot be reached from a sitting position. Figure 3.

**FIG 3**

Note. From *Construction of a Wet Area Shower* (p. 5), by G. Booth [illustrations by L. Windsor], 1984, New Zealand Disabilities Information Bureau. Reprinted with permission.

Figure 83

NZS4121:1985 Shower Room

NZS 4121:1985

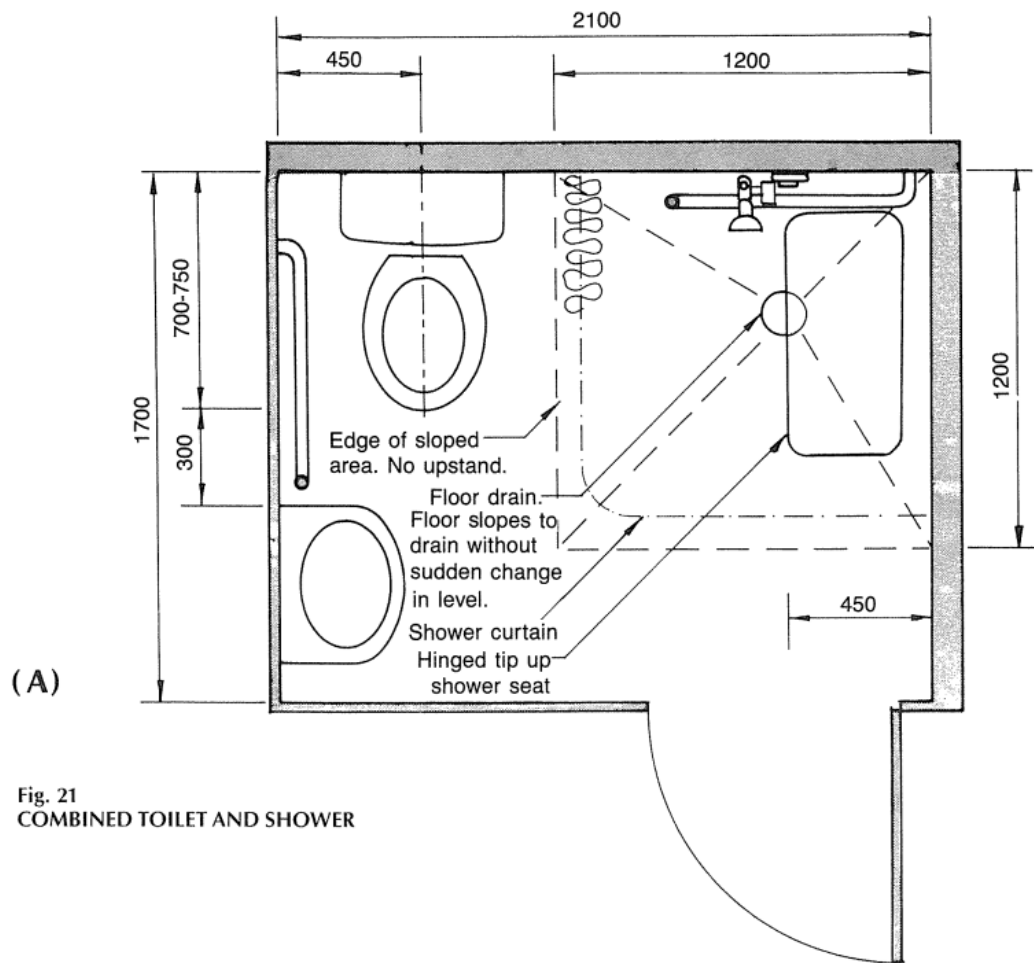
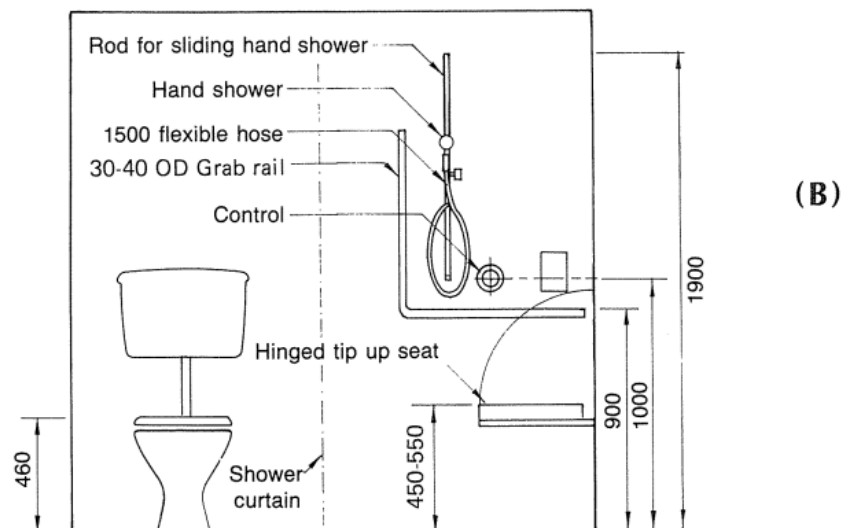


Fig. 21
COMBINED TOILET AND SHOWER



Note. From *NZS4121 Code of practice for design for access and use of buildings and facilities by disabled persons* (p. 25) by Standards Association of New Zealand, 1985. Copyright in NZS 4121:1985 is owned by the Crown and administered by the New Zealand Standards Executive. Reproduced with permission from Standards New Zealand, on behalf of New Zealand Standards Executive, under copyright licence LN001461.

Appendix VI

v. Level access showers

A level access shower is considered in one or more of the following situations:

- the person is unable to safely use the existing bathing or showering facilities and the use of a more cost effective option such as equipment (eg, a tub transfer bench or a bathlifter) does not meet the person's identified disability related needs
- a minor modification (eg, rails or a shower over the bath) will not meet the person's long term disability related needs
- the need for regular and thorough washing every day due to behavioural, continence and skin integrity issues cannot be achieved using the existing facilities or by any other means
- support people including family, whānau and carers are unable to safely carry out their role to assist the person with personal cares
- other options such as the provision of personal care support or alternative bathing arrangements (eg, showering as part of attendance at a regular day programme) are not viable and will not meet the person's identified needs
- the person is likely to remain living in the home for at least two to three years.

The modification may result in a reduction in the person's support package for personal cares or prevent escalation of, or the need to introduce personal cares.



A level access shower is where the shower floor is level with the rest of the bathroom floor. The shower area is generally 1200 mm x 1200 mm and slopes four ways into a floor drain. There is a curtain around the sloped area to contain the water.



Where the modification is high cost or complex, evidence of collaboration with the NASC is required, using the [EMS and NASC joint reporting template](#). This collaboration is to ensure that all support options have been considered and the NASC supports the proposed intervention.

(MOH, 2014a, p. 23-24)

5. Discussion

Studying the genealogy of the shower, modified for use by Disabled-People, reveals a complex history that justified Jay seeking funding for a modified shower and me, as a community occupational therapist, telling her that she did not qualify. In this discussion chapter I draw on the findings of my analysis of the dispositif to discuss how the past has produced the conditions of possibility of our current practices. I discuss the influence of discourses that initially established a connection between Jay and her shower; and then Jay, her shower, and MOH funding for a shower modification. Previous studies have presented the effects of housing access barriers on the recipients of the service. However, there has been no analysis of the contribution to such barriers created by the modification system that, on the surface, one would think should address them. My discussion focuses on the MOH (2014a) Housing Manual to reveal why the current housing modification system is as it is; and, importantly, what the current system does to contribute to a grim picture of housing Disabled-People in Aotearoa New Zealand.

My discussion builds on recent post-structural and critical scholarship that has challenged the individualising discourses associated with occupational therapy and its associated science (Barlott et al., 2017; Farias et al., 2016; Gerlach, et al., 2018; Hocking, 2012; Laliberte Rudman, 2013; Mirza et al., 2016; Monclus & Tarres, 2016). In addition to perpetuating inequality through individualising, occupational therapy has a tradition of working to normalise, employing disciplinary technologies to reconstruct the lives of Disabled-People (Molke, 2011). Calls have been made for researchers “to move beyond (often romanticized) accounts of individual experiences if the discipline is to make any contribution to understanding and responding to the occupational issues of people who experience systematic disadvantages and marginalization” (Hocking, 2012, p. 59). And beyond academia; “Occupational Therapists need to be able to identify socially structured inequalities that constrain equality of occupational opportunity” (Hammell, 2015, p. 450). The following discussion provides a critical analysis of the practice of applying for housing modifications through the MOH to the discursive construction of the shower and its part in biopolitical disablism.

Jay the Showerer

When I met Jay, she was unable to shower independently. Prior to being unable to reach up to turn her shower on and off, she had been a regular Showerer, connected to a long-forgotten history of contagions that had prompted the birth of the hygiene shower. Nearly 150-years prior, now taken-for-granted truths were established regarding health, access to clean water, and washing skins. In Europe, these truths

had transformed the Cold-Water-Shock hydropathic shower into warm hygiene shower cells as an economical way to reduce disease in the confined, collective spaces of army barracks and prisons. Initially designed as a way to wash and surveil the skins of multiple Showerees at once, from their beginnings it was hoped that the power of anatamo-discipline would produce Showerers who would disperse through the population, improving the health and productivity of the nation at large.

As a technology of biopolitical normalisation of the population, the hygiene shower became connected to Public Baths, made possible through the earlier establishment of the Hydraulic City. The Hydraulic City was government at a distance, creating a milieu in which drains and pipes supplied and removed fast-flowing water to and from private dwellings to induce cleanliness and good moral habits (Osborne, 1996). While Public Baths had limited success in terms of producing Showerers, the connection between water, sanitation, and the Properly Plumbed House produced the possibility of comfortable and convenient warm water showering at home. Gerhard's 1908 Rain-Bath-Compartment reduced the bath of the shower-bath down to a tray, creating an economical standalone shower unit that could be attached to bathrooms in private dwellings. By the time Jay's home was built (around 1980), the shower unit with a showerhead mixer was a common place installation and an economical solution for achieving population hygiene in small dwellings, such as Jay's.

Jay was part of a population that considered showering an essential everyday activity to avoid being dirty, unhealthy, smelly, unrefined, and unattractive. One hundred years earlier, such regular washing would have been highly unusual. However, by the time Jay's home was built, it was made for a nation of Showerers. The availability of the shower and pastoral power that connected a failure to wash to rejection from society induced the population to shower. The ideal subject—strong, upright, and displaying health through their complexion, and their acceptability through a lack of B.O.—was a showering subject. Showering had become an investment in one's own human capital, and insurance against exclusion from society. While it remains possible to shower in collective spaces today, such as in sports clubs, the shower unit of the private dwelling was designed for a single, upright adult. It is a private space, where the naked body is hidden from the household and others. In this way, it is part of the government of sexuality, creating a territory in which the naked body belongs to, and may be protected by, the Showerer.

Jay the Showeree

As Jay had aged, her shoulders refused to let her reach her showerhead mixer. As a single older woman (perhaps seen by others as a Little-Old-Lady), she had moved

into a small dwelling and was living on her own. Without family to help her, and now identified by the health system as a Disabled-Person, she had been granted assistance from the state for an attendant to turn the shower on and off. While such assistance allowed Jay to continue to be a Showerer, this arrangement also made her a Showeree. Jay was now a Disabled-Person within the health system structure; identified, categorised, and subject to the practices of that system. Her shower became the workspace of the attendant, a stranger not of Jay's choosing entering into her private space, whose allocated minutes and work schedule dictated when the shower could be turned on and off.

Jay's connection to the health system as a Disabled-Person raised the possibility of government funded housing modifications and led to my visit.²⁷⁴ The idea of Disability-Design, born in the Rehabilitation Facility to produce Independent Physically-Disabled-People, had become a possibility within the private dwellings of such people. A history of compensation for Disabled-Veterans, associated with the idea of reciprocal duty, had connected governments to the provision of private dwellings, or rooms within these dwellings. Modifications were designed to shift those dependent on the architecture of the Rehabilitation Facility, but otherwise eligible to be discharged, out into society. Design that had once been the therapeutic operation of the Disciplining Hospital surfaced like the islands of an archipelago in the few private dwellings of those who could lift themselves around and take care of themselves.²⁷⁵ Once set free of the hospital, further islands of Disability-Design surfaced, initially in the University of Illinois, to connect paraplegic-veterans to the disciplinary society. From the University of Illinois, a discourse of Accessibility emerged that attempted to tie the interests of Disabled-People (originally Physically-Disabled-People) to that of the collective,

²⁷⁴ In 2015, the MOH Disability Support Services website advised people to "contact a Ministry of Health Equipment and Modification Service (EMS) qualified housing assessor to help you work out what modifications are the most cost-effective option for your disability needs and if we might help fund these modifications. If you are eligible for Ministry of Health funding, the EMS assessor will help you request the funding" (MOH, 2022). In 2022 the services were shifted to the Ministry of Disabled People who state "Your home should be safe and comfortable. Find out how to get support with general housing costs, modifications, help around the home and door to door transport services" (Whaikaha – Ministry of Disabled People, 2022b). They maintain the need to connect with an EMS assessor. "An Equipment and Modification Service (EMS) qualified housing assessor can work with you on what modifications best suit your needs. They will also help you work out the most cost-effective option and if you can get funding" (Whaikaha – Ministry of Disabled People, 2022a, Getting Home Modifications Section, para. 1). This page also has information on "Level Access" or "Wet-Area showers" for Disabled-People to help decide "Is a level access shower the best option for you?" (Whaikaha - Ministry of Disabled People, 2022c).

²⁷⁵ I must acknowledge an article titled "The Rotoroa Island and Auckland Zoo partnership: Connecting heterotopic spaces" (Kearns et al., 2016) that describes the two connected but distanced spaces of an island reserve and the Auckland Zoo as archipelago. Kearns is a Waiheke Island academic who has worked with the Waiheke Health Trust, which employs me as a community occupational therapist, and is how I became familiar with this work.

resulting in legislation and standards associated with public spaces (such as the NZS4121). However, in Aotearoa New Zealand, liberal and then neoliberal government of private property resisted the idea of the private property market being a territory that included Disabled-People as a Right. While it was possible for Jay's home, built in the 1980s, to have been designed to be Accessible to a Disabled-Person, or even Universally Usable, it was not. Rather than the shower (or indeed any of her home) being built with consideration given to those who could not step up, stand, or reach, it was a shower for the strong and upright.

