Doctorate of Psychotherapy by Public Works

Metanoia Institute and Middlesex University

CONTEXT STATEMENT

The Blossom Method
Development of a Somatic Psychotherapy Model, its use in Clinical and Everyday Settings: A Heuristic, Reflexive Inquiry

Vivien Sabel

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Student Number: Metanoia DP04171680
Student Number: Middlesex M00655046
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ABSTRACT

The Public Works considered for this submission include The Blossom Method Model, a parenting book on this approach, and a therapeutic children's book. The submission includes a detailed, heuristic and reflexive account of the life experiences, clinical and linguistic training, and influences which have contributed to these works, and considers the impact the works have made to the field of psychotherapy.

Originally, The Blossom Method was developed with a focus upon non-verbal communication between parent and infant, using an integrative, relational approach with a particular emphasis on visual, kinaesthetic, gestural, sensorimotor communication. The model's key components and the theoretical framework that it provides can be considered for use in psychotherapy training and practice.

In this account the submission reflects upon the author's formative years and the experience of being raised by a profoundly deaf, non-signing mother. It is recognised that parent-child communication and connectivity has been complex for the author, which influenced their decision to study linguistics and undertake immersion training as a sign language interpreter with a university, developing fluency in both BSL and English. The context statement explores the author's leadership role in a charitable organisation; the various professional and personal challenges which led to psychotherapy training; the experience of infant loss; and motherhood which provided an opportunity to experiment with non-verbal communication and promote connection with the author's daughter, Blossom. The model has been developed through heuristic learning, reflexive study and anecdotal research undertaken with parents and their infants, and it brings together linguistic training and therapeutic experience. The concepts of the model have been disseminated internationally through a popular parenting book, which has led

to further research, speaking engagements, article writing, course content writing, and an involvement in training and developing a practice with parents and their infants, both Deaf and hearing.

The submission provides the model explanation initially published in the book and discusses the theoretical influences which form the content for the Public Works.

During the course of writing this submission, a particular feature in relation to influence and impact emerged, as the author noted that recognition reach has been achieved through the careful use of social media platforms. This has resulted in the author reaching international audiences in India, Australia, South Korea and South America.

Although the model is perhaps not distinctly a ‘new’ approach to psychotherapy, the considerations and findings in relation to the ‘language of infants’ provide a platform for additional research in the field of infant somatic narratives. Furthermore, there is a distinctive synthesis of personal background, linguistic training, professional knowledge and expertise as a psychotherapist with both Deaf and non-deaf adults, children and infants.

KEY WORDS

Observe, mirror, respond, contemporary, model, method, infant, child, maternal, paternal, caregiver, parent, mother, father, relationship, deaf, disability, access, mental health, connectivity, attunement, misattunements, social model, medical model, communication, contact, perinatal, sensorimotor, somatic, embodied, psychotherapy, The Blossom Method (TBM), The Blossom Method Model (TBMM), BSL (British Sign Language), Sign Supported English (SSE), body, language, research, reflexive, heuristic, narrative.

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Abbreviations

APPG	All Party Parliamentary Group
BACP	British Association for Counselling and Psychotherapy
DPPW	Doctorate in Psychotherapy by Public Works
IMH	Infant Mental Health
LSE	London School of Economics
NICE	National Institute for Health and Care Excellence
PIP	Parent-Infant Psychotherapy
PND	Postnatal Depression
PPD	Postpartum Depression
PPP	Postpartum Psychosis
PTSD	Post Traumatic Stress Disorder
TBM	*The Blossom Method*
TBMM	*The Blossom Method Model*
UKCP	United Kingdom Council for Psychotherapy

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Time4PhD. Dr Machón died unexpectedly in August 2018 and even though the group continues in her absence, I wish to acknowledge her encouragement, enthusiasm and creativity.

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CHAPTER 1: INTRODUCTION

‘The distinction between mind and body is an artificial dichotomy, a discrimination which is unquestionably based far more on the peculiarity of intellectual understanding than on the nature of things’ (Jung, 2001: 76).

