View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by University of Calgary Journal Hosting

Journal of Applied Hermeneutics
ISSN: 1927-4416
November 12, 2020
©The Author(s) 2020

Healing Touch: Hermeneutics of Trauma and Recovery

Richard Kearney

Abstract

This is an edited, abridged, and revised version of a chapter written by Richard Kearney which will appear in his forthcoming book *Touch: Recovering Our Most Vital Sense* to be published by Columbia University Press in 2021. The chapter in the book contains many extensions, footnotes, and references that do not appear in this paper. Many thanks to Professor Kearney for his permission to print a version of this chapter in the *Journal of Applied Hermeneutics.*

Keywords

Touch, trauma, healing, carnal hermeneutics

Men have sunk very low. They've let their bodies become mute and they only speak with their mouth. But what d'you expect a mouth to say? What can it tell you?
-Zorba the Greek

No mortal is ever silent. If he does not speak with his mouth he stammers with his fingertips
-Freud

Corresponding Author:
Professor Richard Kearney
Boston College
Email: kearneyr@bc.edu

Psychoanalytic Beginnings

Sigmund Freud is generally recognized as the founder of trauma therapy. His first major insight on the subject came in *Beyond the Pleasure Principle* (1920), which he wrote while treating "shell shock" veterans returning from the trenches of World War I. His question was this: how are humans so wounded that they prefer to return to their pain compulsively than follow their normal "pleasure principle"? His answer was the existence of a death drive (*thanatos*) that accompanies our life drive (*eros)* and sometimes overwhelms it. Curiously, the mature Freud played down the role of touch in healing, privileging the intellectual interpretation of words over more embodied approaches. And yet Freud himself was a wounded healer in many respects. Not only did he suffer from his outsider status as a Jew in an anti-Semitic Vienna, but he also bore a more private suffering: his irremediable pain at the death of his daughter, Sophie. Indeed, it was arguably this personal trauma that enabled Freud to empathize with the pain of his own grandson, Ernst, at the "absence" of his (Ernst's) mother – the same Sophie – in a famous section of *Beyond the Pleasure Principle.* I am speaking of the much commented upon *fort/da* scene where little Ernst plays with a cotton spool in imitation of the coming (*da*) and going (*fort*) of his mother. Yet when Freud witnessed the cries of his grandson, he did not reach out and hold him. He sat and observed, recording the scene of suffering from a theoretical distance. He even appears to have ignored the obvious fact that his anguished grandson responded to this missing mother not only with the words *fort/da* – "now she's here now she's gone" – but also with *physical* child-play: a game of bodily gestures. Freud does, of course, note that Ernst casts the toy back and forth, but his diagnostic eye focuses on the psychic compensation provided by the play of words rather than the play of hands. He opts for a Hippocratic model of psycho*analytics* over a more Asclepian model of psycho*haptics*. Thus, Freud missed an opportunity to acknowledge the key role of tactility in therapy. He failed to see that talk therapy sometimes calls for body therapy. Little Ernst needed to handle the spool as well as speak the syllables *fort/da.*

To be fair, the early Freud did allow a limited role for the therapeutic laying on of hands when it came to recovering repressed memories – establishing a connection between the disremembered pathogenic scenes and the symptomatic residue traces of such events. He conceded in a letter to his colleague, Josef Bruer, that while verbal interpretation was primary, "reminiscence *without affect* almost invariably produces no results" (Freud, 1960). But these initial concessions were overshadowed by the whole controversy of transference and countertransference between analyst and analysand – confirming Freud's disapproval of the boundary-free experiments of disciples like Carl Jung, Sabina Spielrein, and Wilhelm Reich. Touch became the *bête noir* of the mainstream psychoanalytic movement. Cure was more about minds than bodies, as Freud felt it increasingly necessary to keep a distance from his patients, declining emotional or affective contact. Hence the great fear of countertransference – namely the overinvestment of the analyst's feelings in those of the patient. Perhaps his one Homeric nod was permitting his dog, Lün Yu, to sit in on sessions in the belief that the hound not only calmed his patients but also possessed the flair to signal peak moments with a wag of the tail.