Though a discourse of Accessibility was limited to public spaces, the connection between Family-Homes and housewives, and a preponderance of women amongst the elderly, meant that standardised Disability-Designs (i.e., not those made-to-order) for private dwellings were in circulation. While Jay's inability to reach up to the showerhead mixer was not the result of an injury, accident compensation legislation history first connected state funding to adapting, or assisting with adapting, private dwellings in Aotearoa New Zealand. Such adaptations were for the continuation of injury rehabilitation to all of the population disabled by injury. The idea of comprehensive state accident insurance extended the idea of reciprocal duty and the reach of Rehabilitation beyond Disabled-Veterans, and past those who could sue a liable party for the loss of human and material capital associated with their injuries. It came to include the young, the Elderly, and Housewives. Injury sustained at home, and the cost to the worker of having an Injured Housewife, became connected to the interests of the nation, and the ACC became involved with the provision of housing designed or altered for all people disabled by injury. Such houses could be inhabited by Disabled-Housewives, (even if they were not entirely designed for their use), or perhaps families with Disabled-Children, or Disabled-Elderly. Although this discourse did not connect directly to Jay's want or need for a modified shower, it did make the idea of government funding for modified showers in private dwellings for any Disabled-Person a thinkable thing.

Had her housing modifications been covered by ACC, I would not have met Jay and she would not have been subject to the Critical Questions Checklist, or the requirements outlined in the MOH's (2014a) Housing Modification Manual (the "Manual"). However, at the time I visited, people not disabled by injury remained (and remain at the time of writing) excluded from the idea of reciprocal duty. Such people were reliant on the provisions established by the DPCWA (1975) and maintained by the MOH. Forty years before I visited Jay, the original Disabled Person's Community Welfare Bill (1975) had only included provision for housing alterations to accommodate a wheelchair, walking frame, or other appliance. Jay's need for a shower modification

was not associated with the need to accommodate her as a body-object complex. If the provisions had not been extended by the idea of alterations promoting Independence (initially argued as necessary to enable a Housewife to continue with her work, thus avoiding the need to employ help), she would have been ineligible from the start. Such ideas can be traced back to the discourses that produced the Accident Compensation Act 1972 and the 1973 amendment.

While Jay was a Showeree when I met her, MOH housing modifications could make it possible for her to once again be a Showerer. As discussed in the prologue, funding was initially declined. While Jay's story ended up with her shower being modified, the grim picture of housing for Disabled-People in Aotearoa New Zealand would suggest that the current system in which "demand for services regularly exceeds the annual allocated budget" (MOH, 2014a, p. 7) meaning that many Disabled-People with a need are being excluded. In the following part of the discussion, I discuss the Housing Modification Manual (MOH, 2014a) and the Critical Questions Checklist (Enable New Zealand, 2010) that are used to determine who will, and who will not, be funded. I connect the discourses employed in these present-day documents to the findings of my study, revealing the historical truths that make these exclusions possible.

Disable-People's Private Dwellings Enter a Grid of Specification

While Jay's new status as a Disabled-Person may have made her eligible for a modified shower, the Critical Questions Checklist (Appendix A) required that as the EMS assessor, I attend to questions regarding "the person's home environment" (p. 1). The house enters into a "grid of specification" (Foucault, 1969/2002, p. 46) in which I, the EMS authority, must identify areas that had "No Issues", "Not Sure", or "Issues". As part of the assessment process, the Housing Modification Manual (the "Manual") stipulates that the assessor must consider alternatives such as human supports and equipment solutions. They must evaluate the person's essential need and ability to benefit from the modifications, the costs and benefits of the modifications and:

- the physical features of the home and surroundings, the suitability of the property to meet the person's disability related needs in the long term and the feasibility of any proposed modifications

(MOH, 2014a, p. 9)

As such, the Critical Questions Checklist that I completed with Jay led us to identify an additional feature of the surroundings of the home (the stepped path) which was failing to meet Jay's "disability related needs".

5. Discussion

While the DPCWA (1975) had provided suspensory loans, housing modifications under the MOH were designed to prevent the perception of a right to move, or to be able to apply for further funds every 5-years. As a partial investment in a permanent home, it was important to identify features of the home that, from a “long term” perspective, were starting to cause problems. Jay did not need assistance to get up and down her path; however, it had become difficult and could be thought of as becoming more difficult as her osteoarthritis continued to progress. Although it was not apparent to me at the time, the reviewers of the application identified an issue in this section of the Critical Questions Checklist, in which EMS assessors are asked to attend to the condition of the house:

14. Are there any issues with sufficient space for the number of people living in the home? Such as several people living in a 2 bedroom property which is a social rather than a disability related need.			
15. Are there paths or steps which are unformed, broken or steep which would be unsafe to walk on even if the person did not have a disability?			
16. Does the home have generally accepted building standards? <i>No issues means that the home is fit for habitation, and/ or has standard services, such as water, power, plumbing, sanitation, drainage services and that there are no known significant home maintenance (rectification) issues relating to the modification.</i>			

(Enable New Zealand, 2010, p. 4)

In this section of the checklist the assessor is asked to report on the condition of the house, overcrowding, a failure to maintain the home, or other conditions that could make it unfit for habitation. A history of governing contagions by identifying homes where people “are detrimentally affected by existing housing conditions” (Housing Survey Act 1935 3 [1c]), and the power of the state to demand that dwellings meet specified standards and are maintained to such in the name of population health, empowers the assessor to investigate and report on the condition of the house. The problems associated with the unfit dwelling are identified as not being “a disability related need” and, as such, can create issues with a housing modification application. For Jay, a failure to maintain the amount of gravel in her stepped path, or at least for the gravel to be pushed up against the wooden uprights, produced steps “which would be unsafe to walk on even in the person did not have a disability”, thereby excluding her from modification funding.

Modifications Which are Not Funded

The Manual includes a section outlining “HOUSING MODIFICATIONS WHICH ARE NOT FUNDED” (p. 38). This includes circumstances where:

it is not considered cost effective to proceed because alternative support options or relocation to a more suitable home would be more appropriate

the long term sustainability of the person remaining living in their home for at least 2-3 years cannot be supported

rectification work is required to allow the housing modifications to be undertaken or completed. Rectification or remedial work is the responsibility of the property owner and must be completed before funding can be made available



For example, replacement of rotten or water damaged floorboards, upgrading of plumbing facilities to accommodate installation of a tempering valve

(MOH, 2014a, p. 38)

In addition, exclusions include where “a property does not meet Building Code or does not have a permit (where a building consent is required to complete the modifications)” (MOH, 2014a, p. 39). While the rest of the population are permitted to live in dwellings that are not continually brought up to building standards (that are in a constant state of change), this criterion can be used to produce the idea of stairs that “are dangerous for anyone”.

Substandard Dwellings

Failing to maintain a dwelling emerges from the historical government of contagions and the prevention of injury and is thus not “a disability related need”. Luckily for Jay, the Manual does include the possibility of “rectification or remedial work” being done by the property owner before funding can be made available. Although the initial decision had not included this possibility, the review allowed Jay to rectify the problem of the stairs by adding more gravel, thus allowing the modifications to be funded. However, there are connections between Disabled-People and sub-standard dwellings that make this point of exclusion particularly problematic. Prior to becoming a Disabled-Person, Jay had been able to participate in the disciplinary society and then in the market society, using her human capital to acquire material capital. As such, Jay owned her home which had generally been maintained and the danger of the cost of rectification was fairly small. Being the homeowner also provided Jay and the Ministry assurance that she was likely to remain living in her home for the next 2-3 years. This was her permanent home in which she could be “expected to enjoy the benefit of the alterations to the home for a period sufficient to justify the amount of expenditure involved” (DPCWA, 1975, p. 935). Many Disabled People do not have such human and material capital.

Substandard Rentals

While Eugenics had separated a population of Disabled-People from society, a Rehabilitation discourse aimed to produce Independent Disabled-People who could invest in a Made-to-Order house. The idea of Disabled-People acquiring capital and being able to compete in Accessible public spaces creates the possibility of Disabled-People competing in the property market. This idea maintains neoliberal government of private property and produces the rationale that Disabled-People have the freedom to choose to live in a dwelling with the comforts and conveniences that they might require. While Jay had only recently become a Disabled-Person, studies have found that Disabled-People in Aotearoa New Zealand are most likely to live in rental properties or social housing:

Māori, Pacific, disabled and low-income people have lower rates of home ownership. Owner-occupied houses are generally less crowded, newer, higher quality and better maintained, so Māori, Pacific, disabled and low-income people are more likely to be exposed to poorer quality rental housing and suffer potentially avoidable housing-related hospitalisations. (Howden-Chapman et al., 2021, p. 18)

According to the Donald Beasley Institute (2020), these poorer quality rental houses are more likely to be poorly maintained by property owners who are unresponsive to requests for improvements, producing homes that Disabled-People feel are a risk to their health and safety. These issues can then produce exclusion from housing modification funding.

In addition to the problem of rental housing being in disrepair, there is the obvious conflict between living in rental housing and being assured of the “long-term sustainability” of the person remaining living in the home for 2-3 years. While “forced eviction” (MOH, 2014a, p. 30) is considered one of “genuine and exceptional circumstances for repeat funding” (provided the eviction was not due to “wilful neglect or damage” p. 30), the Manual stipulates that the Disabled-Person should move to a house that “is already suitable or requires only minimal modifications” (p. 28), otherwise repeat funding will not be provided:

7.2. Moving to another home

When choosing to move to another home the person and their family or whānau should, as far as practical and reasonable, choose a house that is already suitable or requires only minimal modifications to meet the person's disability related needs.

Consideration should be given to the likelihood of the person's needs changing in the future.

The Ministry will not consider funding towards modifications to a newly purchased or rented home where the person has knowingly chosen a property unsuited to their disability related needs.

(MOH, 2014a, p. 28)

Given the findings from the Donald Beasley Institute (2020) that Disabled-People face significant challenges when attempting to find adequate housing, and that “the disparity between the need for adequate housing and its availability is cause for concern and urgent action” (p. 22), Disabled-People are unlikely to be able to move to a dwelling that is already suitable or requires minimal modification. Thus, even those who are forced to move risk being excluded if they are only able to find a dwelling that is “unsuited” to their disability related needs. As such, Disabled-People living in rental properties continue to live in dwellings that do not make it possible for them to do essential daily activities, and which may “serve as a veritable prison” (Gutman & Gutman, 1968, p. 3).²⁷⁶

Moving Home

While repeat funding for housing modifications is permitted for certain circumstances where the Disabled-Person might move house,²⁷⁷ within the MOH housing modification system, moving home is otherwise identified as “Circumstances not covered for repeat funding”:

²⁷⁶ “The refusal of reasonable accommodation appears to be an issue for, in particular, persons living in homes rented on the private market. For example, one resident who used a wheelchair said that for several years he had lived in a private rental that had stairs to the entrance. Another resident told the Special Rapporteur that she had to shower at work because she could not access the bathroom in her house” (Farha, 2021, pp. 16-17).

²⁷⁷ For example, divorce resulting in the Family-Home being sold, blended families, domestic violence, natural disaster, company redeployment or redundancy, death of a main carer, young adults leaving home for the first time, and moving closer to care (such as an elderly parent moving to live with family) (MOH, 2014a, pp. 29-30).

5. Discussion

7.4.2. Circumstances not covered for repeat funding

Funding for repeat modifications is generally not considered when a person has moved home for reasons including, but not limited to a move:

- due to personal preference
- for social reasons
- to a smaller home requiring less maintenance or for downsizing purposes
- due to forced eviction from a private rental property where they have been evicted due to willful neglect or damage to a rental property
- to a home that is not suitable to meet their disability related needs.



A move due to personal preference includes moving to a bigger home to accommodate the number of people living in the home.



Funding is not available for access modifications to a new home where the person has purchased a multi-level property with the knowledge that they have a progressive mobility impairment.

(MOH, 2014a, p. 30)

The ideal of partial investment in what should be a permanent home, places populations at risk for exclusion. Studies have found that people in low socioeconomic areas living in rentals move frequently (Howden-Chapman et al., 2021) creating barriers to funding for housing modifications. Overcrowding in Aotearoa New Zealand is an increasing problem, with Māori and Pasifika people, women, people living in poor quality housing, and those on lower incomes more likely to live in overcrowded conditions (Stats NZ, 2018). Not only does this become an issue on the Critical Questions Checklist potentially preventing modifications, Disabled-People living in crowded conditions are potentially ineligible for further modifications if they move as a “personal preference” to address the issue!

Another population that is excluded through moving, is the Little-Old-Lady. Disability and aging are linked, with the proportion of Disabled-People (people “living with activity limitations or functional difficulties that affect everyday life” [Stats NZ, 2020, p. 6) exceeding non-disabled from around the age of 55 years (Stats NZ, 2020). The practice of identifying Elderly who fail to maintain their dwellings and then being moved to smaller dwellings can exclude them from repeat funding. Discourse connects a failure by the Elderly to maintain the Family-Home to being categorised for removal from their home to Pensioner-Flats, or Large-Permanent-Homes (i.e., “relocation to a more suitable home”). As with those in rental properties, the risk of their home not having “long-term sustainability” can put the Elderly at risk of exclusion. While Jay would have been considered Elderly at the time of the assessment, the minimal amount of personal assistance she was receiving meant that she was not yet close to

being categorised for institutionalisation.²⁷⁸ As such, she was not excluded as a risk to long-term-sustainability.

As with those moving due to overcrowding, moving to “downsize” is excluded from funding. Even living in a dwelling designed for the Elderly to “downsize” to, excludes them from (or will “not generally provided for”) funding for “housing which are purpose built for an intended age group or need” (MOH, 2014a, p. 39). This includes pensioner flats, and “properties where the person has a ‘licence to occupy’” (MOH, 2014a, p. 39), which includes retirement villages.

Towards the completion of writing this thesis, I learned that Jay had moved to a rest home. While the modified shower had continued to serve its purpose, over five years later the stepped path became increasingly difficult. It may have been possible to bring the driveway up to the level of the house to enable access; however, driveways are excluded from funding (MOH, 2014a, p. 30). Other possibilities, such as lifts, would have likely crossed the funding maximum threshold which would have had the cost of the rail that was previously installed deducted from the total (MOH, 2014a). With accessible, low-cost housing on Waiheke near non-existent, Jay had to leave the island, her community, and the life she had created there. While modifying her shower had granted her some more time to live her life in her community (for a length of time to justify the expense!), as she became more disabled the problem of housing Disabled-People led her to a Large-Permanent-Home outside of the environment she had occupied for many years. In Aotearoa New Zealand, moving into a Large-Permanent-Home also involves the person and the home being assessed, but now the home becomes a capital asset that the State can use to pay to cover the accommodation costs for people over the age of 50 in a hospital or rest home (Work and Income, 2022). These Large-Permanent-Homes are mostly commercial interests (New Zealand Care Aged Association, 2020), subsidised by the state, shifting the responsibility for the accommodation of the elderly to the market. Jay’s house was sold, returned to the property market, and no longer governed by the MOH. The material capital she had accumulated passed on to the commercial-industry that now owns Large-Permanent-Homes.

In this final part of my discussion regarding my findings, I conclude by revealing the danger of the current system of housing modifications to the lives of Disabled-People.