1.1 Overview of the chapters and content

In order to introduce each of my Public Works, I have written chapters that outline the context, the theoretical frameworks and the development of the model. I have taken the original The Blossom Method Model (TBMM) and expanded upon it in both my MA Psychotherapy and Doctorate in Psychotherapy. In order to illustrate these developments, two visual models relating to The Blossom Method are included (Vol 1: Figure 1, Figure 2). My aim in this context statement is to present a ‘backdrop’ to these findings and to the model, introducing the foundation upon which it has been built and the landscape in which it finds itself.

My Public Works include *The Blossom Method* book and related research and commentary; *Robot Meg, She Lives in my HEAD*, a therapeutic children’s’ book; a record of public commentary in relation to the above publications; and a record of my published research, public speaking engagements, performance and associated materials.

In the following chapters I aim to explore the relevance of my Deaf Studies training, and I have included information regarding ‘Deafhood’ (Ladd, 2003: xviii), BSL acquisition, and the nuances within this rich culture. In unpicking this training, technical learning and experiential development, I aim to offer knowledge in relation to the political landscape and social norms pertaining to the Deaf community, Deaf identity, the complexities of Sign Language Interpretation and Deaf Education. These foundational studies have guided

my perspective on and positioning of both whole-body communication and connection in infancy and elsewhere. As a result of significant traumatic events, I attended therapy during my training. This initial contact with therapeutic services influenced my choice to engage in clinical training of my own.

For further consideration I have provided an overview of my experience of a senior managerial position in a highly politicised landscape. I shall discuss models of disability and 'Deafhood' (Ladd, 2003: xviii) that have influenced my practice and my findings in relation to connection and The Blossom Method. I introduce the creative use of sensorimotor and kinaesthetic practice through gestural performance. I have further analysed my breadth of clinical experience, and major influences in discovering The Blossom Method (Vol 1: Table 3; Table 4). To this end, I have created TBM Synthesis Model (Vol 1: Figure 1), to demonstrate the elements of influence that are embedded in the model's infrastructure.

Included within further discussion of The Blossom Method are the concepts of prenatal and perinatal connection. I present my personal, original findings on 'tongue-talking' phenomenology, discursive content and the introspective considerations of The Blossom Method.

The notion of 'hyperspecialism versus universality' is considered, highlighting a dual perspective in the search for a model of unification. Reach and impact, connection in cyberspace and domains of influence are explored in consideration of contemporary forms of connection. Cyber-connectivity has been useful in the dissemination and sharing of these Public Works. Included is a Social Media History Timeline (Vol 1: Timeline 3) and an Instagram Engagement poster (Vol 1: Figure 10) as an example of how to successfully engage, using Instagram as an example of a social media platform. The careful use of multi-platform social media has influenced all of my Public Works. They prove to be particularly useful in connection, reach and impact.

Finally, I present my reflections on this journey and my hopes for the future of The Blossom Method.

1.2 Gesture, dualism and embodiment

The developing understanding of the inseparable links between gesture and language is vital to this study. The Blossom Method was born out of tacit, intuitive, embodied, experiential and academic knowledge, which is foundational to these findings.

Language is dynamic and inseparable from imagery (Damasio, 1994; 1999). Furthermore, as Reich (1970) suggested, 'The living not only functions before and beyond word language; more than that, it has *its own specific forms of expression which cannot be put into words at all'* (italics in original) (1970: 361). It has multi-dimensional qualities and instinctive gestures that appear in many forms. As McNeil asserts, 'Gestures are part of language' (2005: 13). Morris separates gestures into seven categories (2002: 21-45). Table 1 below summarises his findings.