The Freudian discretion regarding therapeutic touch was rigorously observed – with few exceptions – for several generations, reaching its hyper-linguistic extreme in Jacques Lacan's obsession with "floating signifiers" at the expense of suffering bodies. But things were to change with the emergence of a new era of trauma studies from the 1980s onward – a critical movement responding

to the diagnosis of PTSD symptoms after the Vietnam War and the rise of Holocaust and postcolonial studies, with their focus on somatic questions of affect and material questions of race, gender, and class. The leading figures here were often women – retrieving the neglected work of Melanie Klein – and included pioneers like Judith Lewis Herman, Cathy Caruth, Juliet Mitchell, Françoise Davoine, and Helen Bamber. The last of these, Helen Bamber, was one of the first therapists to enter Bergen-Belsen after the liberation and later went to work with Amnesty International where she treated torture victims in Argentina, Chile, and elsewhere. Bamber discovered that the best way to help sufferers of trauma was to be physically present to their pain. Not only to interpret, but to bear bodily witness. Not just to talk, but to receive and "hold" the suffering. To experience what she called a felt catharsis or "purging" (Bamber, 1998, p. 228). In her book *The Good Listener*, she describes sitting on bunks in concentration camps, holding the hands of inmates as they stammer and stumble through words and recall scenes of violation committed against them and their loved ones. "I would be sitting there in one of those chilly rooms, on a rough blanket on a bed, and the person beside me would suddenly try to tell me what it was like…and what was most important was to stay close to the survivor and listen and receive as if it were part of you and the act of taking and showing you were available was itself a healing act" (Bamber, 1998, p. 228). Bamber points to the need for affective witness, which goes deeper than the chronicling of facts (though that too is crucial). "We must," she says, "*acknowledge* the truth as well as having *knowledge* of it." We must *re-cognize* the somatic symptoms of trauma as well as *cognize* the causes. This double duty of being both physically present to the sufferer *and* representing clinical evidence is, she believed, central to healing. Without some element of embodied testimony, the inmates of the camps could not rise from their beds and walk. They could not survive their own survival.

Flesh Keeps the Score

Skin is the largest organ of the body, a total wrap-around surface that goes deep. It covers over two square meters of flesh with millions of neural connections, relating our inside to our outside. Skin has two sides, epidermal and endodermal, serving as a double cutaneous agent of tactility. The phrase "skin deep" actually means what it says. The physiological response to touch goes like this: "Receptors in the skin detect pressure and temperature and movement, and these signals shoot up the spinal cord and into the brain, which adjusts its chemical output accordingly. That the emotional responses become physical in predictable patterns suggests that our bodies evolved to respond favorably to touch – or at least to miss out on benefits where we are physically isolated" (Van der Kolk, 2015, pp. 27, 245-247). James Hamblin offers this basic account of tactile functioning in his book *If Bodies Could Talk,* a study that charts therapeutic map for the healing of the human body. He cites evidence of MRI scans showing how physical touch activates areas of the cerebral cortex, and he rehearses numerous studies demonstrating how touch lowers heart rate, blood pressure, and levels of the stress-related hormone cortisol. He also demonstrates how deep tissue massage therapy has proven effective for depression, stimulating neurotransmitters that modulate and decrease pain (Hamblin, 2016).

But this is only half the story. For, if the tactile body possesses extraordinary powers of healing, it is also the barometer of past hurts. The body carries traces of our shame, guilt, childhood conditioning, repressed desires, and deepest fears. Hence the need for a highly sensitive approach to touch in the treatment of trauma victims in therapy. This involves delicate discernment regarding

the classic too close/too distant question. While touch can, in certain circumstances, retrigger trauma, it can, in other circumstances, help establish a sense of trust and containment – areas crucial to trauma sufferers, for whom insecure and disorganized attachment and childhood abuse are often central. Reaffirming trust levels (a pre-requisite to good therapy) can release energies that have been frozen in the body by traumas too overwhelming to be registered in purely verbal-conceptual accounts.

In a groundbreaking study, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*, Bessel Van der Kolk (2015) presents cogent evidence for a therapeutics of touch. Confirming the basic thesis of physioneurosis – that our primary traumas are lodged in our bodies – the author argues that "talking cures" need to be grounded in bodily cures. Words are not enough to address the carnal "imprint" that a traumatic event leaves in our memory. Only some kind of incarnate gesture can recover the original wounding and help us realize that the danger is gone and that we can live in the present. "Healing depends on experiential knowledge. You can be fully in charge of your life only if you can acknowledge the reality of your body, in all its visceral dimensions" (p. 38). But in most contemporary Western medicine, the brain disease model has taken control out of our hands. In the U.S., the Hippocratic method has sidelined the Asclepian, with over one in ten Americans taking antidepressants and Medicaid (a U.S. government health program) spending more on antipsychotics than any other form of medication. Nondrug treatments are minimal and usually labeled as "alternative." Mainstream medicine, writes Van der Kolk, "is firmly committed to a better life through chemistry, and the fact that we can actually change our own physiology and inner equilibrium by means other than drugs, (that is) by such basic activities as breathing, moving and touching...is rarely considered" (p. 46). The Asclepian approach of body therapy, by contrast, proposes to treat sufferers of PTSD less as "patients" to be administered with pharmaceuticals than as "participants" in an interactive haptic healing process. As Peter Levine put it: "I grew up in a profession where it was deemed unethical to touch a client. I await the day when it will be unethical not to" (Levine, 1998).