²⁷⁸ “Every person who wishes to receive disability support services funded by a DHB must be needs assessed by the NASC. The information from the assessment is then used to determine the level of need the person has – very low, low, medium, high or very high. The criteria for residential care entry is that the person has been assessed as having high or very high needs which are indefinite and cannot be safely met with a package of care in the community” (MOH, 2016, para. 2).

The Freedom to Move About and Exclusion from Neoliberal Life

While the DPCWA (1975) and its provision for housing alterations have been repealed, the idea of a partial investment in accommodation of Disabled-People in permanent private homes remains. As noted in my introduction: The purpose of this study is to interrogate the history that connected New Zealand's government to the funding of modified showers in the homes of disabled people, and that established the "consistent, principled and equitable approach" that could determine those who would miss out. Using a genealogical methodology, I have argued that rather than housing modifications for Disabled-People promoting the quest for life, the Manual is part of the discourse that encourages exclusion from community life. The "consistent, principled and equitable approach" aims to attach funding to people and dwellings that the nation can gain the most benefit from. While the Manual claims:

The purpose of Ministry funded Equipment and Modification Services is to:

- support people with disabilities and their families, to live as independently and safely as possible
- make a significant, consistent and reasonable contribution to enabling people with disabilities to participate (if and when they want to) in activities inside and outside their home, and in their local communities.

(MOH, 2014a, p. 7)

I argue that the current system maintains the exclusion of Disabled-People from community life, attaching the problem of Accessibility issues to individuals and their dwellings. This 'solution' limits their participation in society and masks the continuation of biopolitical disablism towards Disabled-People.

In a dispositif in which individuals of unsound physical and mental health are calculated as a depreciation of the nation's capital, various strategic responses have emerged to reduce the cost of their existence. In the first half of the 1900s, the idea of human capital being maximised through the expansion of disciplining practices highlighted the problem of those with bodies or wills who would not be normalised. Eugenics connected the problem of unproductive Disabled-People to their genetic inheritance and sought to remove the bodies of such subjects and the genetics they contained from circulation within the population as soon as possible. In Aotearoa New Zealand this involved removing them from their Family-Homes either for specialised training or interning them in Large-Permanent-Homes. Rehabilitation sought to discipline the bodies and wills of Disabled-People, connecting them temporarily to

disciplining spaces in which their Independence could be established. Within these heterotopias, the walls, floors, and ramps acted as therapeutic operators to remove dependence on human assistance. The Independence of Disabled-People thus became connected to architecture designed for their use.

While a discourse of Accessibility in public spaces aimed to extend the therapeutic operations of the Rehabilitation Facility into the disciplinary society, Disability Design within private dwellings was connected to the individuals who lived or would live in them. Like a prosthetic, the problem of inaccessible dwellings become attached to the person. Accessible dwellings become islands, heterotopia that sit outside of the state's interest in the government of buildings for "building users" (Building Act, 2004).

Practices of Exclusion

In the housing modification process, the EMS assessor evaluates if both the dwelling and the person are worthy recipients, and whether the benefit is sufficient to justify the expense involved. Those seeking modifications must live in dwellings that achieve building standards that the rest of the population are not required to meet (i.e., older dwellings being required to meet current building code or "several people living in a 2 bedroom property" [Enable New Zealand, 2010, p. 4]). A failure to maintain the level of gravel in a stepped path can come to be deemed "dangerous for anyone" and justification for exclusion from modifications that would permit one to remain a Showerer.

In contrast to the MOH's stated purpose, which is to make a significant, consistent, and reasonable contribution to the possibility for Disabled-People to participate in their homes and their community, the Manual and associated Critical Questions Checklist empower the EMS Assessor to identify and exclude those who are a risk to the State's partial investment in accommodating Disabled-People. The very problems associated with housing and Disabled-People thus result in Disabled-People being excluded:

Housing accessibility, affordability, security and quality in New Zealand is a significant social issue that is integrally connected to poverty. Unhealthy homes, is one of the most significant social determinants of poor social and health outcomes; this issue is heightened for disabled people. (Barnett, 2015, p. 27)

McDermot Miller (2005) reported that de-institutionalisation has resulted in 25-30% of people with chronic psychiatric conditions living in substandard housing, that Māori and Pacific peoples are more likely to live in crowded and substandard dwellings, and that discrimination against Disabled-People pushes them into locations with substandard housing. Disabled-People in rental properties, people who are aging, impoverished

people, those who live in “overcrowded” situations, those with poorly maintained dwellings, dwellings that are too big or too small or otherwise unsuitable are at risk of missing out of the modifications they need. Within such spaces Disabled-People report feeling unsafe and isolated (Donald Beasley Institute, 2020).

For those who do receive funding, the history of the state’s partial investment in the accommodation of Disabled-People produces a new type of permanent home. MOH funded modifications bind people to their home, limiting the possibility for movement that is needed for investment in their human and material capital in a neoliberal market society. As noted in my final findings Essay 8, according to Foucault (1979/2008a), opportunities to pursue health and education, and the ability to move around need to be available to the neoliberal enterprising individual to acquire capital; he states:

Migration is an investment; the migrant is an investor. He is an entrepreneur of himself who incurs expenses by investing to obtain some kind of improvement. The mobility of a population and its ability to make choices of mobility as investment choices for improving income enable the phenomena of migration to be brought back into economic analysis, not as pure and simple effects of economic mechanisms which extend beyond individuals and which, as it were, bind them to an immense machine which they do not control, but as behavior in terms individual enterprise, of enterprise of oneself with investments and incomes. (p. 230)²⁷⁹

In Aotearoa New Zealand, housing has been seen “as an asset for wealth accumulation and growth over the last decades” (Farha, 2021, p. 9). Associated with this property market society, Aotearoa New Zealander’s are typically mobile and rarely stay in one dwelling for long periods (Howden Chapman et al., 2021). The funding works to limit the possibility of moving for Disabled-People, excluding them from neoliberal life.

Biopolitical Disablism to “Let Die”

As noted in my methodology, biopolitics may function to smooth the harsh effects of neoliberalism to maintain neoliberal life (Mavelli, 2017). Disabled-People are excluded from entrepreneurial norms, abandoned by the regime that produces neoliberal life (Christiaens, 2019). A biopolitical governmentality means the State is involved in funding modifications, somewhat creating a milieu in which Disabled-People can live in private dwellings and do the essential everyday activities that other members of society do. However, both the practice of provision of housing modifications, and excluding from housing modifications, connect Disabled-People to

²⁷⁹ Foucault is referring to migration in his discussion of mobility; however, the freedom to mobilise within the property market is also necessary to the functions of a neoliberal governmentality.

permanent homes (either small or large). It is this connection that I propose is dangerous—and not only because it excludes mobility in the property market.

The current system attaches the problem of architecture that discriminates to the people that are discriminated against, requiring that they and their dwelling be identified by the State, evaluated and entered into a calculation of costs and benefits. The risks associated with these costs and benefits are also passed on to the Disabled-Person, and include the possibility of the Disabled-Person being required to pay for part of the modifications (even in a rental property [MOH, 2014a]), and compromising safety:

For example, one participant reported that under the MoH funding model, they only had access to one housing modification in their lifetime. As a tenant they moved around, meaning they had to choose where to use this entitlement, and when to compromise their safety within the home by choosing not to have a rail installed. Other Interviewees referred to a fear of having one issue addressed but knowing that it meant they would probably have something else taken away from them: “I think everywhere else is pretty um hard to get a house these days. Um, I mean most of it is just the cost. Cost is building houses for our needs and that, eh. Really down to it, just like if you need something done, you gotta take something away. And that thing is what do you have to take away?” (Donald Beasley Institute, 2020, p. 89)

For all of those connected to MOH Housing modifications, the freedom to move, have choice and control over where one lives, and remain outside of the gaze of the state are all things that are taken away by the current system. My study reveals that the current system for modifying showers and the houses that contain them does not address the problem of housing for Disabled-People. Instead, the system contributes to hiding the problem: The existence of funding masks the problems associated with housing for Disabled-People, hiding the discrimination embedded in New Zealand’s government of housing. For example, in response to Disabled-People arguing for their needs being included in the recent Building Act reforms (see Appendix D), rather than supporting the call for reform, the Minister for the Ministry for Disability Issues stated that:

She had been advised that some disabled people may be able to access housing modification funding through the Ministry of Health or ACC. “This assistance provides funding for people with serious disabilities to enable them to have essential alterations made to their home to meet their specific needs”. (Sepuloni, cited in Bhatia, 2021)

Aotearoa New Zealand is caught up in a particular architectural regime that creates additional costs for accommodating Disabled-People in society. This thesis shows that despite the idea of Disability-Designs revealing the discrimination against Disabled-People of established objects and architecture, the need for modification is attached to Disabled-People themselves. While most of us will become Disabled-People from our late 50s onwards, biopolitical disablism continues to construct

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Disabled-People as the 'others' whose interests compete with the population. I repeat a quote from my Building Act Reform for Building Users (Appendix D), which relates to a proposed "Homeless Persons" bill that was tabled under the same government that removed the suspensory loan and the perceived automatic right to move:

A further complication of interpretation in the Bill is on the position of disabled people. In recent years there has been a lot of talk about all disabled people moving into the community as of right. In some cases that has been found not to be in their best interests. It has also been found to be enormously expensive and there can be duplication, not only of housing, but also of medical care and other care that those people need. As a result of that fairly recent experience, it is clear that the Bill would not address that kind of problem. In fact, what is worse, it could open up a whole area of litigation in which disabled people, or those people who represent them, could argue about what is appropriate or inadequate. That could reflect on what is the appropriate degree of medical assistance and a variety of social matters that cannot be appropriately determined by a court in any event. It is really for the medical people to make a decision that is in the best interests of the disabled people (Hancock, 1991, p. 680).

Despite Eugenics going out of fashion, Hancock's statement shows that little has changed since Triggs et al. (1925) and Pomare (1923) advocated for the removal of Disabled-People from community life. It remains in the interests of the individual and the community for Disabled-People to be excluded from society. Disability continues to be seen as a medical problem, attached to the Disabled-Person, and best governed by medical people. As controversial as Hancock's statement may seem, there was no rebuttal to it. Indeed, the legislation that tried to establish housing as a right for all members of the population was rejected.

In times where there is an annual budget that goes at least some way towards meeting these costs, it is easy to take for granted that the biopolitical function to "make live" will continue to maintain Disabled-People in society. However, so long as the dispositif attaches the problem of architecture that discriminates against Disabled-People to Disabled-People, so long as Disabled-People are required to become the subjects of a government department that attaches the problem of inaccessible housing to them individually, and while medical authority (including the occupational therapist EMS assessor) maintain the power assess, evaluate, and classify Disabled-People and their homes, the biopolitical function to "let die" will persist. It is this very issue of the authority of "medical people to make a decision that is in the best interests of the disabled people" (Hancock, 1991, p. 680) that led Disabled-People to the most notorious of showers—the Nazi gas chamber shower (Figures 84 & 85):

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Figure 84

Survivors congregate in the Dachau shower barracks after liberation, 1945



Note. From *Survivors congregate in the Dachau shower barracks after liberation, 1945*, by United States Holocaust Memorial Museum, 2006.

(<https://collections.ushmm.org/search/catalog/pa14705>). Reprinted with permission.

Figure 85

View of the door to the gas chamber in the Dachau concentration camp. A sign above it which reads "Brausebad" identifies it as a shower, circa 1945



Note. From *View of the door to the gas chamber in the Dachau concentration camp. A sign above it which reads "Brausebad" identifies it as a shower, circa 1945*, by United States Holocaust Memorial Museum, 2020.

(<https://collections.ushmm.org/search/catalog/pa1158576>). Reprinted with permission.

Mostert (2002) writes about how the “methods used for mass extermination in the Nazi death camps originated and were perfected in earlier use against people with physical, emotional, and intellectual disabilities” (p. 157). As in Aotearoa New Zealand, Disabled-People were institutionalised in Germany and the idea of those living a “life unworthy of life” (Binding & Hoche, 1920 cited in Mostert, 2002, p. 159) allowed the idea of euthanasia, previously a voluntary “right to die” (Mostert, 2002, p. 159), to be applied to those who were calculated as a cost and subtracted against the nation’s physical capital. Indeed, occupational therapy played an important part in distinguishing who did and did not have economic value (Stekhan, 2019). These were not the ideas of a few isolated members of the Nazi party. Physicians, even parents of patients, accepted the extension of the euthanasia discourse to their patients and children, although the murders were carried out in secrecy. Eugenics added to the idea that undesirable biological and social differences in the population should be eradicated and, in combination with the idea of Aryan supremacy, led to forced sterilisation and “mercy killings” (Mostert, 2002, p. 162) for the ill and injured. Mandatory reporting of disability by medical professionals and teachers resulted in children being categorised as permitted to survive, or subject to state sanction murder by physicians.²⁸⁰ The programme (“Action T-4”) was then extended to adults and the elderly to “free up hospital beds and nursing staff for war casualties” (Mostert, 2002, p. 165). Asylums were reported to be the first site of gas chamber killing, with the original ‘inhalation rooms’ converted to ‘shower rooms’ through the addition of shower heads through which the physician could administer the gas. It is estimated that over 80,000 adults with disabilities were murdered within the Large-Permanent-Homes that were designed to contain them. These deaths were calculated against savings on meat, jam, cheese, and bread (Mostert, 2002). The calculation of the individual as a deficit against the interests of the nation, the trust that the medical profession would know best what are the interests of Disabled-People, and the acceptance of institutionalisation of such people made it possible and convenient for this state-sanctioned murder to occur.

While it may seem upsetting or outrageous to compare Aotearoa New Zealand’s current system of constructing, modifying or not modifying showers to the Nazi showers, what they illustrate is the danger that is a possibility so long as Disabled-People are connected to medical authority and do not have the same freedoms to move about. As Rabinow and Rose (2006) stated:

Giorgio Agamben, in a series of haunting books, identifies the Holocaust as the ultimate exemplar of biopower, and biopower as the hidden meaning of all forms of power from the ancient world to the present. In particular he explores the moments that he terms, after Carl Schmitt, ‘states of exception’, when a

²⁸⁰ Mostert (2002) explained such murder was called “‘treatment’ (Lifton, 1986), ‘disinfection’, ‘cleaning’, ‘therapy’ (Glass, 1997), or ‘selection’ (Proctor, 1988)” (p. 163).

sovereign state declares a time or a place where the rule of law can be suspended in the name of self-defence or national security (Agamben, 1995, 1996, 1998, 2000a, 2000b, 2005). There is much to be learned from these studies of the profound traumas that mark European histories: we agree that Holocaust is not an exceptional moment of throwback to a singular barbarianism, but an enduring possibility intrinsic to the very project of civilization and the law. (p. 200)²⁸¹

Though it seems unlikely that we will return to state sanctioned mass murder (“make die”), we already accept the biopolitical death of Disabled-People through their exclusion from the community and their abandonment from neoliberal life. The grim housing situation for Disabled-People also exposes them to conditions that literally let Disabled-People die (Barnett, 2015). The absence of mandatory standards requiring any new dwellings to be made Accessible to Disabled-People is used to justify the continuing construction of dwellings that divide Disabled-People from Society (Disability Connect, 2020).²⁸² As resources become rationed, biopolitical disablism can justify further withdrawal of the state from the population (e.g., “Megan Woods not ruling out cuts to funding for housing for disabled people”, 2022), increasing the dangers associated with the current, already grim, system of housing Disabled-People.

