Volume 17
Issue 1
2023

Touching at Depth During the COVID-19 Pandemic: What Not Touching Babies Can Teach Us about How to Improve Healthcare

Kathleen Rice

> After maybe three days, my husband's parents came over from Salt Spring Island. We made a mug of coffee, we got muffins, and they brought their own lawn chairs. They sat out on the lawn below our apartment balcony and looked up at their grandson, our baby, and I just bawled the whole time. I just cried and cried because it just seemed impossibly sad that they couldn't properly hold, or smell, or touch their first grandson, their first grandchild … . Eventually, after about four weeks, we decided that they could actually hold the baby. There were a lot of tears on all sides about that. (Interview extract, July, 22, 2020)

> We drove to my parents and let them see the baby through the car, which is not the same. It's really sad, actually. My parents couldn't even hold her or touch her. They had to just look at her through a car window. (Interview extract, August 7, 2020)

The statements above were recounted to me by "Vanessa" and "April," first-time and second-time mothers, respectively, when I interviewed them as

part of a large qualitative research study looking at the impacts of COVID-19 pandemic policies on experiences of pregnancy, birth, and early parenthood in Canada. Theirs were among the first interviews that I carried out for this project, and both conveyed a theme that has since come up frequently in the nearly 70 interviews that I have collected with people who were pregnant and gave birth in Canada during the first pandemic year. Specifically, I refer to repeated expressions of grief and concern expressed by new mothers over the fact that friends and family had not been able to hold their babies. Although most of these mothers introduced their newborns to close friends and family from a safe distance quite soon after giving birth, their narratives suggest that seeing the baby, but not touching it, failed to meet their expectations for how their newborn should be welcomed, and was often emotionally difficult rather than joyful.

I didn't make much of this at first, but as I conducted more and more interviews, I began to wonder why this particular issue came up so often in response to very general questions about what it had been like to give birth to and care for a newborn during the pandemic. I've ruminated long and hard about the significance of this, especially in relation to other data from the study, which shows that many women who gave birth in hospital during the pandemic felt neglected and abandoned by the Canadian healthcare system. In making sense of this, I take you on a journey through my study data, social theories of touch and affect, and my own autoethnographic experience of early parent-

hood during the pandemic, to reflect on two step-wise questions. Firstly, what can reactions to social distancing practices and related policies teach us about the relationship between touch, affect, and intimacy in Canada? And secondly, how can this knowledge help us improve healthcare?

Social norms of interpersonal touch are cultural (Classen, 2020), as are the affective experiences that touch evokes and entails (Classen, 2020; Kinnunen, Taina, and Kolehmainen, 2019). In Western society, physical or "haptic" touch is closely aligned with emotional intimacy—as implied for instance, in expressions like "being touched" by a kind gesture. Philosophers who have addressed physical touch and affect, such as Maurice Merleau-Ponty (2013) and Luce Irigaray (2009), root the connection between touch and affect in the simultaneous reciprocity of touch—these hands are both touching and being touched; I am touching you at the same time as you touch me. I learn that I am a subject through the intimacy of being touched, and in touching-being-touched, subjectivity is necessarily intersubjectivity vis-a-vis the world (Maclaren, 2014). Bringing this closer to my research, for Merleau-Ponty, the mother-infant relationship is the touchstone example of inter-embodiment and intersubjectivity that is illustrated by the hand touching hand (2013). Ample research suggests that mothers of newborns experience their bodies as phenomenologically entwined with those of their babies, a sense that is enhanced by acts of physical intimacy, affection, and care (Lupton, 2013). Although a baby likely does not have the

same affective experience that a grandparent does when the grandparent holds a baby for the first time, being securely held *is* arguably the first affective experience of human life (Walkerdean, 2010). Given all this, having loved ones hold your newborn may be an affective touch experience that exceeds most other forms of indirect touch. The pandemic has obviously placed a barrier between opportunities for this kind of intersubjective intimacy.