Such an ethic of tactile therapy endorses a model of "somatic dialogue" whose benefits in the form of affirmative mutual mirroring between therapist and patient are associated with non-verbal formative processes. These processes are accessed through the therapist's psycho-bodily sense of their patients, as they register them via voice, gestures and touch still often ignored in standard therapy. Good trauma therapists, attentive to projective identifications, will often feel in their bodies an intuitive sensing of the patient's primal family world, their prelinguistic lived being and mode of relating. And this indeed is a "dramatic" presence, for we are first of all incarnate actors, performing with tactile bodies on the stage of life (Grey, 2010).

Faced with trauma, the mind often goes into denial and proceeds as if nothing happened. Meanwhile stress hormones continue sending signals to the muscles and tissues of the body – resulting in certain forms of somatic illness. Drugs, alcohol, or other addictive behaviors can temporarily delay unbearable feelings, but the body keeps the score. And no matter how much understanding the rational brain provides, it cannot "talk away" the pain. For real healing to happen, sufferers need to reintegrate the event into their felt lives: they have to move from "there" (where the trauma occurred) to "here" where they can be present to experience now. This doesn't mean that talk

therapy and medication are not useful or necessary, only that they are not sufficient. More is needed.

Van der Kolk cites current neuroscientific research showing the existence of an "emotional brain" in direct touch with the body. This middle brain operates at a different level than the rational brain, located in the prefrontal neocortex, and combines both the reptilian brain and the mammalian brain (known as the limbic system). It serves as a neurological center of operations and is deeply informed by our earliest relations with others, beginning at birth and forming our basic instincts for negotiating what is nurturing, pleasurable, or dangerous (pp. 274, 276). This emotional space is the first theater of "carnal hermeneutics," serving as a base camp for what neuroscientists call "mirror neuron" activity: a sensorium where we first respond to others in terms of bodily imitation and empathy – thereby prefiguring the onset of language. The emotional brain records our first steps in life, when mind and body are synchronous, and continues to keep us in touch with others' feelings – positive and negative – making us angry or vulnerable, calm or anxious (Gendlin, 1978, 2000; Levine, 1997, 2010; O'Hanlon, in press). *Respondeo ergo cogito.* Contemporary neuroscience clearly confirms the claim of both phenomenology and clinical therapy that we do not really know ourselves until we feel and interpret our sensations. Our most fundamental sense of ourselves is our body.

Body Therapy

Recent body-based methods – including sensorimotor and somatic psychotherapy – treat psychic wounds by going behind verbal explanations and tracing physical sensations back to the imprint of past trauma on the body. One thereby learns to revisit buried feelings that overwhelmed the patient at the time but can now, in retrospect, be re-accessed to allow for a modicum of tolerance, helping restore a physical capacity to engage and reprocess, even going so far as to transform the sensations of fear and panic into a more positive fighting energy. When the brain is knocked out by trauma, one first responds to the shock not in terms of plots with beginning, middle, and end but in fragments of feelings (Bosnak, 2007; Weineger, 2017). By going behind conscious surface narratives to the wounding sensations of the past, one can reintegrate screened traumatic memories into a "that was then this is now" recovery mode. The aim of somatic therapy is to get us back in touch with these pre-narrative sensations so that we may re-live them (and re-tell them), eventually incorporating them into our future. The goal is to reintegrate one's bodily experience of past trauma without being overwhelmed by the original pain and panic. A survey of 225 people who escaped the Twin Towers in 2001 showed that the most effective treatment in overcoming their experience was not talk therapy or sedation (though these greatly helped) but tactile therapies like acupuncture, massage, yoga, and EMDR (see Kearney, 2019). Trauma affect is registered first as sensation, then as image (flashbacks), then as story. Each step is important, but embodied sensation is primary. The aim of somatic reintegration is to relive the past "tactfully" in the here and now. Only then can one transform injured history into healing story.