A Politics of Hope

Although I am writing at a time where the dispositif that aims to reduce the cost of those of “unsound” physical and mental health has led us to this dire place, the matter is not yet settled. The establishment of the “Whaikaha Ministry of Disabled People” provides “ground for a politics of hope and a politics of the future” (Olssen, 2014, p. 47). The Accessibility for New Zealander’s Bill (2022) aims to “Accelerate progress towards a fully accessible New Zealand” (s3[1]). While the wording of the Bill is problematic in terms of achieving this aim, it does empower a committee to investigate “Accessibility Barriers” within government departments, agencies and statutory entities, and to recommend actions to remove barriers to the Minister, who then presents such recommendations to the House of Representatives. This opens up the possibility of making visible the effects of the discourses employed by multiple

²⁸¹ For example, discourse recently connected “pre-existing conditions” and “care home” to lives that are expendable during the covid epidemic (Abrams & Abbott, 2020).

²⁸² For Disabled-People funded by the MOH these limits on mobility are not restricted to the Permanent Home. Funding is provided for equipment such as wheelchairs and walkers only if they are needed for mobility within the home, educational facility, or the workplace (which includes volunteer work) provided the work meets particular criteria (MOH, 2014b). Access to the community is specifically excluded, although the “home” does include the area around the home to where a car can be reasonably parked. While the manual stipulates that “home” includes the area around the home as far as getting to where a car can be parked, this extension of the idea of “home” is not apparent in secondary sources that describe the access criteria (e.g., Allied Medical, 2022). Funding for vehicle modifications have similar limitations (MOH, 2014b).

government agencies to maintain the biopolitical disablism against Disabled-People that results in their inability to “participate fully on an equal basis with others” (Accessibility for New Zealander’s Bill, 2022, S6).²⁸³ There is hope yet that Disabled-People may become both Showerer and Showeree, a speaking subject who can shower where, when and how they wish, with the assistance as needed.

The establishment of a government department empowered to identify Accessibility Barriers provides the opportunity to detach the problem of disability from the individual, revealing the discriminatory practices of government agencies and their agents. To return finally to the problem of autonomy, and the Showeree and the Showerer, Olssen (2002) argued Foucault’s work connects autonomy, freedom, and diverse, decentralised democracy:

Because autonomy and freedom are relational, they involve nondomination and a certain equalization of power. This in turn involves the organization of a complex political space, that is, one that must be politically constructed in relation to rights, capacities, and opportunities. Against contemporary liberal political theorists, like Kymlicka, Foucault’s notion of autonomy is not a liberal notion, neither is it explainable as counterfactual to the liberal notion as it depends on a completely different order at the level of ontology. Freedom, in this sense, is a historically and politically constructed space that is structured as nonexclusive, democratic, decentralized, or multiple, and allowing for maximum diversity. (p., 491)

Democratic power, materially connected to the idea of rights as I have posited in this thesis, can be employed to tie the interests of individuals to the collective, and governed through ensuring that the interests of those individuals are “rightly understood” (Tocqueville, 1961, cited in Cruickshank, 1996, p. 242). While the problem of housing accessibility remains tied to the individual in competition within a liberal property market, Disabled-People will remain imprisoned within their homes, excluded from the right to life. It is now time for the rest of the population to rightly understand the dangers of the way Disabled-People are governed.

However, the problem of housing for Disabled-People is a wider problem of Aotearoa New Zealand’s property market society. The most recent United Nations “Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living and on the right to non-discrimination in this context” found:

²⁸³ At present, the Whaikaha website indicates that although some MOH services, such as housing modifications are now being governed by the Whaikaha Ministry of Disabled People, it also lists those who are excluded, such as people with health issues, people aged over 65 with age-related conditions and those with mental illness and addictions, who remain within the MOH (2022). The Accessibility for New Zealanders Bill (2022) does not define who is “Disabled” for the purposes of membership on the Accessibility Committee. An important function of this committee will be to ensure that discourses that construct and create accessibility barriers within their own Ministry do not maintain biopolitical disablism that excludes populations that face accessibility barriers.

5. Discussion

The housing crisis in New Zealand is, in fact, a human rights crisis. High rates of homelessness, unaffordability and escalating rents, substandard conditions, overcrowding, insufficient security of tenure, housing largely inaccessible for persons with disabilities, and a lack of social, affordable and community housing for those in need are all inconsistent with the enjoyment of the right to housing. Such conditions would not have reached such a point had housing been fully understood, recognized and implemented by national and local governments as a human right and a social good rather than as an asset for wealth accumulation and growth over the last decades. (Farha, 2021, p. 9)

Putting the interests of “those people” (Hancock, 1991) at the forefront of the response to this crisis, could result in a further strategic elaboration of the dispositif in which it is the architecture of inaccessible housing that can be calculated as a deficit against the physical capital of the nation. Within this dispositif, Disabled-People are an asset, best positioned to eliminate the burden to the nation of unhealthy, unsafe, and unavailable housing.

While an inversion of the established order might seem like a far-fetched fantasy, the shower reveals the possibility of design for Disabled-People becoming the gold standard of design. The 2020, Winner of the Trends International Design Awards Bathroom of the Year includes “This shower – behind the door as you enter the bathroom and opposite the vanity – is wheelchair friendly with a generous entry and includes a wide niche for soap or other accessories” (Trends, 2021) (see Figure 86).

Figure 86

Award Winning Shower, 2021



Note. From “Classic furniture and distressed tiles give this bathroom a sense of history”, by Armstrong Interiors [photograph by M. Stephenson], 2021, *Trends*, 19(11). Reprinted with permission.

The level access shower has become an object of comfort and convenience, found in hotels (“A Suite Celebration at Park Hyatt Auckland”, 2021), a “walk in luxury” (Reid, 2020), and feature of designer bathrooms (Hawkes, 2017). The wheelchair friendly shower could be “a historically and politically constructed space that is structured as nonexclusive, democratic, decentralized, or multiple, and allowing for maximum diversity” (Olssen, 2002, p. 491). While it is “wheelchair friendly”, it has escaped the architectural regime that requires people to stand, step, and reach. However, as a luxury shower it remains out of reach for many Disabled-People. But there is hope that the wheelchair friendly shower may become part of a world in which the shower is accessible to everyone.

The construction of housing accessibility as an issue for specific Disabled-People within specific homes is central to the problem, illustrative of the western discursive construction of disability belonging to the person. In the spirit of the elaboration of the dispositif that I hope for, where those historically seen as a deficit are recognised to be an asset, best positioned to eliminate the burden to the nation of unhealthy, unsafe, and unavailable housing, I leave the final words of this thesis to Dr Huhana Hickey²⁸⁴ and Professor Denise Wilson.²⁸⁵ They redefine what disability is, and advocate for the collective action that is needed to restore balance and eliminate that which compromises anyone’s ability to achieve or undertake essential everyday activities:

Whānau Hauā is grounded in the collective whānau and individual members’ experiences of someone with a disability. In addition to a collective orientation, the key aspect that makes Whānau Hauā distinct from common understandings of disability is that from this perspective a disability does not define a person. In other words, disability is positioned within a person’s background, coming to the forefront in times of need and compromised ability to achieve or undertake necessary activities. Whānau Hauā manage disability as part of their daily life rather than it being central to an individual’s identity or everyday life. The concept of Whānau Hauā is similar to the Western social model of disability, which holds that barriers to daily life do not originate from the disabled person, but are those perpetuated by society. Higgins, Philips, Cowan, Wakefield, and Tikao (2010) argued that “society disables Whānau Hauā people by taking no account of their identity, their culture, or the meanings they give to disability” (p. 14). What makes Whānau Hauā distinct from the social model of disability,

²⁸⁴ Tainui/Ngāti Tahinga. Health Research Council Māori Research Postdoctoral Fellow, Taupua Waiora Centre for Māori Health Research, Auckland University of Technology who describes herself as “Doctor Who... a great ‘Who-vian’ and ‘Star Trek’ fan... from Waikato... around Pukerewa, Weraroa Marae. Ngāti Tāhinga is my hapū, but I’m also Aboriginal, Navajo and Sámi. So I’m a bit of a mongrel really, from around the whole world, globally, as many of us are. My work: I’m very passionate about Human Rights, and my background is in law, and human rights law in particular. I also sit on the Human Rights Review Tribunal and have done for nine years. And I currently sit as a crown director, one of the first openly disabled people to ever sit on a crown directorship, and I’m sitting with Housing New Zealand. A lot of work to go, but I’ve started” (Hickey, 2020b).

²⁸⁵ Tainui/Ngāti Tahinga. Professor of Māori Health, Taupua Waiora Centre for Māori Health Research, Auckland University of Technology.

however, is the added cultural dimension of whānau working together to restore balance in their lives (Hickey, 2015). Therefore, Whānau Hauā sees disability as a collective endeavour of both the individual and the whānau as a whole. Whānau Hauā are driven by a collective effort and the cultural obligations and responsibilities that whānau members have to each other and the whānau as a whole, while they strive to achieve balance within an environment of change and institutional barriers. (Hickey & Wilson, 2017, pp. 86-87)

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Appendix A – Critical Questions Checklist

Critical Question checklist for Ministry of Health Equipment Modification Services (EMS) funded Housing Modifications

This checklist is a tool for EMS Assessors to use when considering applications for housing modifications funded by the Ministry of Health through its two contracted providers, Accessable and Enable New Zealand. It is designed as a supplement to prompt critical thinking around the person's eligibility and essential need and can be used prior to submitting an application. Where issues have been highlighted it is recommended the EMS Assessor investigates the issues further and tries to resolve them. Where an EMS funding application is to be made all of the issues must be fully described.

CRITICAL QUESTIONS RELATED TO THE PERSON	No or No Issues	Not Sure	Yes
1. Did the person have their disability when they moved into their home?			
2. Is the person's primary disability a "personal health" issue? (<i>definition below</i>)			
3. Are there any concerns that the person may not remain in their own home for a minimum of 2 – 3 years? Such as degenerative/deteriorating conditions, transitions in living arrangements, carer resilience etc			
4. Does the person live in a shared care arrangement? (<i>definition below</i>)			
<i>If the answer to Q 3 or 4 is Yes complete the NASC Outcome Summary Report* to demonstrate the outcome of consultation between NASC and the EMS Assessor regarding whether the proposed EMS solution is sustainable long term.</i>			
5. Does the proposed solution relate to the person's behavioural support needs?			
<i>If the answer to Q5 is Yes, and the application is for a child or young person, provide documentation to demonstrate the "Children and Young People with Challenging Behaviours – process for consideration of EMS" has been followed</i>			
6. Has the person ever received funding for the same type of modification before?			
<i>If the answer to Q6 is Yes explain if and how the person meets the extenuating circumstances criteria</i>			



Appendix A – Critical Questions Checklist

CRITICAL QUESTIONS RELATED TO THE PERSON'S HOME ENVIRONMENT	No or No Issues	Not Sure	Yes
8. Are there any issues with property ownership? <i>"No Issues" means that all owners documented on the Council 'rates demand notice' or agent/s have signed their approval.</i>			
9. Is the property a private rental which is not Housing New Zealand (HNZC) or Council owned?			
If the answer to Q9 is Yes respond to the following issues: a. What other accessible rental or social housing options (including HNZC and Council) have been made available or considered by the person? b. What is the term of the lease on the property? c. Is the landlord willing to confirm the tenancy will be secure for 2-3 years? d. Has there been discussion about moving to a more suitable home?			
10. Does the person live in a HNZC home which requires extensive modifications to meet the person's disability related needs? Such as needing an access modification solution for a rise of over 1m or a major internal redesign.			
If the answer to Q10 is Yes respond to the following issues: a. Has there been discussion with HNZC about the suitability of the home? b. What other accessible options have been made available to/considered by the person?			
11. Does the person live in a home purpose built by an organisation (e.g. HNZC, Council or Retirement Village) for a specific age group such as the elderly?			
12. Are there any issues with sufficient circulation space for the person getting around within and between essential rooms of the home, e.g. small room, narrow hallway etc?			
If the answer to Q12 is Yes is the situation complex and needs more consideration about suitability for the person's long term needs, please describe the issues fully.			
13. Does the home have multi levels (either into or between levels of the home) ? <i>No issues for Q 13 means the person does not need to have to</i>			

August 2010

Adapted by the Housing Working Group 2010 with permission from Accessable



access essential rooms on the upper levels of the home, eg they can live on the ground level or the access to the home can be modified with a non-complex modification to make it suitable for the person's long term needs.			
14. Are there any issues with sufficient space for the number of people living in the home? Such as several people living in a 2 bedroom property which is a social rather than a disability related need.			
15. Are there paths or steps which are unformed, broken or steep which would be unsafe to walk on even if the person did not have a disability?			
16. Does the home have generally accepted building standards? <i>No issues means that the home is fit for habitation, and/ or has standard services, such as water, power, plumbing, sanitation, drainage services and that there are no known significant home maintenance (rectification) issues relating to the modification.</i>			



CRITICAL QUESTIONS RELATED TO THE PROPOSED SOLUTION	No or No Issues	Not Sure	Yes
17. Do you support the application?			
18. Are there concerns that access into the home and the internal layout of the home may not be suitable for the person's long term needs? <i>No issues means that with the proposed modification to the home it would be suitable long term to accommodate growth of the person or changes in their disability status.</i>			
19. Does the person wish to include additional features over and above the modification required to meet the assessed need or use their own builder? <i>No issues means that the modification will be completed by Accessable or Enable New Zealand List Contractor as per the assessed need / plan. Where the person wants additional features or to use their own builder, please note this in the application including details of the additional features or modifications. A Cost Contribution process may need to apply.</i>			
20. Is the proposed solution essential and the most cost effective option? Have all other alternatives been considered including equipment or a more cost effective modification?			
21. Are you aware that the proposed solution may include modifications which involve significant internal re-design of the home? Such as changes to load bearing walls, complex sanitation or drainage solutions, significant redesign of internal layout of home, or needing changes outside the structural roof 'footprint' of the home.			
22. Are you aware if the proposed solution may include modifications which involve significant external re-design of the home environment? Such as changes to drainage, retaining walls, driveways or parking areas.			
<i>If the answer to Q21 & 22 is Yes, complete the NASC Outcome Summary Report*. Where issues are identified please describe these fully in the application and ensure the person is aware that the situation is complex and will need careful consideration in collaboration with the EMS Provider. Please also note if the input of a consultant is being requested to assist with the evaluation of potential options?</i>			



Appendix A – Critical Questions Checklist

23. Does the proposed solution include an access modification where the rise is more than 1m from the ground /entry level? <i>No issues means that the proposed modification has a rise up to 1m and is not likely to be over \$15,000.00 including GST maximum threshold.</i>			
23. Does the proposed solution require adjacent land to complete the modification which is not owned by the property owner or shared with others?			
24. Where funding is being sought for modifications to the inside of the home only (such as a level access shower) or for access into or between levels of the home only (such as a chair stair lift). Confirm that the other aspect of the home has been considered and is suitable to meet the long term needs of the person?			