Table 1 : Morris' Gestural Table

Gesture Type	**Gesture Explanation**
Incidental	Mechanical actions with secondary messages
Expressive	Biological in nature and shared with animal species
Mimic	Imitation gestures which transmit signals
Schematic	Abridged or abbreviated imitations
Symbolic	Gestures which represent moods and ideas
Technical	Specialist minority gestures
Coded	Formal systemic gestures (Sign Languages)

Created from Morris (2002: 21-45)

Seeking to learn more about connection and communication requires a drive to be an active observer of human nature and the gestural language of human beings. This involves accumulating and developing a multi-layered and multi-sensory approach to the usage and comprehension of language and a consideration of the 'dynamic dimensions' (McNeil, 2005: 12) of communication, regardless of form, in psychotherapy and elsewhere. Observation of dynamic language forms encourages the examination of language patterns; this may support a deeper understanding of the coded transmission of messages and may potentially provide a platform for the decoding of language in human interactions.

I have considered the fundamental inconsistencies in how the body is viewed in psychotherapy (Wolfe, Dryden and Strawbridge, 2003). There is a lack of research in this area and theories relating to embodiment as part of the therapeutic encounter reflect the 'mind-body split'.

Mollen (2014) infers apportioned attention between therapist and client in relation to 'mind to mind' and 'body to body' in the therapeutic space. This suggests that the mind and the body should be considered as separate entities and as a result a sense of dualism arises. Shaw (2003) suggests that psychotherapists themselves are uncertain as to whether their focus should be on the body of the client or their own bodily responses to the client.

The origins of these ideas may be traced to the 17th century and the work of the philosopher Descartes, whose dualistic approach influenced and pervaded the field of well-being and health in the Western world (Bayer and Malone, 1996, in Stam, 1998). The striking reality is that this 'mind-body polarity' is mirrored in the wider environment: whilst medics look after our bodies, psychiatrists tend to our minds. As Mehta explains, 'The field, which is facing crisis today, is that of medicine, and the paradigmatic stance that is responsible for the crisis is Cartesian Dualism – a view that mind and body are essentially separate entities' (2011: 202). This dualistic approach may

have hindered growth in the understanding of the place of embodiment in the psychotherapeutic ‘solar system’. In contrast, Merleau-Ponty’s (1962) vision purports a singular unification of mind and body as one. This perspective implies inseparability and the presence of both mind and body in our intersubjective lives. This suggests that ‘it is through my body that I understand other people’ (Merleau-Ponty, 1962: 186). Connolly forewarned of an inherent danger within the dualistic methodology, believing that it ‘fails to take into account, the way in which the mind and the psyche are shaped by our embodied corporeal experiences’ (2013: 636). Totten advises, ‘Our theory of the therapeutic relationship needs to be remade from the ground up as a fully embodied account - not just of body psychotherapy but of all psychotherapy’ (2015: xviii).

Van de Kolk (2015: 95) discusses the concept of ‘Agency’ or being in charge of your life. ‘Agency’ he suggests, ‘starts with interoception: the awareness of our bodily state and the subtleties in our sense of physical being. The greater our awareness, the greater our potential to control our lives’ (van der Kolk, 2015: 95). This bodily knowing will provide ‘sensory interiority’ (van der Kolk, 2015: 96) which will promote individual capacity to develop knowledge of the self and the ‘other’, and subsequently create change.

Apperception of the criticality of the body as well as interiority of the mind has created a shift in the field of psychotherapy, which appears to be promoting significant integration between different therapists themselves (Carroll, 2003; 2014). Therapeutic approaches which incorporate the needs of individuals and their environment and that encompass intrapsychic, embodied, relational, cultural and transpersonal factors (Norcross and Goldfried, 2005; Finlay, 2015) are necessary for relational connectivity.

Ogden and Fisher (2015: 13) describe ‘the body’s intelligence as a largely untapped resource in psychotherapy’. Their work clearly postulates the value of understanding the somatic, sensorimotor narrative and ancient wisdom

associated with the comprehension of prosody, facial expression, gesture, posture and gait. As previously stated, there is potential to utilise these primary responses in psychotherapy and possibly elsewhere.

My interpreter-level fluency in British Sign Language (a technical, symbolic, schematic, iconic and coded gestural language) has been acquired over a twenty-six-year period and my regular (daily) use of BSL underpins the technical and experiential insight developed in this study. My fluency in both BSL reception and production means that I am often presumed Deaf.