Additionally, social researchers interested in touch, affect, and intersubjectivity in Western societies have noted that the degree of intimacy in a relationship is held to be measurable and perceivable to self and others in spatial and temporal terms (Tahhan, 2014). That is, in close relationships and during weighty interpersonal encounters, like goodbyes, long-awaited reunions, or in situations where emotional support is called for, closeness, intimacy, and care are built, sustained, and reproduced through the phenomenon of little space between individuals (e.g., a tight hug) and longer time investment (e.g., a lengthy embrace). Emphasis is placed on showing care and emotions through action that is strongly haptic. The pandemic disrupted this as well.

In my research study, the inability to touch in this way was not only upsetting for many participants. In some cases, it actually *harmed* relationships between new mothers and people who are emotionally close to her. For instance, "Audrey's" second child was born in Toronto at the beginning of the first wave in Canada, in April 2020, long before anyone was vaccinated and when there was

much fear and little known about the virus' transmissibility and virulence. She had a difficult birth, followed by serious medical complications for both Audrey and her newborn son, which required days of hospitalization. Once she returned home with her baby, she did not receive the attention and support from friends and family that she had expected. She recognized that the pandemic was a factor in keeping people away. Public health guidelines strongly discouraged contact outside immediate households, and people were likely reluctant to come in close contact with individuals who had recently been in hospital. Nevertheless, Audrey viewed their physical distance, particularly their refusal to visit or touch her son, as sad and unnecessary:

> I just felt like nobody was acknowledging that he was born, and then nobody came. Or they'd just be like, "Oh, I wish I could hold him," and me and [my husband] would be like, "Oh, you're totally welcome to," and they wouldn't. You know? They just wouldn't, and it would just be so sad that nobody would hold him, even with a blanket, with gloves, with masks, outside, two meters away from me. (Interview extract, August 31, 2020).

As the interview progressed, it became clear that she perceived this as a conscious act of affective distancing from her:

> One could say no one was able to help us because of the quarantine, but I perceive it as no one was wanting to help us.

> I'm really angry because no one even did the two-meters—apart outside visits with the kid. My parents also, for example, were at home at my house, looking after my toddler while we were at the hospital, but they left two days before we brought the baby home. They could have obviously just maybe stayed two more days and met the baby, but they didn't, they went home two days early, and then they didn't meet him for months. My husband's brother didn't hold him until the last day of June, and he was born March 15. That was really upsetting for me. (Interview extract, August 31, 2020).

Mothers in my study were not always angry in this way. Some experienced and expressed sadness, confusion, or a sense of neglect. These damaged relationships are one outcome of the pandemic that may take some time to mend. However, beyond the ramifications of this for the relationships between study participants and their loved ones, with time I have begun to see connection between these experiences and emotions, and similar emotions of anger, sadness, and neglect expressed by mothers who had difficult experiences in hospital. These women were left alone in hospital to recover from medically complicated births because pandemic policies required their partners to leave shortly after they gave birth or prohibited their partners from being present in hospital altogether:

> It was terrifying. I'd never had a baby before, and I had the whole night and then

the whole next day to take care of a newborn by myself after having a hard labour and delivery. I was there alone. I was on pain medication, but I was still in pain. It was not set up to help women at all. It was more helpful for the staff than it was for the parent. I felt—not by my partner, but by our health care system during this time—abandoned and forgotten about ("Amanda," first-time mother, Interview extract, July 7, 2020).

I was using a wheelchair to move around because the NICU is up several floors. We would try and sneak [my husband] in to just wheel me to the place, but then a nurse recognized us, and we got yelled at and he had to leave, and so I had to start walking to the NICU by myself. Again, this is days after the [emergency cesarian] surgery, to go on these huge walks up to the fourth floor … I was just breaking. Then I had to go sit in this crazy uncomfortable chair with the baby, and it was just really hard physically, by myself, to do all this stuff. The nurses weren't allowed to come near me. I'm like, "I need help, I need help with all of these wires, my baby is attached to 7000 wires. I can barely move, the baby is nursing, my water is over there," and no one could help me. Instead of just being understanding, I was yelled at. I was like "Don't you understand?! I just

had a surgery, and my baby is sick." I was pretty depressed. I would cry every day; I was so upset. (Audrey, Interview extract, August 31, 2020)