August 2010

Adapted by the Housing Working Group 2010 with permission from Accessable
(Enable, 2010)



Appendix B – Poster Essay

An Essay on Making an Odd Poster

An activity that will be familiar to many academics is the creation of a poster to present at a conference. Typically, a summary of information regarding a research project is printed onto paper or a special fabric (to prevent issues with creasing during transport). The summary usually follows academic conventions so will outline a research question, the methodology and methods used to find the answer to the question, and the answer to the question. Information is presented in text, diagrams, and photographs. This Essay tells the story of my struggle, and eventual success, with developing such a poster under the influence of Foucault and Latour.

The Idea of a Poster

The department I worked for at the time, the Department of Occupational Science and Therapy at Auckland University of Technology, was instrumental in organising the 2016 Australasian Occupational Science Symposium. Having had my PhD proposal (titled “A post-structural discourse analysis of eligibility for New Zealand government funded housing modifications”) recently accepted by the University, it seemed like a good idea to share my research interest with a broader audience. However, it turned out that making a poster, while under the influence of post-structural philosophers, was terribly uncomfortable, full of doubt and compulsion, and wandering out into unexpected and interesting avenues.

This was not the first time I had made a poster. I produced one following my Masters studies. I found a template, summarised information under appropriate headings, included some colourful photographs. I like my poster. It is a typical poster, made of glossy paper, A1 size. It hangs on the wall of my office. But I found that this time when I tried to start creating my poster everything had become uncertain, every convention that I was familiar with seemed problematic. In particular, why would I print a poster on paper? What does paper have to do with New Zealand government funded housing modifications? Why should paper be privileged over other materials? What had once made sense to me, now, while under the influence of post-structural philosophies, failed to make sense anymore. So, began my search for a way to assemble a poster that would preserve the importance of materials to my study.

Searching for a Meaningful Assemblage

I confess that the poster was not my first encounter with new found discomfort for “the way things are”. During the presentation of my thesis proposal I had provided

my reviewers, supervisors, and some of the audience with a small picture book that complemented my presentation. While I still made use of powerpoint, the presentation was formed as a book, rather than a slide show, with the intent of linking the presentation of information to the primary source of data I had used up to that point (books of various forms such as textbooks, journals, manuals etc). I had hoped to use much of the information from that presentation on my poster; however, it was far too much information to fit on the A1 page size I was permitted to use. As I had also progressed beyond books to gather data, the book format no longer seemed relevant.

It is a very fortunate thing, not just for myself, that my husband (Karl) is a craftsman carpenter. A builder of the very best sort, who can make beautiful, intricate, impossible buildings, overlooking the most stunning beaches, materialise from rock and mud on the side of the most inhospitable cliffs. In my search for material to assemble my poster, he and I paid a visit to his building site at the time to explore materials that are used in the building of houses that could have the unlikely secondary ability to perform as a poster. Although my research topic is housing modifications, after a time I decided to focus my research around the specific phenomenon of showers modified for people with physical disabilities. Perhaps not surprisingly, I began encountering discourses regarding the nature of water, how it behaves, what functions it might serve and how we might control it or suffer from its misdirection. Numerous materials are involved in the construction of showers in particular, and houses in general, in attempts to gain greater control of water or moisture in and out and through our homes. It was these materials that I was particularly interested in.

A scrounge around a couple of building sites identified a couple of materials that had potential. This included a plastic paper wall lining; however, experiments concluded that printing or attaching other materials to this lining was unsuccessful. Karl then suggested we experiment with waterproofing material. A generous waterproofer donated a bucket of leftover waterproofing paint (a synthetic rubber paint) for us to experiment with.

Coercing Materials to Perform Never Before Performed Functions

Waterproofing is a fundamental step in modern level access shower construction. As I learnt alongside the process of experimenting with the waterproofing paint, the synthetic rubber that it is made from was developed during World War II when the USA's supply of natural rubber was cut off. Chemists were set the task of developing a synthetic alternative to ensure the supply of rubber tyres that their military vehicles relied on would not run out. Synthetic rubbers are made out of (in the least scientific terms possible) a blend of oil and gas. While the rubber itself functions to

resist water, it has to have a fibre imbedded into it to hold it together. In addition to serving the needs of the level access shower, these materials dictate the form of the shower, with the synthetic rubber requiring that it be accommodated by at least 1.5 metres of floor from the showerhead. Today a polyester fibre is used for this purpose. Application of these waterproofing materials into Aotearoa New Zealand buildings is carried out (or is at least supposed to be carried out) by qualified and waterproofing professionals. To our knowledge, waterproof membranes have never before been asked to be a conference poster; and, to our knowledge, the use of such materials for this purpose falls outside of the Aotearoa New Zealand regulations for application by an accredited waterproofer. Indeed, the waterproofer was slightly bemused about our intentions with his paint.

However, Karl and I set about working with our pot of rubber paint, and our sheets of polyester fibre, to create a conference poster that expressed both the philosophy and the subject of my study. Quite by chance, we had an old glass shower door hanging about in storage halfway up the garden. This was commissioned to provide a flat surface that the paint could be spread out on and (hopefully) not stick to. We marked out the boundaries of the poster as determined by the conference organisers (840mm high x 594mm wide). I was then set the somewhat gendered task of cleaning the shower door with isopropyl alcohol, following which Karl spread the paint, layered over the fibre sheets, which were then painted over to become embedded. Several coats of rubber paint followed, somewhat (but not entirely) in accordance with the manufacturer's instructions. Once three or four layers had been applied, Karl attempted to remove the rubber from the glass. While we had hoped that it would simply peel off the glass, when applied to a shower floor the rubber is asked to do anything other than peel off the surface. Indeed, it did resist being removed even from the glass, and had to be scrapped off the surface rather than peeled. Further layers of rubber paint were added, and the poster backing was complete.²⁸⁶

So, I had the foundation for my poster, but more work was needed to convey information about my proposed study. For this I experimented with two shower materials, the fibre sheets that held the rubber together, and shower curtain material. Cutting and sewing, and then coercing the fabric through my printer by taping it to paper eventually resulted in a series of small curtains that could be layered onto each other were glued to the rubber to form my final product. I rolled my poster up as

²⁸⁶ If you are interested in seeing more images that document the creation of the poster click on this link:

https://photos.google.com/u/1/share/AF1QipO8CD2_N0I7uJwQF_I4yE5orkuVDIJmf9D3GwFYy_Vyi9KWTAdAUCWjDDXpnyKcC0w?key=eEttZU9FSDlstdnZfVGljNDJtZ2czT0VzejN0QW5R

precious cargo and put it in a wheely shopping bag to transport it to the conference. I had visions of pinning it up, only to have it fall apart and slide immediately to the floor. However, the poster stayed hanging just as it was asked:



Indeed, all these years later it is still successfully hanging from the four original pin tacks that it was stuck up with:



Layer 1 (close up of each section follow below):



Appendix B – Poster Essay

Layer 2:



"Is it difficult for you to get around and do tasks in your home because of your disability? If you need modifications to help you remain in, or return to your home, the Ministry of Health may be able to help"

Ministry of Health, 2014, para. 1

"The rising costs of equipment and modifications are not sustainable, so we need to look at how we can manage demand with the money that is available"

Ministry of Health, 2010, p. 1

"The EMS Assessor needs to consider...

The person's essential need for, and their ability to benefit from, a proposed housing modification the long term sustainability of the person remaining in their home for at least 2 to 3 years

The physical features of the home and surroundings, the suitability of the property to meet the person's disability related needs in the long term..."

Ministry of Health, 2014, p. 9

Research Question

What are the discourses that have established, ordered, maintained or disrupted the government's funding of showers modified for people with disabilities?

Discourses establish and reinforce strategies of governance, and include language and images, practices and material objects such as space, architecture and tools

Hook, 2001

Governing

Governing houses for population health and safety

Governing people – the unemployed and the colonised

Designing for the disabled – disability and the built environment

Governing houses for population health and safety

Public Health Act 1872

"Persons acting in the execution of this Part of the Act... may at reasonable times in the daytime enter and inspect any dwelling or place, if there be ground for believing that any person has recently died of any such epidemic or contagious disease in such dwelling or place, or that there is any filth or other matter dangerous to health therein or thereupon" (S24)

Governmentality & Biopolitics

"The population" as a measurable health entity is proposed by Foucault to be a radical idea that is a pillar of modern practices of governance.

Foucault 1972, 1974, 1977 in Rabinow & Rose, 2003

CRITICAL QUESTIONS CHECKLIST FOR MINISTRY OF HEALTH EQUIPMENT MODIFICATION SERVICES (EMS) FUNDED HOUSING MODIFICATIONS

Does the home have generally accepted building standards?

No issues means that the home is fit for habitation, and / or has standard services, such as water, power, plumbing, sanitation, drainage services and that there are no known significant home maintenance (rectification) issues relating to the modification.

"Funding for housing modifications will not be considered in circumstances where... rectification work is required"

Ministry of Health, 2014, p. 38

As a result, areas such as Northland "are characterised by substandard housing that does not meet the criteria for housing modification approval with the effect that a disabled person is doubly exposed to a dysfunctional dwelling"

Saville-Smith et al., 2007, p. 17

Academic literature connects housing maintenance, economics and disability stating that...

People with physical disabilities are less able to carry out house maintenance themselves (Saville-Smith, James, Warren, & Coleman, 2009)

People with disabilities are more likely to have low incomes (Statistics New Zealand, 2014)

People with low incomes are more likely to live in a house in need of repair (Page & Curtis, 2013)

There is a strong connection between low income and unmet housing modification needs (Stark, 2003)

Appendix B – Poster Essay

Layer 3:



Top Row Left Column:

The Ministry of Health funds building modifications

“Is it difficult for you to get around and do tasks in your home because of your disability? If you need modifications to help you remain in, or return to your home, the Ministry of Health may be able to help”

Ministry of Health, 2014, para. 1

“The rising costs of equipment and modifications are not sustainable, so we need to look at how we can manage demand with the money that is available”

Ministry of Health, 2010, p. 1

When New Zealanders with a long-term physical disability are no longer able to participate in essential occupations within their home, they may apply for housing modifications (such as a level access shower) funded by the Ministry of Health (MOH).

Systems have been established to manage the budget that is allocated to fund such modifications.

First Row Centre Column:

The characteristics of some houses result in exclusion from this funding

“The EMS Assessor needs to consider...

The person's essential need for, and their ability to benefit from, a proposed housing modification the long term sustainability of the person remaining in their home for at least 2 to 3 years The physical features of the home and surroundings, the suitability of the property to meet the person's disability related needs in the long term...”

Ministry of Health, 2014, p. 9

The community OT (called the Equipment Modification Services [EMS] Assessor) assesses the need for and applies for housing modification funding. They are required to determine the eligibility of the person, their long term needs and the general acceptability of the house.

The characteristics of some houses or properties can render applicants ineligible. Housing maintenance and not meeting current building standards are some characteristics that can exclude people from funding.

First Row Right Column:**Research Question**

What are the discourses that have established, ordered, maintained or disrupted the government's funding of showers modified for people with disabilities?

Discourses establish and reinforce strategies of governance, and include language and images, practices and material objects such as space, architecture and tools

Hook, 2001

I will use discourse analysis to explore the boundaries of practice that govern the funding of housing modifications. Governing is not only performed by "the Government". It is any activity of arranging, or steering people and things and is a practice carried out by discourse (Foucault, 2003a).

I am focusing on showers as phenomena at their most basic level must be analysed to see "the manner in which they are invested and annexed by more global phenomena and the subtle fashion in which more general powers or economic interests are able to engage with these technologies that are at once both relatively autonomous of power and act as its infinitesimal elements" (Foucault, 1976, In Rabinow & Rose, 2003, p. 99)

Second Row Left Column:**Governing**

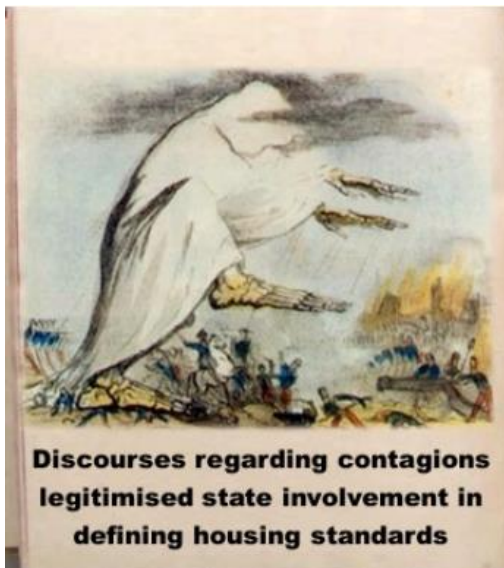
Governing houses for population health and safety

Governing people – the unemployed and the colonised

Designing for the disabled – disability and the built environment

A review of the literature found strategies that exclude particular dwellings, and therefore those who live in them, from eligibility for funding.

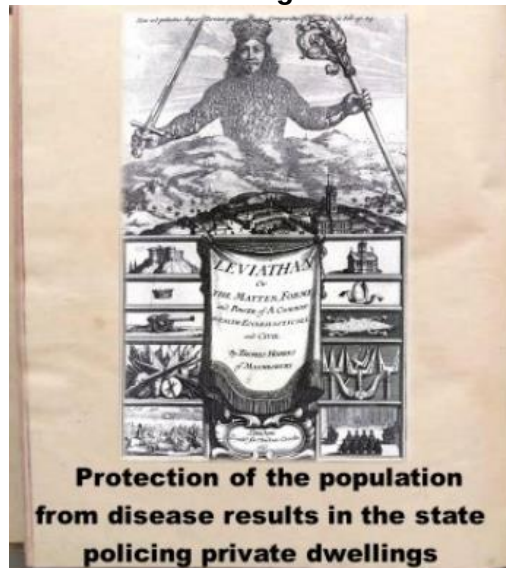
Histories of governing houses for population health and safety (the control of contagions, fire and falls / injury prevention through the inspection, construction and destruction of houses); housing strategies for governing people (to limit the problem of the unemployed and colonised, through strategies of housing development and property ownership); and designing for the disabled (which establishes the relationship between disability and the built environment, productivity and civil rights, and the idea of universal design) can all be traced to current practices of exclusion from housing modification eligibility.