> Sign Language interpreting practice is 'bimodal' (Brennan and Brown, 1997; Napier, 2011, 2015; Nicodemus and Emmorey, 2012) in that Sign Language Interpreters work between two languages, a spoken and a signed language, that are produced and perceived in different modalities: auditory-verbal and visual-spatial (Napier and Leeson, 2016: 198).

In illuminating these findings, I acknowledge the potential risk 'that new knowledge can lead to new forms of exploitation of the ignorant by the knowledgeable' (Morris, 2002: xvi). However, I also recognise that deepening understanding may support the development of insight into both the 'self' and others. In 'maintaining an attitude of evolutionary humility' (Morris, 2002: xvii) there is hope that these findings will be of use in working with human beings in psychotherapy and in other environments.

Through this process of reflexive study, I have identified my culminating events and experiences: being parented by a deaf mother; entering into the Deaf community; acquiring linguistic insight and British Sign Language; working with oppression; striving for connection, clinical experience and training; infant loss; 'scientific people-watching' (Morris, 2002: xvii); becoming a mother; infant observation; and an untiring belief that connection is always possible regardless of form. All these factors have enabled the development

of this model and the publication of a ‘heart-based semi-academic book’ (Sabel, 2017) *The Blossom Method: The Revolutionary Way to Communicate with your Baby from Birth* (Vol 1: Evidence 1). The following chapters will support the reader in understanding more of how these ideas were conceptualised, developed and are applied in parenting, psychotherapy, supervision, training and public speaking. A multi-layered, unified, bidirectional, relational, integrative, sensorimotor approach is applied in working with adults, children, parents and their infants.

CHAPTER 2: DEAFHOOD

No Self

Cross eyed cross faced little girl
Sad, bad little girl
Eared, heard little girl
Give me your ear
Give me your voice
Give me your tongue, your mouth
I gave you life
Your life is mine
I did not have ears
I made a pair
Be me, sad bad little girl
You are lost and I am lost
I love you for you are mine
Little girl, little girl
(Sidransky, 1990: 186-187).

2.1 Introduction: Deaf versus deaf

Aside from being mothered by a deaf parent, my immersion into the Deaf community has been key to developing The Blossom Method. Within this context statement, I analyse the impact of my formative immersion study of a technically-coded, iconic, expressive, purposive language – British Sign Language (BSL) – and 'Deafhood' (Ladd, 2003: xviii).

Throughout this paper, the reader will note the intermittent capitalisation of the word Deaf. This is an important feature in the Deaf community and bears

relevance to my experiences of being raised by a deaf mother.

> The lowercase 'deaf' refers to those for whom deafness is primarily an audiological experience. It is mainly used to describe those who have lost some or all of their hearing in early or late life, and who do not usually wish to have contact with signing Deaf communities, preferring to retain their membership of the majority society in which they were socialised (Ladd, 2003: xvii).

In contrast, the capitalisation of the word Deaf relates to 'those who affiliate themselves with signed languages, communities and cultures of the Deaf collective' (Ladd, 2003: xvii). As a result of dualism being built upon a biomedical model, it is not surprising that the biomedical and socio-linguistic model of deafness holds a dualistic perspective. This dualism enhances the divide within the environment, mirroring the 'mind-body split' between a pathologising medical perspective and the Deaf linguistic cultural viewpoint.

Ladd, in discussing Deafhood, suggests the term was:

> developed in 1990, in order to begin the process of defining the existential state of Deaf 'being-in-the-world'. Hitherto, the medical term 'deafness' was used to subsume that experience within the larger category of 'hearing-impaired' the vast majority of whom were elderly 'hard of hearing' people, so that the true nature of Deaf collective existence was rendered invisible (2003: xviii).