Many women spoke of being left alone with their babies for hours and hours, in pain, in sterile hospitals rooms with no one checking on them, feeling abandoned and in despair. Some, like Amanda, stated that they had lost trust and confidence in the healthcare system. This is obviously concerning. I've written elsewhere some pragmatic recommendations around practical support for women in these and similar situations, but I think there is an opportunity here to think about this on a more affective, relational level as well. To accomplish this, I draw inspiration firstly on my own experience of a situation where I have felt *not* alone despite the maintenance of physical distance—that is, where the pandemic has provided a new opportunity to overcome the physical boundaries that separate us. While we are likely all now familiar with online meetings and Zoom catch-ups with friends that we have not (or at least, until recently) seen in person for months or years, what comes to mind is a new friendship with my two-year-old son's best friends' parents. We met them during the pandemic because our sons go to preschool together. I consider these people friends, but until very recently I had never touched them, been in their home, or met any of their other friends. We have, though, felt close and supported by one another through difficult times, via a friendship built around watching our sons play together at

the park; waiting, masked, outdoors in winter for our turn to go in, one at a time, to the preschool to fetch our children; and through frequent messages from the preschool about our sons' friendship via an app. Sharing enjoyment of our sons' joy in each other's company has been the foundation of a friendship cultivated largely at distance.

Such experience leads me to believe that during the pandemic we may, as a society, have become more attuned to fostering closeness and intimacy without haptic contact. In theorizing this form of closeness at distance, I have found it helpful to look at anthropologist Diana Adis Tahhan's concept of "touching at depth," ("The Japanese Family, 2014"; "Touching at Depth," 2013), which she describes as "a thick, inhabited space between people, which enable[s] feelings of intimacy and closeness" (Tahhan, 2014, p. 8) without the need for physical touch. Tahhan developed this concept from the work of Merleau-Ponty—specifically, his concept of "flesh," that is, the body in its wholeness that is meaningful in its participation with the world—and from Japanese philosopher Hiroshi Ichikawa's concept of *mi*. *Mi* is a concept of the body as an all-encompassing whole that includes physical body, mind, heart, self, and relationality, with all its interconnection to the environment. Both philosophers offer a theory of embodiment and affect that breaks down the binary opposition of subject/object and reveals a different ontology of personhood that is *both* subject and object at once (Tahhan, 2014).

For Tahhan, touching at depth is an analytic tool that first helped her understand a phenomenon that she experienced during long-term ethnographic fieldwork in Japan, where "physical touch is uncommon and relationships usually rely on more indirect and subtle forms of communication" (Tahhan, 2014, p. 16). She describes touching at depth as a "relational quality" (Tahhan, 2013, p. 46) that is not "locatable in a particular body part or particular sense" but rather "finds meaning through an embodied, felt relation and deep sense of connection" (Tahhan, 2013, p. 46). I want to turn your attention to her description of touching at depth as depicted in her memories of watching TV sitcoms with her family in childhood:

> There is a sensuous quality to this experience that connects the family at the deeper level, one where sight and sound connect them in the depths of touch … . Touch simply happens through this connection, via the TV and the laughter, but this is not comprised of separate subjects or bodies (mother, father, children). Instead, there is a new, mixed, inclusive body that emerges through relation … . There is an 'everywhere-ness' to this experience where everyone is in relation, implicated, touching, and laughing. The relaxed tone of this experience … emerges between the family (p. 49).