Second Row Centre Column:**Governing houses for population health and safety****Public Health Act 1872**

“Persons acting in the execution of this Part of the Act... may at reasonable times in the daytime enter and inspect any dwelling or place, if there be ground for believing that any person has recently died of any such epidemic endemic or contagious disease in such dwelling or place, or that there is any filth or other matter dangerous to health therein or thereupon” (S24)

The community OT (called the Equipment Modification Services [EMS] Assessor) assesses the need for and applies for housing modification funding. They are required to determine the eligibility of the person, their long term needs and the general acceptability of the house.

The characteristics of some houses or properties can render applicants ineligible. Housing maintenance and not meeting current building standards are some characteristics that can exclude people from funding.

Second row right column:**Governmentality & Biopolitics**

“The population” as a measurable health entity is proposed by Foucault to be a radical idea that is a pillar of modern practices of governance.

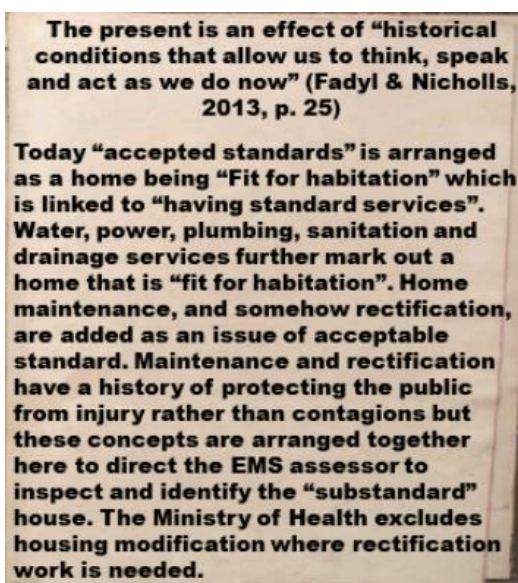
Foucault 1972, 1974, 1977 in Rabinow & Rose, 2003

Governmentality (discourses that function to both legitimise and limit the involvement of the state in the lives of the states subjects) and Biopolitics (a particular form of governmentality that connects the health and wealth of the population to state security) help with understanding practices of governing houses to reduce the spread of contagions.

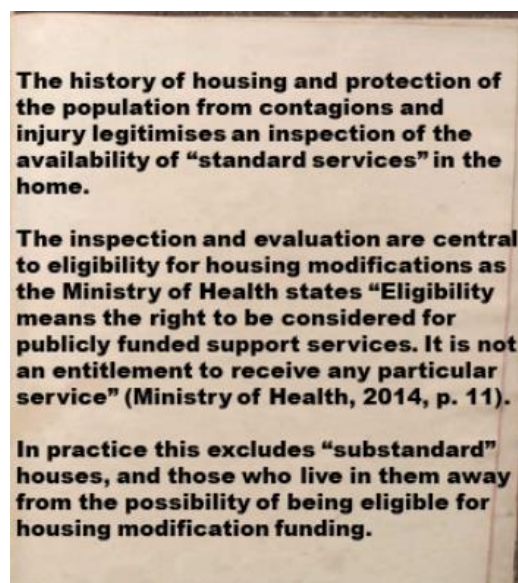
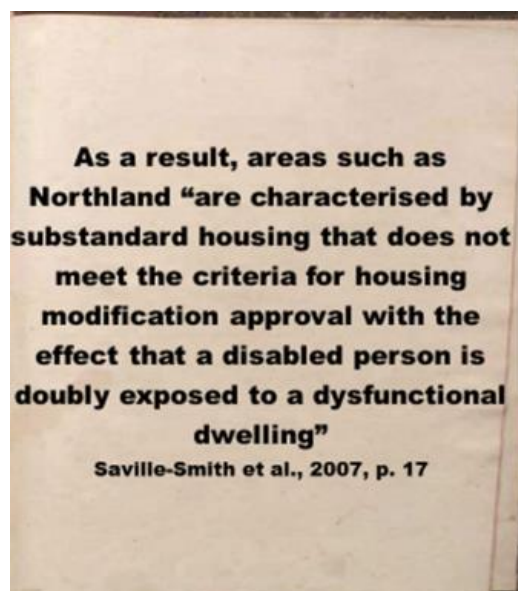
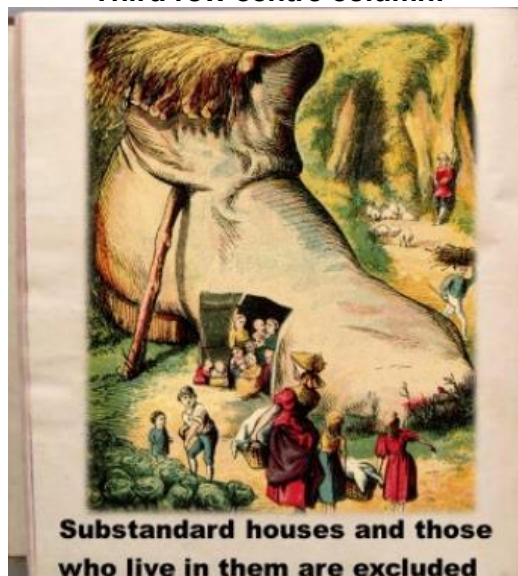
As the population (comprising of economic agents and potential soldiers) is under attack by contagions the extreme measure of the state claiming authority over private dwellings is then legitimised to protect the security of the state.

You might be asking: What on earth does the science of cholera have to do with housing modifications?...

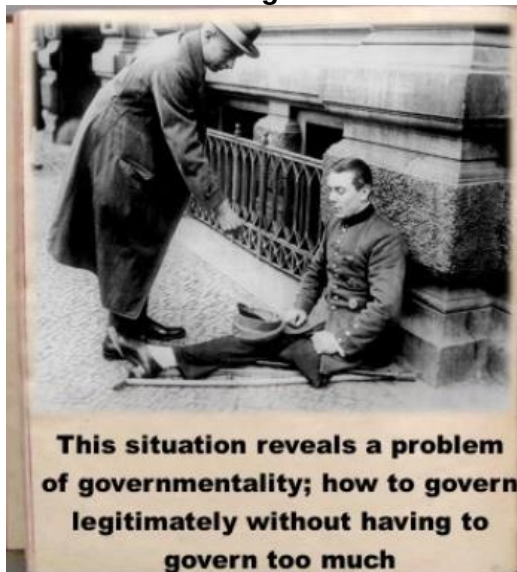
Third row left column:



Third row centre column:



Third row right column:



Academic literature connects housing maintenance, economics and disability stating that...

People with physical disabilities are less able to carry out house maintenance themselves (Saville-Smith, James, Warren, & Coleman, 2009)

People with disabilities are more likely to have low incomes (Statistics New Zealand, 2014)

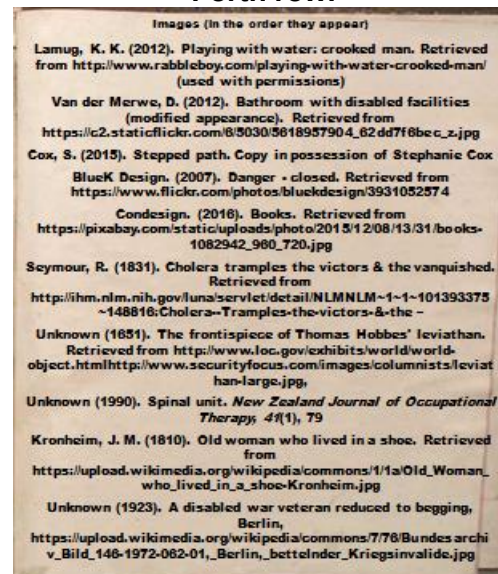
People with low incomes are more likely to live in a house in need of repair (Page & Curtis, 2013)

There is a strong connection between low income and unmet housing modification needs (Stark, 2003)

The arrangements between houses, the population, economics and the disabled person reflect a problem of governmentality: How to legitimise government intervention, while avoiding having to govern too much. It is in the interest of state for houses to be maintained to a standard that protects the population from disease and injury, however the obligation is on the individual to maintain this standard. Here ideas compete such as "freedom of the market", versus "protection of the population". Is the house a personal asset or part of the housing stock?

Who should invest in a house, and who should profit from this investment? Who would benefit from improving the house to a "standard" level and how can individuals be encouraged to do this at their own cost? I am embarking on a PhD to explore these and other questions that function to exclude people from eligibility for housing modifications

Forth row:



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Appendix C – Information Sheets & Consent

Participant Information Sheet

Consultant

Date Information Sheet Produced:

4th November, 2015

Project Title

A post-structural discourse analysis of eligibility for New Zealand government funded housing modifications

An Invitation

I would like to invite you to participate in a project researching the way that showers modified for people with disabilities have been funded in New Zealand. My name is Stephanie Cox and I am a Doctorate degree student with the Auckland University of Technology (AUT). I am looking for documents regarding non-ACC funded shower modifications prior to 1985, between 1993 and 2003, or in the past 5 years. With your consent I would like to have access to the documents you hold related to this topic. There is no requirement for you to agree to participate and you may withdraw your consent before I access the documents you hold.

What is the purpose of this research?

The findings from this research will be published in a series of scientific journal articles, then combined to form a thesis. The articles are likely to be published in international journals, the thesis will be available in the AUT library and from the AUT library website. Findings will also be presented at conferences and have the potential to be included in academic book chapters.

How was I identified and why am I being invited to participate in this research?

You have been identified or identified yourself as someone who was involved in showers modified for people with disabilities either before 1985, between 1993 and 2003 or in the last 5 years. You have indicated that you hold documents in your personal collections that relate to this topic.

What will happen in this research?

If you are willing to give me access to your collections, and you sign and return the attached consent form, I will then be able to access your personal collections. With your permission I will review and where possible take copies of your documents. I will be looking at a wide range of other information (such as Ministry of Health manuals, laws and building regulations) to find out how the government influences which applications for funding are approved and which ones are not.

There is a move to digitalise archive material to increase access. If you are willing, documents you provide may be scanned and made publicly available at a later date through an open access database.

What are the discomforts and risks?

Some of the documents you hold may contain information that you do not want made public.

How will these discomforts and risks be alleviated?

We will discuss and you will identify what information you hold that you are happy for me to copy and use for my research.

We will discuss and you will identify what information you hold that you are happy for me to digitalise and potentially make publicly available.

What are the benefits?

Your collections contain the record of the way that various people discuss and explain the processes of shower modification funding being approved or declined. It is important these processes are reviewed

and critiqued so that the status-quo can be understood and contested. As I mentioned above, the findings of my research will be published in journals and a thesis as part of the requirements of my doctoral degree.

How will my privacy be protected?

If you are willing, you will be named and thanked for your contribution to my research. Any of our personal communications (face to face, on the phone or by email) will not be included in my research. Only the information you provide will be included and the specific information provided by you will not be identified.

If your name or contact details are on any of the documents you provide we will discuss whether you want these details to be included in digitalised material or in any raw material presented in articles, the thesis or conferences.

What are the costs of participating in this research?

It may take some time for us to go through your collections. There are no other anticipated costs.

What opportunity do I have to consider this invitation?

Could you please let me know within 3 weeks of this invitation if you would like to participate.

How do I agree to participate in this research?

Please read and sign the attached consent form then return the form to me in the enclosed envelope.

Will I receive feedback on the results of this research?

I will send you a summary of findings once my research is complete. You will also be able to access my full thesis via the AUT library.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Clare Hocking, chocking@aut.ac.nz, 09 921 9162.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Stephanie Cox, stcox@aut.ac.nz, 027 294 8683, 09 372 9999 ext 7128.

Department of Occupational Science and Therapy | School of Rehabilitation and Occupation Studies
Faculty of Health & Environmental Sciences | AUT University | Private Bag 92006, Auckland 1142, New Zealand

Project Supervisor Contact Details:

Professor Clare Hocking, chocking@aut.ac.nz, 09 921 9162.

Department of Occupational Science and Therapy | School of Rehabilitation and Occupation Studies
Faculty of Health & Environmental Sciences | AUT University | Private Bag 92006, Auckland 1142, New Zealand

Consent and Release Form

Project title: *A post-structural discourse analysis of eligibility for New Zealand government funded housing modifications*

Project Supervisor: *Professor Clare Hocking*

Researcher: *Stephanie Cox*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 4th November 2015.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that I may withdraw myself, my image, or any other information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information will be destroyed.
- ☐ I permit the researcher to use the photographs that are part of this project and/or any drawings from them and any other reproductions or adaptations from them, either complete or in part, alone or in conjunction with any wording and/or drawings solely and exclusively for (a) the researcher's portfolio; and (b) educational exhibition and examination purposes and related design works.
- ☐ I understand that the photographs will be used for academic purposes only and will not be published in any form outside of this project without my written permission.
- ☐ I understand that any copyright material created by the photographic sessions is deemed to be owned by the researcher and that I do not own copyright of any of the photographs.
- ☐ I agree to take part in this research.
- ☐ I permit the researcher to make digital copies of the information that I have provided so that this information may be made publicly available on an open access data base.
- ☐ I permit the researcher to make digital copies of the information that I have provided so that this information may be made publicly available on an open access data base with the following exclusions:

- ☐ I do not permit the researcher to make digital copies of the information I have provided to be made publicly available.

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....

.....

Date:

Appendix D – Building Act reform for Building Users

Stephanie Cox, Clare Hocking, Deborah Payne

Abstract

The Building Act 1991 established the New Zealand Government's role in ensuring the safety, health, independence and well-being of building users. To this end, the 1991 Act and subsequent iterations recognise that people with disabilities need buildings that met disability design standards; however, these standards are not required for the design of private dwellings. This article uncovers the historical practices that made such exclusion acceptable, and challenges policy makers to rethink the relationship between government, private dwellings and the health and wealth of the nation. The purpose is to highlight flaws in the framing of the review of the current Building Act, identify critical questions that need to be addressed by policy analysts, and to call for a full review of the Act's failure to achieve its stated purposes.

Keywords: Building Act, private dwellings, disability design, population health, safety, wealth, shower, institutions, law reform

Stephanie Cox is a PhD candidate at Auckland University of Technology. Clare Hocking is a Professor of Occupational Science and Therapy at Auckland University of Technology. She is the Executive Editor of the Journal of Occupational Science and recently contributed to the revision of the World Federation of Occupational Therapy's Position Statement on Human Rights. Deborah Payne is an Associate Professor at Auckland University of Technology, in the area of Disability & Health.