2.2 Deaf studies and sign language interpreter training

Whilst employed as a project leader with Deaf and Disabled people, I engaged in some part-time BSL study for four years and developed my BSL skills to an intermediate level. I also studied to a basic level as a deaf blind

guide-communicator.[1] My interest and enthusiasm grew, and I decided to apply for the Deaf Studies and Sign Language Interpreting Course at the University of Bristol. It was rigorous immersion training. Contact time at the university was approximately 25-30 hours per week. For two years the course was mainly facilitated in BSL. Lectures included Sociolinguistics; Deaf People in Society; Sign Linguistics; Deafhood; Deaf History; Deaf Research; Deaf Education; Deaf Community and Culture; BSL acquisition modules graded 1 to 8; Simultaneous Interpreting; Consecutive Interpreting and an Interpreting placement. The Consecutive and Simultaneous Interpreting lectures were provided for hearing interpreter trainees where a combination of BSL and spoken language was used in teaching and facilitation. Video and recording equipment used for microanalysis of eye gaze, eyebrow positioning, body positioning and head movement aided our learning. We also analysed role shift in interpreting where the individual executing the signing relays a conversation between two or more people and utilises his or her body to identify the individual speakers. This work was crucial and very helpful in recognising a BSL user's purposeful use of the technical linguistic features and additional somatic narrative to express characterisation and signed 'utterances'. All other modules and lectures were facilitated in BSL with a combination of Deaf, Hard of Hearing and non-Deaf trainees.

During our introductory lecture at the Deaf Studies Institute, we were reminded that speaking was not allowed. We were politely and firmly informed to 'zip up our mouths, to unzip our hands and use BSL'. This rule was respectfully adhered to.

We had a strong academic teaching team and were fortunate to be taught by

[1] Deafblind guide-communicators and interpreters use hands-on signing: they are able to sign with the hands of the person for whom they are interpreting placed over their hands, so that the Deafblind person can feel the signs being used. https://www.england.nhs.uk/wp-content/uploads/2016/07/bitesize-guide-improv-deaf-ppv-nhs.pdf [Accessed 13 September 2018]

Dr Paddy Ladd, who is a dominant figure in Deaf cultural and identity studies and Deaf activism, and who is a recognised pioneer in his seminal Deaf works (Napier and Leeson, 2016).

This training encouraged a ‘culturo-linguistic’ model of deafness: ‘This construction focuses on the essentially collective nature of the Deaf experience. Deaf people see themselves as beings who are already whole’ (Ladd, 2003: 164). Ladd suggests that a lack of hearing is ‘rendered secondary to the positive experiences created by their social, cultural and artistic lives together, experiences which are situated within the 250-year-old history of Deaf clubs, schools and organisations’ (Ladd, 2003: 164).

Immersion training was profoundly insightful and is widely respected. During this two-year period, and in addition to the technical and linguistic skills previously mentioned, I developed my sensorimotor observational skills.

I feel comfortable using BSL and feel profoundly connected to this technical, expressive, rich, sensorimotor language, and the culture of the Deaf community. As a child growing up around deafness, I knew the impact a lack of hearing had upon my mother and I believe my drive to understand more about BSL developed from my need to embrace and connect with deafness in a way that my mother was unable to, which was ultimately an attempt to profoundly connect with my mother. I am aware that within this Context Statement, my need to personally connect is being revealed. Connection regardless of form is one of the key themes I wish to develop in this account. The theme of restitution will emerge too. On reflection, I understand the strong and somatically experienced need to compensate for or to change the life of my mother as a formative influence on me. My desire to make reparations for my mother has been dominant since my early years. My own perception of these experiences appears to be entwined with a need to protect and take responsibility for my mother and her deafness. Boszormenyi-Nagi and Spark developed the concept of ‘Parentification’ in

1973: a term used ‘to describe a common component of relationships whereby parental characteristics are projected onto to an individual’ (Engelhardt, 2012: 45). In consideration of a familial setting with a hearing child in a D(d)eaf[2] familial environment, the child may assume the role of intermediary and act as a conduit to facilitate communication, to decipher written information (as English in Deaf families will likely be a second language), and act as a go-between for the hearing and D(d)eaf worlds.