We have argued that Hippocratic medicine is good at treating symptoms but ignores the underlying wounds. This is where Asclepian methods come in. Flesh keeps the score as the bruise behind the scar. The bruise is deeper than the scar, for while the scar is visible for all to see, bruises lie beneath the skin, pointing inward to subcutaneous injury and observing a different modality of sense and temporality – what we might call "infra-sense" and "infra- time" (Gallagher & Kearney, 2018;

Kearney & Gallagher, 2017). Deep therapy calls not for instantaneous cures but a painstaking work of hypodermal recovery. As Joan Wickersham (2008) notes: "While some healing does happen, it isn't a healing of redemption or epiphany. It is more like the absorption of a bruise" (p. 317). In contrast to the exterior scar that everyone can see, the healing bruise reabsorbs pain from inside. Indeed, sometimes there is no feeling in that spot for years, and when the nerves finally awaken, the sensations can be transferred to other parts of the body, as if replacing the wound with new feelings (Gallagher & Kearney, 2018)). While unconscious wounds take shape in time, and scars take shape in space, bruises are where time and space meet.

When describing the therapy of touch, the story of Helen Keller is instructive. Deaf, blind, and mute from a viral infection she contracted at the age of nineteen months, Helen regained her power to communicate at age 5 thanks to the training of a partially blind teacher, Anne Sullivan. The breakthrough came when Sullivan led Helen to a water pump on April 5, 1887, and, holding her hand under the flow, finger-spelled the five letters w-a-t-e-r onto her palm. Something tangible happened, and the meaning of words became clear. Anne could see in Helen's face that she understood. This manual alphabet, triggered by the crossing of word and touch, restored Helen's ability to relate with others. It brought Helen's "tactual memory" into full communion with another human being (Hederman, 2019). Helen later recounted the key collaboration between hands and words in her autobiography:

> We walked down the path to the well-house, attracted by the fragrance of the honeysuckle with which it was covered. Someone was drawing water and my teacher placed my hand under the spout. As the cool stream gushed over one hand she spelled into the other the word water, first slowly, then rapidly. I stood still, my whole attention fixed upon the motions of her fingers. Suddenly I felt a misty consciousness as of something forgotten, a thrill of returning thought, and somehow the mystery of language was revealed to me. (cited in Hederman, 2019, p. 237)

Langston Hughes writes of Helen's healing through touch: "She, in the dark / Found light / Brighter than many ever saw" (Hughes, 1994, p. 146).

Reintegrating Trauma

When it comes to healing trauma, the body is the bridge. Flesh harbors places not easily accessed by our rational, linguistic consciousness – however necessary the latter is before and after the process of "tactful" engagement. Van der Kolk calls such primal tactful perception "interoception" which he sums up as follows:

> We can get past the slipperiness of words by engaging the self-observing body-based self system, which speaks through sensations, tone of voice and body tension. Being able to perceive visceral sensations is the very foundation of emotional awareness. If a patient tells me that he was eight when his father deserted the family, I am likely to stop and ask him to check in with himself. What happens inside when he tells me about that boy who never saw his father again? Where is it registered in his body? When you activate your gut feelings and listen to your heartbreak – when you follow the interoceptive paths to your innermost recesses – things begin to change. (pp. 62-63)

In other words, getting in touch with deep self-pain involves a visceral perception that only subsequently translates into verbal-conceptual thinking.

The primary work of transmission is located in the amygdala: two small almond-shaped structures that reside within the limbic brain. The amygdala serves as a "smoke detector," interpreting whether incoming sensory data from skin, ears, eyes, and nose (registered by the thalamus) are relevant for our well-being or survival (Van der Kolk, 2015, p. 65). It tells us what is safe and unsafe. If it senses pain, it summons various stress hormones (cortisone and adrenaline) and our automatic nervous system to organize a full body response, putting us into flight or fight mode. For this reason, it is important that our somatic alarm system responds to others' behavior with tact and savvy lest we overreact or underreact to what is happening. And here the amygdala calls for supervisory expertise from the "watchtower" – the medial cortex situated in the prefrontal brain area that offers rational "objective" guidance on our behavior (Van der Kolk, 2015, pp. 66-73). A sane response to danger requires collaboration between the upper watchtower and the lower smoke detector, lest we "take leave of our senses" – by either flying off the handle (too much emotional brain) or withdrawing into a denial of feeling (too much rational brain). Both our cerebral and carnal cartographies need to be calibrated for the appropriate reaction. Using touch, breath, and movement, trauma therapy can work carnally from below while also inviting top-down adjudication. By contrast, when our two brains, rational and emotional, are out of sync, a tug of war ensues: a battle largely played out in "the theatre of visceral experience" – heart, throat, belly, and lungs – leading to "physical discomfort and psychological misery" (Van der Kolk, 2015, pp. 206-207). Post-traumatic stress disorder is symptomatic of a blanking-out of pain where sufferers may opt to replace the original wounding with numbness and evasion (alcohol, drugs, escape fantasies). In such cases a sense of carnal re-anchoring in current bodily feelings is needed to provide a proper distinction between where I am *now* in the present and where I was *then* in the past. The ultimate goal of trauma therapy, Van der Kolk holds, is to get us back in touch with our injured selves so we can be more fully grounded in the present (p. 76).