In April 2019, New Zealand's Ministry of Business Innovation and Employment (MBIE) published discussion papers regarding reform of the Building Act 2004 (MBIE, 2019). The current Building Act (2004) has the following purposes:

- (a) to provide for the regulation of building work, the establishment of a licensing regime for building practitioners, and the setting of performance standards for buildings to ensure that—*
 - (i) people who use buildings can do so safely and without endangering their health; and*
 - (ii) buildings have attributes that contribute appropriately to the health, physical independence, and well-being of the people who use them; and*
 - (iii) people who use a building can escape from the building if it is on fire; and*
 - (iv) buildings are designed, constructed, and able to be used in ways that promote sustainable development:*
- (b) to promote the accountability of owners, designers, builders, and building consent authorities who have responsibilities for ensuring that building work complies with the building code.*

The focus of the April discussion papers was on building products and processes rather than design, thereby minimising the effect that the review could have on the contribution buildings make to the health (and thus the wealth) of people who use buildings (herein called "building users").

In this paper we argue that the narrow and ahistorical scope of the review particularly disadvantaged people with disabilities and effectively quashed consideration of

accessibility issues in the nation's housing stock. To that end, we offer a historically situated examination of the Building Act, with a particular focus on "Building Users" and the politics that have sustained the practice of separating people with disabilities from the rest of the population throughout the 1900s. By uncovering the history of excluding people with disabilities as "Building Users" we challenge the taken for granted assumptions that maintain their exclusion and identify questions that should have been asked, and were not, to inform the review. The discussion is part of a larger research project that explores governing practices in relation to government funded housing modifications.

Politics and the use of buildings

The New Zealand Government established the right to govern building performance for the people who use them in the original Building Act 1991. That right is the culmination of incremental change as the government extended its involvement in building regulation in the interests of population safety, health, independence and well-being since the late 1800s. A key driver for state involvement in population health, safety, independence and well-being has been for the improvement in the productivity of the nation's citizens, and equally, addressing the problem of the upkeep of non-productive (and thus "dependent") citizens. Towards the end of the 20th Century New Zealand policy makers and citizens put forward radical ways of thinking about the relationship between people and buildings to address that problem. While some of these ideas led to revolutionary ways of governing, others became marginalised as a result of ignorance and prejudice towards a subset of the population.

The task of governing the state might be popularly thought of as the activities that occur within parliamentary buildings, however, it is the governing activities that influence the taken for granted practices of ordinary citizens that more directly create the health and wealth of the nation. Building legislation is a particularly important influence because, unlike the fairly rapid change that can occur in the population's thoughts and activities, built structures and manufactured objects make historically accepted practices more durable and resistant to change. The study of governing at this material level reveals the complex relationship between the state and privately-owned buildings and shows how the interests of the health and wealth of the nation are connected to the business of building legislation, establishing permission for the state to have a stake in the private capital of its citizens.

A commonplace example of governmental control of privately owned buildings is the design and materials used in the construction of showers. Showering may be thought of as one of our most private self-care activities; however, the beliefs that make present-day showering practices acceptable and that make showers available to building users have connections that stretch out across nations and through time. The practice and use of showering emerged in the 18th Century as a sudden, sustained fall of cold water onto the heads of patients diagnosed with mania (Cox, Hocking, & Payne, 2019). By the late 1800s, the shower was transformed into a means of washing people's skin to reduce the spread of disease. Bathing facilities are now a requirement within dwellings and showers have now become an accepted feature of the New Zealand bathroom. However, the Building Act 1991 connected wheelchair accessible

showers to some buildings and not others, meaning that building users do not have equal access to a typical New Zealand shower box. The discussion that follows traces the contested relationship the government has with the private lives of citizens (particularly those who may be “dependent”) as they have materialised in policies and practices through the 1900s. Our aim is to reveal the dangerous implications of current legislation for some members of the population (particularly those with disabilities), demonstrating the need for a complete review of the Building Act.

The problem of the dependent citizen

In the early 1900s, a relationship between the good of the nation and those deemed “dependent” citizens was established by viewing the minds and bodies of the population as possessing a collective labour potential:

Every unit of sound physical and mental health in the community is a public asset, and it is plainly in the public interest that no step should be neglected which, if taken, may have a value in checking any tendency that may exist towards the depreciation of the physical capital of the county. (“The health and development of children”, 1906, p. 8)

The health of each citizen was thus connected to the economic well-being of the nation. Those lacking in human capital were calculated as a deficit against the interests of the population: “the number of dependents which can be maintained by any community necessarily rests upon that proportion of the population which is not dependent – the producers” (Barton, 1919, p. 5). The idea that the unproductive, or potentially unproductive, present a calculable cost to the population creates a public interest in identifying and limiting the burden of such individuals on the nation.

The problem of the dependent was not a new phenomenon. Since the birth of New Zealand’s colonial government, strategies were employed to manage the problem they presented. Legislation initially placed liability on the family (The Destitute Persons Relief Ordinance 1846) and on those who facilitated their immigration to New Zealand (The Imbecile Passengers Act 1873). Despite these measures, within a relatively short time municipal councils were tasked with maintaining the destitute and sick (The Municipal Council Ordinance, 1860) and subsequently resolved to tax their working population to fund institutions that would house orphans, the sick and the insane (The Sick and Destitute Ordinance 1868). In the later part of the 19th century, a review of New Zealand’s hospitals found “they are made the home of aged, infirm, and chronic cases, corresponding very closely to the permanent pauper inhabitants of an English union workhouse” (Inspector of Hospitals, 1883, p. ii).²⁸⁷

In the early 1900s, two schools of scientific thought emerged to resolve the urgent need that the proposed imbalance of dependents presented. These schools of thought were made material through practices and architecture, including the production of new forms of showers. One school of thought, eugenics, was a medico-scientific approach to eliminate dependents by removing them from the population’s breeding stock (via, isolation, sterilization and in some instances death). Another was the scientific engineering of tasks and materials to transform the “dependents” into “producers”.

²⁸⁷ See Moore and Tennant (1997) and Tennant (1996) for a detailed history of New Zealand policy and disability.

These sciences opened the possibility of calculating the relative costs and benefit for determining where and how (and indeed if) certain members of the population should live.

Solution for the Dependent 1 – Useless eaters and Concentrated dwelling

Eugenics emerged as a solution to population health and wealth that involved identifying and segregating subsets of the population. While most commonly remembered for its race-based policies, the focus of eugenics was equally on people with “defects”, including those we might today consider “people with disabilities”.²⁸⁸ In the interests of the nation and overseen by medical professionals, people with disabilities were identified and institutionalised. While one might wish to distance modern day government of building users from such history, we demonstrate that the prejudices and practices of eugenics remained in circulation at the time of the Building Act’s emergence. Further, we point to the dangerous practices of identifying and separating subsets of the population that eugenics advocates and which the current Building Act sustains.

A central tenet of the eugenics discourse is that inheritance of defective genes creates a proportion of the population that consumes more resources than they contribute (the “useless eaters”). It argues that modern government practices increase this proportion of the population by permitting technology to artificially keep alive those who nature would have allowed to die. Securing the health of the nation involves identifying the so called “defective” proportion of the population and preventing them from passing on their genes. Citizens’ rights to anonymity, to control over one’s body, to determine where and even if one should live, are removed in the interests of population health. In the early 1900s, the New Zealand government supported the eugenics practice of identification of defectives (e.g. “The Health and Development of Children”, 1906; “The Health of School Children”, 1913; “Practical Eugenics”, 1917) and advocated for state control over where and how they lived.²⁸⁹ Institutions in which to permanently house defectives were approved by health boards (“Maintenance of Degenerates”, 1910; “Segregation of Female Degenerates”, 1911), educators (“Defective Children”, 1914, 1917), and business networks (“Home for Degenerates”, 1924). This was followed by some advocating for the natural death of defective infants (“Saving the Babies”, 1917), approval of sterilization (“Dealing with Degenerates”, 1923; “Sterilisation of Defectives”, 1932) and entertaining the idea of euthanasia (“Segregation of Unfit”, 1935).²⁹⁰ There was also mention of “lethal chambers” for “imbecile children” (Spencer, 2017).

²⁸⁸ See Sullivan (1995) for an analysis of eugenics discourses in relation to people with disabilities in New Zealand. See Mostert (2002) for a detailed study of the management of people with disabilities as a population of “useless eaters”

²⁸⁹ In 1923, the Minister of Health asked “What is our duty towards the deficient. The answer which common-sense dictates is to place them in an environment where with their little comprehension they will not feel their disability; where they will be as happy as possible; where they will be trained for and engage in simple employments according to their capacity; where, as children, they will not, by association, prejudice the outlook of their normal brothers and sisters; and where, as adults, they will not have the opportunity to come in conflict with the law or to reproduce their kind... for the vast majority, in its interest and the public’s, this should be the permanent home”. (Pomare, 1923, p. 2). The Mental Defectives Act 1911 and its 1928 amendment established and extended legalisation of permanent segregation of the mentally defective.

²⁹⁰ See Paul, Spencer & Stenhouse (2017) for a more detailed account of the practices of eugenics in New Zealand.

Despite a level of acceptance of the eugenics discourse in New Zealand, World War II newspaper articles such as “Peace Talk - Nazi Brutality: Mass Murder of Mental Defectives” (1941) indicate a repugnance to the practice of state sanctioned murder. While New Zealand may have largely rejected eugenics, it is important to identify eugenic practices that remained acceptable at the time the Building Act 1991 was passed, and to recognise the danger presented by these accepted practices.²⁹¹ These practices (which we return to later in our discussion) were:

- A eugenics discourse promotes the identification and concentration of people with disabilities in separate dwellings (“institutions”) as being in the interests of the health and wealth of the nation, and in the best interests of the people with disabilities themselves.
- Identifying and co-locating a subset of the population who are seen to detract from the health and wealth of the nation puts their privacy, autonomy and right to live in the hands of others.

Solution for the Dependent 2 – Rehabilitation and Disability Design

Alongside the eugenics school of thought, a form of human engineering was developing in the early 1900s with the aim of increasing production. The mechanisation of work saw productive roles appear for people previously deemed incapable of being in paid employment. The possibility emerged of people with disabilities being rehabilitated, thus gaining both human and material capital (health and wealth) and becoming socially and economically mobile. Spaces developed for specialised training highlighted the discriminatory nature of architecture in its creation of dependents and generated the birth of disability design. New Zealand’s Building Act (from 1991 to today) recognises the idea of disability design, referring to design standards for people with disabilities. However, such design is limited to spaces where they might work, shop, or otherwise take part in civic life, and excludes private dwellings.

In the USA principles of “scientific management”, which aimed to automate bodily movements to measurably enhance productive performance, were employed. A person could be deemed productive if able to perform even one such movement: “The work of every workman is fully planned out... complete written instruction, describing in detail the task... specifies not only what is to be done but how it is to be done and the exact time allowed for doing it” (Taylor, 1911, p. 39). Factories, in which workers’ eyes, ears and limbs could be employed to operate machinery, were the sites of several studies that advocated for the work potential of impaired bodies (e.g. Dietz, 1933; Ford, 1922). Thus, constructed as a body with some productive parts, the previously “crippled dependent” could be trained via “rehabilitation” into a paid worker, with the capacity to compete for work alongside the “able-bodied” man.²⁹² Although originally construed as “scientific management”, the shift into the realm of disability saw “training” become “rehabilitation” and become transformed into a health service. Other nations (including New Zealand) followed suit and called for all disabled members of the population to be

²⁹¹ Indeed, debates related to rights to life and freedom for people with disabilities continue in recent history (e.g. Jaye, Lomax-Sawyers, Young & Egan, 2019; Klausen, 2017; Stace, 2013)

²⁹² Disabled Servicesmens League, cited in “The Disabled”, 1945, p. 2.

identified and systematically placed into facilities which would enable this transformative promise.²⁹³

These facilities were not intended to be permanent accommodation, but rather a temporary space to collect people with disabilities together in order to facilitate transformation.²⁹⁴ The wheelchair access shower was born in the USA's polio rehabilitation facility, "Warm Springs",²⁹⁵ where the grounds and buildings were engineered to permit wheeled mobility and a sense of freedom for the residents.²⁹⁶ What emerged from this facility was not simply transformed bodies, but rather a radical way of thinking about the role of building design in the creation of disability.²⁹⁷ A new form of "people with disabilities", seeking the freedoms to work and shop, but dependent on a particular set of architectural conditions and mechanical aids, became possible.²⁹⁸ In the USA such citizens successfully breached the confines of the rehabilitation facility to transform Illinois University into a space modified for students with disabilities to study, compete in sports and live.²⁹⁹ This same group were involved in developing the American Standard³⁰⁰ that would then inform New Zealand's first Code of Practice for Design for Access by Handicapped Persons (NZS4121:1971 - Standards Association of New Zealand, 1971).³⁰¹ The Disabled Persons Community Welfare Act 1975 (DPCWA) brought the NZS4121 into legislation to improve access to streets and premises open to the public.

It is at this point that the contentious relationship between the state and private building ownership in modern government comes to light. Rehabilitation claims to produce citizens who, with the help of disability design, have freedom of social and economic mobility. Therefore, they may compete with others to develop their human and material capital. This capital becomes a feature of both the person's and the nation's economy, and facilitates participation in the activities of government. While there is acceptance of state involvement in protecting the population from dangers, it must also ensure that citizens have the freedom to compete for and benefit from personal capital (which includes their health). Therefore, while rehabilitation and disability design led to the existence of facilities such as a shower that people with disabilities could use, a new problematic regarding where such facilities should exist and at whose expense emerged. At the time the Building Act 1991 was passed, the accepted ideas associated with rehabilitation and disability design, and the dangers of the associated practices, were:

²⁹³ "Cripples Care", 1940, p. 11.

²⁹⁴ Giles, 1944, p. 1.

²⁹⁵ Toombs, 1931, p. 1.

²⁹⁶ "Accessibility", 1934, para. 1-2; Donnelly, 1932, para. 5.

²⁹⁷ Donnelly, 1932, para. 32. This radical way of thinking is associated with the so called "social model of disability".

²⁹⁸ Rusk, Taylor, Zimmerman, & Judson, 1953, p. 11.

²⁹⁹ For example "Bathroom modifications letter to Dr. Bone", Blankenship, 1949.

³⁰⁰ American Standard Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped (American Standards Association, 1961).

³⁰¹ The American steering committee had originally included shower design (Nugent, 1961), the final version limited its scope to "general buildings" for the purpose of efficiency, eliminating reference to shower facilities (American Standards Association Project A-117 Steering Committee, 1961, p. 2).