The Deaf Studies immersion training was not easy and, like my childhood, not an emotionally simple journey. In the first few months of training, a familiar yet uncomfortable feeling from my past seemed to emerge and a temporary lack of connection followed. It felt like I did not belong or ‘fit’ comfortably in this environment; in considering this further, I am curious as to whether or not this mirrored my experience in toddlerhood. My mother was absent for a lot of my early life. She was hospitalised and ‘mothers and others’ in the local community cared for me. My father became unwell and I was temporarily homed by local mothers or ‘alloparents’ (Nitsch et. al., 2014) who I imagine provided relational and behavioural models as well as shelter, food and warmth. I believe that they thought of me as a ‘motherless’ infant, but I also imagine, through my psychotherapeutic training, experiencing my absent mother. I have somatically held, tacit memories of my infancy and through the process of personal therapy these embodied memories have been explored. I am curious as to how these embodied, internal, transgenerational, psychosomatic, neurobiological early experiences have influenced my journey and my findings. I am additionally mindful of the transmission of intergenerational trauma and deliberate upon the embodiment of my mother’s sense of belonging, and her mother’s intergenerational impact upon her.

[2] The capitalised and non-capitalised forms have been provided to cover both Deaf (culturo-linguistic) and deaf (medicalisation) community members.

The CODA[3] experience is complex and may leave the hearing child with feelings of isolation and alienation that may contribute to feelings of shame. 'Being *different* from others becomes shameful. To avoid shame, one must avoid being different, or *seen* as different. The awareness of difference itself translates into feeling lesser, deficient' (Kaufman, 1992: 32).

In the Deaf immersion environment, being a COdA[4] of a mother who does not use sign language was seen as different. When I began my training, the concept of 'Deafhood' (Ladd, 2003: xviii) was unknown to me. When meeting a member of the Deaf Community for the first time, a likely initial question is, 'Deaf, you?' generally followed by 'Mother, Father Deaf?' These questions are asked in order to understand your position in and affiliation to the Deaf community.

> This phrase recognises hearing-children's unique link to an often separate and impenetrable land. Because identity within Deaf communities is highly dichotomized, one is either Deaf or Hearing - hearing children of deaf parents are enigmatic with regard to their cultural affiliation (Preston, 1995: 1461).

If you are able to answer 'yes' to both of the questions, then it is likely you will be deemed a member of the Deaf community. The way in which you engage with, attend to, and participate in the Deaf community, the way in which you communicate, and your dominant language use will be observed in the Deaf community. These matters will inform community positioning and acceptance or lack thereof. For hearing sign language users, 'their perceived status [within the Deaf community] is often related to their sign language fluency as well as their attitude towards deaf people and signed languages' (Napier and Leeson, 2016: 215).

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[3] CODA Child of Deaf Adult. This usually refers to a hearing child in a Deaf dominant familial setting.

[4] COdA Child of deaf Adult. I have developed this term for the purpose of this research to indicate the presence of deafness with some cultural features but with the absence of 'Deafhood' (Ladd, 2003: xviii).

During the early training and familiarisation, my Deaf peers consistently asked these questions. My responses caused some confusion and a feeling of disconnect developed for me. My responses in BSL were ‘Me hearing me’, and ‘Mother D(d)eaf, Father hearing’. I wanted to be truthful regarding my mother’s deafness, so I usually clarified my answer by explaining that whilst my mother was profoundly deaf, she did not use BSL. In the Deaf community ‘being culturally Deaf is interdependent on the individual’s identification with the group’s evaluation and acceptance of the individual’ (Preston, 1995: 1461). My mother chose not to use BSL and did not involve herself in ‘Deafhood’ (Ladd, 2003: xviii). Therefore, she was not deemed ‘Deaf enough’ or equipped to be a member of the Deaf Community. As Preston notes, ‘Within the Deaf community ambiguity is rarely allowed: people are either hearing or deaf’ (1995: 1461). My Deaf peers in some ways appeared dismissive, and I detected this quality in their facial expressions and their body language: it was not identified by the specific BSL signs presented but in the ‘unspoken’ and sensorimotor narrative. These responses were familiar to me from my childhood. On the rare occasion that my mother declared her deafness to hearing people, it was received with the same ambivalence and anxiety that I now experienced with my Deaf peers.

