**Paper Abstract: Kinesthetic Intelligence, Care, and the Ethics of ‘Home’ in a Hospital and Ward Setting**

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This paper, which has emerged out of a conversation between the fields of psychiatry, law (particularly criminology), medical philosophy, theatre, and dance, seeks to pose questions about the nature and quality of care in a prison ward setting and, by extension, institutional milieus such as hospitals, and schools. Inmates – “violent offenders” – in a county jail in San Francisco, were treated through an intensive program, the Resolve to Stop the Violence Project (RSVP), designed to deploy a restorative justice system by engaging a variety of somatic approaches to care, while building an ethics and an environment of mutual responsibility and trust. Focused around the “male role-belief system,” whereby men learn to assert themselves aggressively according to relations of dominance, over women, as well as other men, “acting out” in case this relationship should be compromised (resulting from a perceived “lack of respect” or undermining of the man’s dominant “role,” if not his “real” self); and a practice of empathy with “survivors” – victims of violence – through story-telling, and kinesthetic role-playing, this program sought to create an immersive environment in which the “whole” person was treated, and cared for.

Patients from non-Western cultures, long thought to be prone to ‘somatisation’ are now increasingly understood to be using their bodies as an expression of distress, much as patients and inmates from Western cultures might use words (Patel et al., 1995). Participants in the RSVP program included a spectrum of violent offenders charged with assault, domestic violence, armed robbery, and rape. They were mandated to the program while awaiting trial, or after sentencing, and remained in the program for the entirety of their term in jail. The program offered them a variety of activities, from psychotherapy to acupuncture, and job skills to movement therapy. What was found, however, was that the empathy-building practices which resulted from this multi-modal approach (Gilligan and Lee, 2005) might be attributed less to the quality and diversity of the activities than to the total “context” or “home” in which they were located. The program ran 12 hours a day, 6 days a week; participants were housed in open-plan dormitories, focused around a central activity space, and shared meals. This immersive experience built an atmosphere of trust, such that newcomers quickly learned to adapt to a new set of rules, where demonstrations of aggression and “acting out” were not rewarded, but ostracized by the social group.
This shift, this paper argues, should be seen as a focalization of the therapeutic process – resulting in a shift towards great empathy, social cohesion, and a “real” sense of self-worth not dependent upon acting out a male “role” founded in the assertion of a singular superiority – around the “hearth” and home. The “frame,” understood in psychotherapy as well as in theatre, dance and visual art theory, is the site where therapeutic shifts “happen.” It is in engaging the frame – the roof – and the dramaturgy of the house and home (here situated in the central activity space) that trust and empathy begin to happen. Such activities as sleeping side-by-side, in the 62-bed male dormitory, engage a kinesthetic sense of proximity, and touch – without aggression – such that participants learn to be close to one another by virtue of this proximity. The implications for care-giving and medical practice, as well as criminal justice, are enormous, and require further investigation into concepts of “kinesthetic intelligence” as well as kinesthetic empathy.

Bibliography