Most of our primary responses to others are felt in the gut, not the mind. In trauma this is particularly so, wounds being registered less by the rational brain accessible to narrative memory, than by the emotional brain expressing itself in physical responses: "gut-wrenching sensations, heart-pounding, breathing becoming fast and shallow, feelings of heartbreak, speaking with an uptight and reedy voice, and the characteristic body movements that signal collapse, rigidity, rage or defensiveness" (Van der Kolk, 2015, pp. 207-208). Purely logical explanations – why you feel this way or that – do not change your experience. Radical healing calls for a deeper somatic transformation, following the old adage: the hair of the dog that bit you. Where the disease is, there you find the cure. Recovery requires reconnection. And to help us redraft our somatic maps, we need to open revolving doors between the disjoined territories of reason and feeling. The aim of trauma therapy is, accordingly, to put the mind into tactful contact with the body. How many of our mental health issues, from self-injury to drug addiction, begin as efforts to deal with the intolerable pain of our emotions? "Until recently," observes Van der Kolk, "the bidirectional communication between body and mind was largely ignored by Western science, even as it had been central to the traditional healing practices in many other parts of the world, notably in India and China. Today it is transforming our understanding of trauma and recovery" (p. 76).

So, the ultimate aim is to turn visceral *reactions* into felt *responses* – responses we can then

translate into new forms of narrative discourse. This is why so many trauma specialists today are working with breathing, movement, rhythm, and touch to address basic somatic functions of the sympathetic nervous system (SNS) and heart rate variability (HRV). Indeed when it comes to the treatment of PTSD, one of the most effective steps is "limbic system therapy," which brings our rational and emotional brains into collaboration, releasing the body from its default extremes – namely, the shut-down or hyperarousal modes that cause illness.

To see better what this means, just think of our colloquial expressions, "My heart sank," "my stomach churned," "my skin crawled," "I was scared stiff," "I choked up," and so on. We first respond to pain as "humanimals," and it is at this level that we find primary release (Van der Kolk, 2015, p. 88). Most of our psychological illnesses are registered in terms of "dissociation," or what William James called "sensory *insensibility*" – the collapse of connection between our mental and somatic components; so it makes sense that our psychic wellness takes the form of a return to sensory *sensibility"* (William James, cited in Van der Kolk, 2015, p. 92). Neurotic or traumatized people feel notoriously unsafe inside their own bodies, the past gnawing away at the nerves and sinews. But where the harm is, there is the healing. We need to re-own our tactile experience because, where all else fails, our bodies keep count. "If the memory of trauma is encoded in the viscera, in heartbreaking and gut-wrenching emotions, in autoimmune disorders and skeletal/muscular problems, and if mind/brain/visceral communication is the royal road to emotion regulation, this demands a radical shift in our therapeutic assumptions" (Van der Kolk, 2015, p. 112). William James offers this telling account of one of his patients describing how she lost touch with her body and her world:

> Each of my senses, each part of my proper self, is as it were separated from me and can no longer afford me any feeling. This impossibility seems to depend upon a void…due to the diminution of the sensibility over the whole surface of my body, for it seems to me that I never actually reach the objects which I touch. All this would be a small matter enough, but for its frightful result, which is that of the impossibility of any other kind of feeling and of any sort of enjoyment, although I experience a need and desire of them that render my life an incomprehensible torture. (cited in Van der Kolk, 2015, p. 92)

If we lose touch with ourselves, we lose touch with the world. No tactile connection, no resonance between self and other.