I am curious as to whether my mother’s lack of cultural belonging and isolation have influenced my development and choices. As Ward (2009: 33) suggests, a lack of cultural identification may result in a child feeling cultureless, ‘like an outsider, due to an undefined sense of belonging (Myers et. al. 1999; Preston, 1994; Weiner, 1997; Zarem, 2003).’ In an attempt to connect, was there a bid to find ‘belonging’ as an ‘intercultural interloper’ (Napier and Leeson, 2016: 63) in a culture and community where the connection was fuelled by embodied memories?

The Deaf Studies training provided academic, distinctive and idiosyncratic learning. I recall a particular sociolinguistics lecture that changed my

perspective. A mixed (Deaf and hearing trainees) lecture was addressing the etymology of a specific BSL sign. A sign for Jew and Jewish was presented. This sign is iconic and utilises the imagery of a Jewish man's beard. Iconicity is prevalent in BSL and it is useful. However, the imagery provoked ill-ease and discomfort in me. I saw it in some ways as a form of generalisation and oppression through categorisation. A very heated debate ensued, and it was at the end of this lecture that I realised that, as a hearing trainee, perhaps it was not my place to act as a hearing oppressor of Deaf people, a culture and a language that was not mine to alter. The shame that I experienced in this lecture is something that I will never forget and in recalling it, it manifests itself now as heat and redness in my face and body. Kaufman (1992), Yontef (1993) and DeYoung (2003) suggest that shame materialises as a result of negative re-enforcement in our early years. There appears to be 'an enormous amount of shame that can only be worked through by a courageous attempt to uncover as much of the buried parental history as possible' (De Mendelssohn, 2008: 389). In my familial history, the shame carried has been and still is under review in an attempt to lay any 'ghosts in the nursery' to rest (Fraiberg et. al.1975).

My approach to the training altered after this event. After a few months my understanding of the Deaf community, Deaf culture, BSL acquisition and Deafhood deepened. To this day I remain connected to and feel 'relationally embodied' within the Deaf community and in many ways feel 'more at home' in a Deaf environment than a hearing world. On reflection, I seem to have carried the theme of restitution into my studies and the realisation that the Deaf community did not need rescuing hit home hard.

Preston (1995) interviewed hearing adults of Deaf parents and suggested of his informants that the paradox of ambiguous identity continues into adulthood:

> Despite appearing to matriculate within the Hearing world, a

> number of men and women suggested they were not always comfortable with hearing people, nor did they necessarily identify themselves as a Hearing person. The Hearing world's prevailing moral evaluation of deafness and negative responses to deaf people augmented informants' desire not to identify with those who stigmatized and oppressed (Preston, 1995: 1464).

My opinion now is that Deaf people and native BSL users are better placed to make decisions about BSL, sociolinguistics, political correctness, iconic signs and matters of a cultural nature in the Deaf community.

2.3 Trauma

Towards the end of my course in Deaf Studies, I was the victim of a serious assault. I thought I was going to lose my life and these events changed me. My hypervigilance – already present as a result of my early years – became heightened further. As Kimble, Fleming and Bennion state, ‘Hypervigilance toward ambiguous or threatening stimuli is a prominent feature in many trauma survivors’ (2013: 1).

During my period of recovery I attended a group for anxiety management. I also tried creative writing to aid my recovery and wrote poetry (Vol 2: Evidence 39; 40) about this period of my life. However, to overcome the impact of this experience, personal therapy was essential and proved to be beneficial. Although I was not conscious of it at the time, it was these experiences that influenced my decision to undertake clinical training myself.

2.4 Interpreting in action

After working in a college supporting Deaf students and tutors, I held a position in a Deaf school, where I worked to support a Deaf girl to ensure full access in a mainstream school. This interesting position enabled me to

connect with an isolated child in a mainstream setting.