To conclude, I wonder how can we foster this sense of community and closeness at distance and

in healthcare settings—places that are not known for warmth, and where physical distancing has been most stringently enforced? To answer this question, I have read Tahhan's work closely, to determine the mechanisms that she identifies for how touching at depth is cultivated in Japan; I summarize this briefly as follows. Tahhan describes the warm feeling of an "inhabited" space (2014, p. 95). My study participants' grim descriptions of their hospital stays describe the antithesis of this, but surely a hospital room with a new baby *could* feel warm and inhabited. She describes touching at depth as being grounded in greetings or daily rituals that highlight care (Tahhan, 2013, p. 46); achievable, and markedly absent in hospitals during the pandemic. She states that touching at depth entails actively cultivating interpersonal empathy. Again, statements about feeling "abandoned and forgotten about"(Amanda, July 7, 2020), or as Audrey (August 31, 2020) put it, "Hospital rules, the government's rules, they should have room for compassion. That was lacking in our experience." These statements suggest that such compassion has been markedly absent in some hospital-based perinatal care contexts during the pandemic. Empathy and compassion are widely acknowledged as crucial for good medical care, but have been known to diminish over the course of medical training (Rice, Ryu, Whitehead, Katz, & Webster, 2018). Touching at depth is most easily cultivated in spaces that are comfortable—particularly spaces that are physically comfortable for a body to be in. This is something that alternative spaces for birth, such as birth centres, promise to offer, and someth-

ing that labour and delivery wards in Canadian hospitals have, in general, scaled back on during the pandemic. My interviews suggest that many people were not even permitted to bring in necessities like extra underwear or food, let alone pillows or other comfort items. Finally, touching at depth requires a feeling of security. My research shows that this, too, has greatly diminished in healthcare settings during the pandemic.

With pandemic restrictions finally easing, we are now reaching an opportune point to address the many questions that are being raised about the longer-term impacts of COVID-19 on societies—economically, politically, and socially. While we would all like to return to normal, the weak points of our current healthcare system that have been laid bare by the pandemic offer an invaluable opportunity to improve on the old normal. Fostering healthcare settings that are conducive to touching at depth would align with what is already known to be important for good care, while also setting the stage for a better response to future emergencies.

References

Classen, C. (Ed). (2020). Fingerprints: Writing about touch. In *The book of touch* (pp. 1–9). New York, NY: Routledge.

Irigaray, I. (2009). Toward a divine in the feminine. In G. Howie and J. Jobling (Eds.), *Women and the divine* (pp. 13–25). New York, NY: Palgrave Macmillan.

Kinnunen, T. & Kolehmainen M. (2019). Touch and affect: Analysing the archive of touch biographies. *Body & Society, 25*(1), 29–56. doi:10.1177/1357034X18817607.

Lupton, D. (2013). Infant embodiment and interembodiment: A review of sociocultural perspectives. *Childhood 20*(1), 37–50. doi:10.1177/0907568212447244.

Maclaren, K. (2014). Touching matters: Embodiments of intimacy. *Emotion, Space and Society, 13,* 95–102. URL: https://www.sciencedirect.com/science/article/abs/pii/S1755458613001114.

Merleau-Ponty, M. (2013). *Phenomenology of perception*. New York, NY: Routledge. (Originally published in 1962)

Merleau-Ponty, M. (1964). *The primacy of perception: And other essays on phenomenological psychology, the philosophy of art, history, and politics*. Evanston, IL: Northwestern University Press.

Rice, K., Ryu, J.E., Whitehead, C., Katz, J., & Webster, F. (2018). Medical trainees' experiences of treating people with chronic pain: A lost opportunity for medical education. *Academic Medicine, 93*(5), pp. 775–780. URL: https://journals.lww.com/academicmedicine/fulltext/2018/05000/medical_trainees__experiences_of_treating_people.43.aspx

Tahhan, D.A. (2013). Touching at depth: The potential of feeling and connection. *Emotion, Space and Society, 7*, 45–53. URL: https://www.sciencedirect.com/science/article/abs/pii/S1755458612000291

Tahhan, D.A. (2014). *The Japanese family: Touch, intimacy and feeling*. New York, NY: Routledge.

Walkerdine, V. (2010). Communal beingness and affect: An exploration of trauma in an ex-industrial community. *Body & Society, 16*(1), 91–116. doi:10.1177/1357034X09354127

About the Author

Kathleen Rice is Assistant Professor in Family Medicine at McGill University. She is the Canada Research Chair in the Medical Anthropology of Primary Care. Email: kathleen.rice@mcgill.ca