D.W. Winnicott, Bessel Van der Kolk, and Helen Bamber (drawings by Simone Kearney)

A Short History of Attachment Theory

It seems that human health is intimately linked to questions of attachment. In what follows I briefly rehearse some research on this subject from doctors, therapists, and ecologists as it pertains to the tactile therapy of trauma.

It was the British child psychologist John Bowlby who first developed "attachment" theory in the 1940s and 1950s to explain the formative relationship between mother and child before, during, and after birth. Our prenatal existence, he showed, is already one of deep tactility and sound (the fetus responds to the rhythm of the mother's voice and movement). As we enter the world, we live a drama of attachment and detachment; "we scream to announce our presence. Someone immediately engages with us, bathes us, and fills our stomachs, and, best of all, our mother may put us on her belly or breast for delicious skin-to-skin contact. We are profoundly social creatures; our lives consist of finding our place within the community of human beings" (Van der Kolk, 2015, p. 115). Our interpersonal relations are fundamentally tactual, and the goal of healthy child-rearing is to balance the double need for somatic attachment and detachment in right measure. The premature removal of a young infant from its parents – for reasons of health or hospitalization (isolation or quarantine) – can have a deep impact on its later experience. On the other hand, it is well known that excessive infantile fusion with the mother may require timely weaning, toilet training, and regularly spaced feeding.

Donald Winnicott developed the theory of attachment into the related notion of "attunement." Studying the way mothers hold and caress their infants, he surmises that the tactile interaction between mother and child, well before the acquisition of language, was at the root of the child's sense of self and other, informing a lifelong identity. The way the mother carries her infant influences the capacity to experience the body as "the place where the psyche lives," and it is this "visceral and kinesthetic sensation of how our bodies are met" that prepares for what we later experience as "real" (cited in Van der Kolk, 2015, p. 122). Indeed, untimely withdrawal of touch may do worse psychic damage than outright hostility or anger. The notorious case of abandoned orphans in Ceaucescu's Romania – where infants were left untouched for months on end – bears this out. As does the finding of Austrian doctor René Spitz, concerning a postwar orphanage that went to great lengths in 1945 to prevent its children from being exposed to disease, giving them excellent nutrition and medical care, but minimizing physical contact for fear of germs. Thirty-seven percent of the infants died before reaching the age of two (cited in Van der Kolk, 2015, p. 122). Failings in the primary tangible attunement between mother/primary caregiver and child can lead to malfunction in later life. Whence the claim that infants lacking physical attunement are susceptible to missing feedback from their own body as a primary site of pleasure and orientation.

In his book *The Feeling of What Happens: Body and Emotion in the Making of Consciousnes* (2000), neuroscientist Antonio Damasio builds on the insights of former psychologists to explore the relationship between inner states of the body, which comprise our "primordial feelings" and our basic emotions of communication and survival. Damasio describes how our sensible world first takes shape in the womb with tactile feelings of wetness, warmth, fluidity, hunger pangs, and satiation, along with heartbeat and blood flow, fatigue and arousal. All these prenatal sensations inform our basic nervous system prior to any conscious awareness. They are deeply formative and never go away, constituting a "proto-self" of "wordless knowledge" – a carnal subject that in time

enters into communication with our more developed linguistic rational selves. But we ignore this proto-self at our peril, a denial that leads to illness. Only by acknowledging the primal *savoir* of muscles, belly, and skin – and using all our savvy to reconnect with it – can we find healing through "attunement" (Damasio, 2000).

Another contemporary scholar, Tiffany Field, bears out the findings of attunement theory in a series of empirical studies on touch and health. Basic human touch, she shows, leads premature babies to gain weight: a finding supported by a study in the medical journal *Pediatrics* (1986) detailing how ten days of regular "body stroking and movements of the limbs" led babies to grow 47 percent faster and averaged fewer days in hospital. Field, a developmental psychologist, founded the Touch Research Institute at the University of Miami's Miller School of Medicine, where she extended her research of "touch deprivation and enhancement" beyond infants (preterm, full-term, and orphaned) to adults with chronic pain, pregnant women, and elders in retirement or hospice care (Field, 2014). The Touch Research Institute is also dedicated to studying the effects of tactile therapy as it relates to practices such as massage therapy, yoga, tai chi, music, and movement. This application of such research to everyday health care is today evidenced in a series of popular studies of the healing benefits of ordinary handshakes and hugs, with explanatory titles like "The Healing Power of Touch," "Can We Touch?" or "Is It Time We Talked About Touch?".