- As neoliberal discourse proposes, that rehabilitation combined with disability design in the places where people work, shop and take part in the activities of government, can transform people with disabilities into free citizens. They are able to compete with other citizens to further develop their human and material capital, and, as members of the productive population, they are free to make choices regarding where and how they live.
- That the practice of leaving the market to determine what building users need aims to free the market from restrictions that could detract from the nation's wealth, but results in design that discriminates, creating disability. This perpetuates the exclusion of people with disabilities from obtaining human and material capital, being able to compete in the housing market and having their needs recognised by government.
- That private dwellings do not typically have attributes that contribute appropriately to the health, physical independence, and well-being of building users with disabilities; and that building users with disabilities would have difficulty escaping from many private dwellings should they catch fire. Thus, leaving the design of private dwellings to market forces has meant that building users with disabilities cannot use most private dwellings safely.

The role of the state in managing dangers through building control - Injury, the burden of care, and safer buildings for everyone

Although buildings accessible to people with disabilities had become a possibility, the NZS4121:1971 consistently limited its reach. Disability design was limited to general public buildings and facilities,³⁰² maintaining the notion that access for people with disabilities to private dwellings sits outside of the state's interests. However, by this time New Zealand had nearly 130 years of central or local government jurisdiction in private dwellings in order to manage dangers to the health of the general population.³⁰³ The country was also about to see the Accident Compensation Act 1972 and its 1973 (No. 2) amendment revolutionise the relationship between the state and the activities of citizens in their private dwellings, leading to the possibility of resolving the problem of architecture depreciating the country's human capital.³⁰⁴

In order to eliminate the waste of resources caused by litigation related to personal injury, the Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand (Woodhouse, Bockett, & Parsons, 1967) proposed a connection between the interests of the nation and the cost of injured citizens. Recognition of the cost of personal injury to the nation's human capital, regardless of whether the person slips in the shower at work or at home, extended the state's interests into the safety (or otherwise) of the activities of citizens within their private dwellings:

³⁰² The 1971 version only considered passenger and transport terminals, and public lavatories as essential. While there was mention of hospitals, rest homes, hotels, motels, hostels, and swimming baths where showers would likely be available, it was not until the 1985 edition (Standards Association of New Zealand, 1985) that shower specifications were included.

³⁰³ E.g. Raupo Houses Act 1842, Auckland City Council Act 1853, Canterbury Municipal Ordinance 1860, Public Health Act 1872, Bubonic Plague Prevention Act 1900, Maori Councils Act 1900, Health Act 1956.

³⁰⁴ Although the Act also applies to visitors to the country, it is the relationship with citizens that is of interest here.

It is obvious enough that a worker does not cease to be a worker as he leaves his factory at 5 o'clock... If he slips and is disabled in the factory shower-room as he prepares to go home, he will be entitled to all the advantages of the Workers' Compensation legislation and may even succeed against his employer in a negligence action. Yet if he suffers the same accident upon his arrival at his home he will receive nothing at all, or at best the assistance provided by the Social Security Fund. From the point of view of the injured workman these inconsistent results develop from a diagnosis by causes and a disregard of their similar effect. When it is recognised that in each case it is the community which pays, the discrimination assumes an air of unreality (Woodhouse et al., 1967, p. 35).

For individuals with disabilities from injury, the Accident Commission took control of the distribution of material compensation, the resourcing and regulation of rehabilitation processes employed to regain the lost human capital, and monitoring and regulation of the causes of injury. Hospitals and other institutions employed rehabilitation practices to transform the injured, and, with the institution's approval, those deemed capable of being discharged to the community could receive state funding to install a wheelchair accessible shower (amongst other things) that would realize the promise of transformation.³⁰⁵

Although the Accident Compensation Act 1972 initially maintained tradition by not recognising the human capital of non-earners, the potential for housewives to be a cost or benefit to the productive worker³⁰⁶ saw the 1973 Amendment (No. 2) ensure that all injured citizens would be eligible. That entitlement was given whether they had quantified their human capital in the workforce, sustained that capital by providing members of the workforce with a supportive environment, or had been or potentially could be a member of the workforce. State funded modification of private dwellings, where there was a demonstrable cost-benefit,³⁰⁷ was then extended to other citizens with disabilities following the passing of the Disabled Persons Community Welfare Act 1975 (DPCWA).³⁰⁸ The DPCWA also legislated for the NZS4121 to improve access to streets and premises open to the public,³⁰⁹ and registering, resourcing, inspecting and determining standards for collective/group living facilities.³¹⁰

As the installation of disability design into private dwellings by the state, via accident compensation or welfare, was limited to the particular circumstances of the injured or

³⁰⁵ Accident Compensation Act, 1972, s49(2)e

³⁰⁶ "If the scheme can be said to have a single purpose it is 24-hour insurance for every member of the workforce, and for the housewives who sustain them" (Woodhouse et al., 1967, p. 26).

³⁰⁷ "The Director-General shall not make a grant to any person... unless he is satisfied that the disabled person can be expected to enjoy the benefit of the alteration to the home for a period sufficient to justify the amount of the expenditure involved" (Disabled Persons Community Welfare Act, 1975, S14[3])

³⁰⁸ This funding is now governed by the New Zealand Public Health and Disability Act 2000.

³⁰⁹ Limited to new or reconstructed streets, new buildings or buildings undergoing major alterations, and with the proviso that the Director-General may at any time exempt any or all from the requirement for modification. Reference to this section of the DPCWA was included in the Building Act 1991. The current Building Act refers to the NZS4121 directly.

³¹⁰ This regulation is now included in the Health and Disability Services (Safety) Act (2001) and in the categories of buildings that the current Building Act states must now meet NZS4121 standards.

otherwise disabled individual, there was no apparent need for further government involvement in private dwellings in this regard. However, in addition to rehabilitation of the injured, the Accident Compensation Act established a role for the state in surveilling the causes of injury. In 1986 a national series of “safe house” seminars drew on this data to advocate for government interest in the design of houses to reduce the cost of accidents within the home. Aspects of Disability Design, such as the level access shower³¹¹ were identified as safer for everyone (Pope, 1986).

Being in the unique position of having information about the causes and costs of disability associated with injury within homes, disability design was connected to resolving loss of human capital via discriminatory architecture in private dwellings, while preventing the creation of disability via injury. The idea of connecting the interests of disabled users of private dwellings with the health and wealth of the nation was considered revolutionary. A World Rehabilitation Fund Monograph - “From Barrier Free to Safe Environments: The New Zealand Experience” was received as “a way of thinking about our built environment which we have hinted at but never fully conceptualised...the concept that an accessible environment is an intrinsically safe one” (Schechter, 1989, in Wrightson & Pope, 1989, p. 68). Drawing from this idea the NZS4102 Code of Practice for Safer House Design (Standards Association of New Zealand, 1990) was published, providing advice on design for all new dwellings to “eliminate or reduce the risk of injury by accident” (p. 5), recommending level access showers for everyone to prevent trips and slips.³¹² Thus, only one year before the passing of the Building Act 1991, New Zealand was considered at the forefront of thought regarding the safety, health, independence and well-being of all building users. However, when the Building Act 1991 was passed, disability design remained reserved for social and commercial spaces, and excluded private dwellings.

The Passing of the Building Act 1991

Nearly 30 years ago, when the Building Act 1991 was passed, the state established its current relationship with building users and building design. Its purpose was (amongst other things) to ensure the safety, health, physical independence, and well being of building users (Building Act 1991). Alongside this stated purpose the Building Act centralised the government of building activities and established a commercial relationship with local authorities who could charge fees and be held liable for costs. Similarly, the early 1990s saw significant change in the government of people with disabilities in New Zealand, with a shift away from funding or providing disability supports to a market model where services would be purchased (Lay, 1991; Shipley & Upton, 1992; Moore & Tennant, 1997). The rationale for this shift was in both cases argued to be due to increasing costs and a lack of consistency for consumers (Building Industry Commission, 1991; Shipley & Upton, 1992).

Although the Disabled Person’s Community Welfare Act 1975 had gone some way in addressing architectural discrimination, it was clear that its purpose was to provide

³¹¹ And other aspects of disability design.

³¹² Universal design has extended this discourse of what was “disability design” into design that is better for “everyone”. “The basic premise of Universal Design is that all people have differing abilities and needs when using the environment and to create a positive experience for the building user” and aim to create “Buildings for Everyone” (BarrierFree New Zealand, 2019).

financial assistance to individuals with disabilities and to support voluntary and private organisations that were concerned with the community welfare of individuals with disabilities. In contrast, the Building Act provided an opportunity to make all buildings safe and usable to all people, including those with disabilities. However, parliamentary debates demonstrate that in 1991 politicians could draw on discourses that allowed the safety, health, independence and well being needs of people with disabilities to be excluded from private dwelling design.

Despite an apparent rejection of eugenics, the view that “disabled people” should not have autonomy over their lives and that concentrated living in institutions was in the interests of the nation and the “disabled people” themselves, was still considered acceptable:

In recent years there has been a lot of talk about all disabled people moving into the community as of right. In some cases that has been found not to be in their best interests. It has also been found to be enormously expensive and there can be duplication, not only of housing, but also of medical care and other care that those people need... it could open up a whole area of litigation in which disabled people, or those people who represent them, could argue about what is appropriate or inadequate... It is really for the medical people to make a decision that is in the best interests of the disabled people concerned.
(Hancock³¹³, 1991)

While rehabilitation and disability design discourses had promised to transform people with disabilities into citizens able to compete with others to meet their needs in the housing market, the persistence of institutionalised living into the 1990s shows that this promise was never fully realised. Furthermore, although there had been strong involvement of people with disabilities in politics around the time the Disabled Person’s Community Welfare Act was passed in 1974 and into the 1980s (Angus, 1996; Tennant, 1993), their interests were poorly understood by those creating the 1991 Building Act:

The committee received many submissions - and I must say that they were very good submissions that the committee was pleased to receive because those of us who are not affected by disabilities have some difficulty in understanding the problems of those who do - from some people who were able to advise us and to point out the problems that they encounter. I am confident that as a result of those submissions the committee has acknowledged those difficulties and it has done its best in the Bill to provide for people with those problems. (Carter³¹⁴, 1991)

Indeed, in the early 1990s there was much debate about whether people with disabilities should have the right to be protected from discrimination,³¹⁵ and the human capital of those disabled in the absence of accident remained largely unrecognized.³¹⁶

³¹³ National Party MP

³¹⁴ National Party MP

³¹⁵ Dalziel, 1991 – Labour Party MP.

³¹⁶ Cullen, 1991a – Labour Party MP.

While there was a well-established connection between housing, building activities, and the health and wealth of the nation,³¹⁷ at the time the Building Act 1991 was passed, the economy was said to be in decline³¹⁸ and the proportion of dependents was said to be growing.³¹⁹ In determining that private dwellings were not required to be designed in accordance with disability standards, the government was simultaneously attempting to both reduce costs associated with housing modifications³²⁰ and withdraw state responsibility for housing conditions.³²¹

Conclusion

Since the emergence of New Zealand's colonial government, the need to construct places and passages that free citizens could access for the purpose of social or commercial interaction has been deemed essential for the creation of "one great nation" (Wynyard, 1854, p. 8). When the Building Act was established nearly 30 years ago, the members of parliament were immensely pleased that they had maintained the allowances given to people with disabilities to access such public spaces.³²² Despite a 165 year history of New Zealand government involvement in ensuring that private dwellings do not risk population health, private dwellings were excluded from regulation that would make them accessible to people with disabilities. Such exclusion highlights a problematic and dangerous relationship between the government and citizens with disabilities.

Whether or not the government sees an ethical responsibility in ensuring the same benefits for people with disabilities as other users of private dwellings, the interests of the state are entangled with the problem of architecture that creates dependence. This is despite a century of efforts to address the problem of the "dependent". At present, state funded assessment and modification of private dwellings to meet the situational needs of individual citizens represent costs to the nation. This situation not only excludes people with disabilities from free movement within the housing market, but creates additional issues as many private dwellings now function as guest houses, child care centres, businesses, and medical and dental surgeries, which means either further exclusion of people with disabilities from participation in society, or require

³¹⁷ "Housing is a basic social need. Housing is one of the building blocks of the so-called decent society. The Opposition knows that having decent housing leads to good health, proper education, a stable community, and a chance for people to take part in their community, irrespective of wealth" (Swain, 1991a – Labour Party MP); "Everyone knows that the building industry is absolutely pivotal for the economy---it provides jobs and skills, and it has a multiplier effect in the sense that it is able to impact on other industries, and particularly on regional Communities" (Swain, 1991b).

³¹⁸ Matthewson, 1991 – Labour Party MP.

³¹⁹ "For the first time in our history we have reached the point at which every full-time worker in New Zealand---every single one of the people who are working full time---pays taxes to support a person on a benefit or a pension, their spouses and their children. Somebody had to make hard and unpopular decisions" (McLay, 1991 – National Party MP).

³²⁰ Shipley, 1991 – National Party MP.

³²¹ Cullen, 1991b; Luxton, 1991 – National Party MP; Swain, 1991c; Tizard, 1991 – Labour Party MP.

³²² "Members of the House will note that the purposes and principles of the Bill include commitments to people with disabilities. Section 25 of the Disabled Persons Community Welfare Act lays the groundwork by spelling out the categories of buildings to which people with disabilities must have access. The Bill will reinforce that commitment and will help to make it happen. I am particularly pleased about that aspect" (Lee, 1991 – National Party MP).

expensive retrofitting by small business owners. The dangers of this current practice include:

- Retrofitting of buildings that are or were private dwellings is the most expensive way to include disability design (Page & Curtis, 2011). These costs will remain and continue to grow while new buildings are designed in ignorance of the problem that endures.
- By attaching disability design to individuals with disabilities (via Ministry of Health or Accident Compensation Corporation funding), the idea that people with disabilities should be under the control of health practitioners is maintained, putting their privacy and autonomy at risk. This practice also limits the ability of the population to freely mobilise in the housing market and to contribute to the health and wealth of the nation. Furthermore, once the person with the disability vacates a private dwelling, there is no incentive for the homeowner to keep accessible features, meaning accessible dwellings may be converted back to inaccessible ones.
- Current legislation means that people with disabilities do not have their safety, health, independence or well-being assured in private dwellings in New Zealand.
- The lack of availability of private dwellings that people with disabilities can use encourages institutionalised living, with the associated danger of putting their privacy, autonomy and right to live in the hands of others.

The problematic exclusion of people with disabilities as users of private dwellings must be addressed. A full review of the Building Act 1994 in terms of building performance for all building users is needed. Consideration should be given to the buildings that must be required to meet disability design standards (for example by adding private dwellings to the list of buildings that must meet the NZS4121 standard), or state involvement in the building market to ensure people with disabilities are included as building users. This could involve development of incentives to encourage homeowners and developers to meet disability design standards in private dwellings (see for example Hamilton City Council's Development Contributions Policy and Thames-Coromandel District Council Disability Strategy). Radical rethinking about the exclusion of people with disabilities as members of the population of building users is needed, along with recognition that the current exclusion risks citizens' privacy, autonomy, freedom to live outside of institutions and ability to build human and material capital.

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