Recent epigenetic research shows that key alterations in our bodies are made not just by toxins and biochemical stimulants but by the way we resonate with our fellow beings. For all the good medication does for trauma sufferers, the most effective way of alleviating stress and suffering is, new research indicates, by being "touched, hugged and rocked": actions that quell excessive arousal and make us feel "intact, safe, protected and in charge." Moreover, "gestures of comfort are universally recognizable and reflect the healing power of attuned touch" (Van der Kolk, 2015, p. 217). Parents and parental figures know this well, as do most good primary caregivers, nurses, and doctors – even if the tactile gesture in question is as simple as holding a patient's arm or placing a hand on their forehead or pulse. Thus, do professional carers attend to the temperature, breathing, and heart rate of patients, helping them become attuned to their bodies as they regain health and integrate their powers of living connection. Indeed, Dominique Meyniel, professor of medicine at the Hôpital Tenon in Paris, is known for teaching his students the critical importance of touching patients with a gentle but firm clasp, providing them with a sense of physical assurance and trust. This gesture of "holding" proved extremely important in patients' positive response to treatment, and Professor Meyniel was clear on the therapeutic benefits accruing to elderly patients – especially in need of touch – and the accompanying experience of connection, warmth, and concern. Code 10-1993 of Meyniel's medical instructions reads as follows: "It is forbidden for nurses, medical interns and students *not* to touch aging patients. In addition to clinically examining them, they should hold their hands for long periods" (Meyniel, 2015, p. 157). These simple modalities of touch involve a basic reading of patients' bodies and of the reciprocal impact on their carers.

On a more personal note, I would like to say something about my own experience of dealing with depression with the aid of embodied practices. While I was very grateful to medical psychiatry for offering remedial sedatives and antidepressants, I found these treated the symptoms – insomnia, acute anxiety, lack of appetite, exhaustion – rather than the roots. I ultimately discovered modes of "embodied" healing to be more effective and long-lasting. In my case, these included Iyengar yoga practice, Shiatsu massage therapy, pranayama deep breathing, and regular physical exercises

like swimming and fishing in the Irish Sea, planting trees and shrubs, and spending as much time as possible with animals (especially horses and dogs). The more I walked the Wicklow hills with my retriever, Bella, the more the black dog slipped away. In all this I followed the advice of a wise friend: "Enough talk, back to the body." And another important step on this path of embodied healing involved walking pilgrimages from Vézelay to Santiago de Compostella and from Rishikesh to Gongotri, source of the Ganges. I didn't manage the full trip in either case, I confess, but both journeys offered deep affective healing – a slow, steady reintegration of head and heart, mind and body, spirit and flesh.

Toward a Commons of the Body

The body is the place where the psyche lives – both personally and communally. The implications of tactile embodiment for public health practice and policy today are enormous. Van der Kolk concludes his monumental review of somatic therapy research with the claim that trauma is the "greatest threat to our national wellbeing" (p. 350). This is a startling claim largely unreported in official trauma statistics, which tend to focus on victims of war, genocide, natural disasters, or terrorism, while neglecting more common casualties of physical and psychic wounding found in domestic abuse, car accidents, neighborhood gang feuds, or school bullying. These lower-case traumatisms tend to pass beneath the Big News grid and are often treated with quick-fix solutions like painkillers, antidepressants, short-term behavioral therapy, or social work. But such solutions, while satisfying the criteria of busy professional clinics and insurance companies, do not always work in the long term, for they rarely address the underlying causes; and they frequently neglect what current research shows to be the most important thing for any successful treatment of trauma, namely sufficient human contact. Institutions that treat traumatized people all too often bypass the "emotional-engagement system" that is the register of our pain, concentrating on reforming "faulty thinking" and suppressing difficult behaviors. But deep healing only comes, as Asclepius knew, when we acknowledge the primacy of deep embodied interactions – both personal and communal. Public health strategists take note.

The need for healing through "contact" is evident at the collective public level quite as much as the private therapeutic level. Of particular relevance here for the development of what I am calling a "commons of the body" is the work of communal memory. I am thinking particularly of truth and reconciliation projects in postconflict societies like South Africa, Rwanda, or Northern Ireland. Here enemies come face to face and share physical space and gestures with each other, as a way of acknowledging and overcoming violence. Victims and perpetrators of seemingly irreparable communal traumas make contact in public tribunals in efforts to find escape from cycles of recrimination and bloodletting; they engage in a collective "working through" of wounds in hopes of some kind of healing. Especially instructive here, for example, is the testimony of Pumla Gobodo-Madikizela, a founder of the antiapartheid movement in Capetown, who tells the story of touching the hand of one of the most criminal executioners of the apartheid regime, Eugene de Kock (see Gobodo-Madikizela, 2019). Her testimony is all the more remarkable for the fact that she happened to touch his "trigger hand" (Kearney, 2020) used for shooting his victims. It was her totally unpredictable gesture of touch, she realized, that sparked a moment of "impossible forgiveness": her forgiveness somehow triggering his retrospective empathy for his victims, which no amount of legal or institutional retribution could have achieved. Pumla Gobodo-Madikizela

challenged the senseless repetition of wounding where trauma breeds more trauma, pain replicates pain. That is why endless revenge cycles need to be broken. Why we need to replace handguns with handshakes.

Such exemplary experiences suggest that language – while essential – cannot substitute for body work. No matter how much talking sufferers of collective historical conflict engage in, they continue to suffer recurring pain until they convene in a communal space – psychic or physical – with their adversaries. Stories are very important, but they are not always sufficient (Kearney, 2002). Vital engagement with bodies sometimes seems necessary for more lasting healing to occur. It is not sufficient to recount one's wounds, one also needs to touch and be touched.

In sum, one might describe the healing arc of trauma therapy – at both personal and communal levels – as a movement through different somatic stages. One could put it like this: wounded by a *foreign body* (a common trope for trauma), we become a *nobody* (dissociation) that requires connection with *another body* (healing) in order to become *somebody* again (recovery). Moving thus from traumatized nobody to reintegrated somebody is an empathic opening to *everybody* who has suffered pain. Human sense is ultimately embodied sense. A commons of the body.

References

Bamber, H. (1998). *The good listener.* Wiedenfeld and Nicolson.

Bosnak, R. (2017). *Embodiment: Creative imagination in medicine, art and travel.* Routledge.

Damasio, A. (2000). *The feeling of what happens: Body and emotion in the making of consciousness.* Houghton Mifflin Harcourt.

Field. T. (2014). *Touch.* MIT Press.

Freud, S. (1920/2003). *Beyond the pleasure principle.* (original title *Jenseits des Lustprinzips*; J. Reddick, Trans. & Ed.) Penguin Books.

Freud, S. (1960). *Letters of Sigmund Freud 1873-1939* (E.L. Freud, Ed.). Dover.

Gallagher, S., & Kearney, R. (2018). *Wounds to scars.* https://www.youtube.com/watch?v=O3i5W9w-jTg

Gendlin, E.T. (1978). *Focusing.* Bantam Books.

Gendlin, E.T. (2000). *Let your body interpret your dreams.* Hushion House.

Gobodo-Madikizela, P. (2019). Preface. In D. Veldsman & Y. Steenkamp, *Debating otherness with Richard Kearney: Perspectives from South Africa.* Oasis.

Grey, E. (2010). *Unify your mind: Connecting the feelers, thinkers, and doers of your brain.* CMH&W.

Hamblin, J. (2016). *If bodies could talk: A guide to operating and maintaining a human body.* Doubleday.

Hederman, M.P. (2019). *Living the mystery: What lies between science and religion.* Columba Press.

Hughes, L. (1995). *The collected poems of Langston Hughes* (A. Rampersad, Ed.). Vintage.

Kearney, R. (2019). The recovery of the flesh in Ricoeur and Merleau-Ponty. In R. Kearney et al. (Eds.). *Somatic desire: Recovering corporeality in contemporary thought* (pp. 41-55). Rowman and Littlefield.

Kearney, R. (2002). *On stories.* Routledge.

Kearney, R., & Fitzpatrick, M. (2020). *Radical hospitality: From thought to action*. Fordham University Press.

Kearney, R., & Gallagher, S. (2017). *Twinsome minds: An act of double remembrance.* Cork University Press.

Levine, P.A. (1997). *Waking the tiger: Healing trauma.* North Atlantic Books.

Levine, P.A. (2010). *In an unspoken voice: How the body releases trauma and restores goodness.* North Atlantic Books.

Meyniel, D. (2015). *Le Couloir des urgences.* Cherche Midi.

O'Hanlon, R. (in press). The potential of touch. In *The art of mourning.* Bloomsbury.

Van der Kolk, B. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma.* Penguin.

Weineger, R. (2017). *Heartwork: The path of self-compassion – 9 practices for opening the heart.* Shambhala.

Wickersham, J. (2008). *The suicide index.* Harcourt.