> There has been a shift by some educational providers in recognising that deaf children can be educated in a sign language (rather than requiring them to attempt to hear, speak and lip-read the majority spoken language) (Napier and Leeson, 2016: 25).

Nobody spoke my student's language and it was apparent that without the aid of an interpreter, she experienced a lack of connection to her educational environment.

This post, together with my freelance interpreting, gave me additional insight into the language of the body. I observed technically-coded sensorimotor narratives, connection, disconnection, and the nuances in BSL and other forms of sign language. I became more aware of the differences between signed language, Signed Supported English (SSE), combined forms of signed language, the decision to communicate in BSL, 'Home' sign and all the personal inflections which present regional, cultural and linguistic insight (Vol 1: Appendix 2). These posts extended my experience of Deaf culture and I developed an understanding of the Deaf community, an 'unspoken' knowledge that highlighted the isolation of Deaf people in mainstream settings.

I became skilled in my craft, but in some ways unfulfilled. Sign Language Interpreters are 'third culture' (Napier and Leeson, 2016: 65) professionals who speak different languages, with feet in both camps. In order to provide a professional and accurate interpretation, keen observational and linguistic skills are required. Interpreters connect with Deaf people at the contact boundary and share common ground. Napier and Leeson (2016) describe the profession of Sign Language interpreting as a 'cradle to grave' profession. Interpreters accompany deaf people in all situations where they engage with an inaccessible majority community. Interpreters are conduits

through which information is passed from one person to another. They are insured and registered and follow a strict code of practice and ethical policy.

For me, the life of an interpreter was sometimes frustrating. Daily observation of non-deaf people mistreating, patronising and insulting Deaf people was shaming and wearisome. I found the oppression and suppression familiar and uncomfortable: I needed to be more active within the Deaf community. Napier and Leeson, (2016: 5) discuss the concept of 'Deaf (hearing)'[5] (Napier, 2002, 2016; Ladd, 2003; Stone, 2007; 2009), an identification I have adopted.

In search of a change, I applied for a city-based, senior charitable CEO role. The charity supported the sensory loss community. The opportunity to relocate and leave behind memories of my traumatic experience was appealing.

[5] 'Some authors have suggested different naming conventions, such as subverting the D/deaf convention to refer to 'hearing' people who are members of the deaf community and 'Hearing' people as outsiders (Napier, 2002; Ladd, 2003); or to referring to community members as 'Deaf (hearing)' and outsiders as 'hearing' (Stone, 2007, 2009)' (Napier & Leeson, 2016: 5)

CHAPTER 3: A CHANGE IN DIRECTION

‘Everything that irritates us about others can lead us to an understanding of ourselves’ (Jung, 1973: 247).

3.1 The CEO experience

In my new position, I was operating on a different level. I drew upon my knowledge of the sensory loss population and my developing knowledge of people with learning disabilities. I was required to provide information in an accessible form to the communities that the charity served. I had to be creative to successfully communicate complex data in a fully accessible manner. I used multi-media platforms such as video with subtitling, produced large print documents and accessible information booklets, and utilised forum theatre performance to explore discrimination.

I found this new environment, like the Deaf community, to be highly politicised. My position did not support the concept of a medical model of disability. In addition, I did not support the concept of Disabled people as passive receivers of care or services where the overarching theme encompasses a ‘need to fix’. ‘Bad. Attitude-bad’ is a term used in BSL to describe hearing people who ‘serve in roles where they try to “fix” or “save”’ (Napier and Leeson, 2016: 66). Following immersion, I am an advocate of a social model of disability and specifically, in relation to the Deaf community, a culturo-linguistic model (Ladd, 2003: 164). See Table 2 for a summary of these distinctions.

Table 2 : Medical model versus social model of disability

MEDICAL MODEL OF DISABILITY CONCEPTS	SOCIAL MODEL OF DISABILITY CONCEPTS
Individual Disabled person seen as 'faulty'	Individual seen as a human of value
Labelling	The individual defines self in a linguistic or self-chosen method. Disabled people further define barriers and develop strategies and solutions.
Diagnosing and pathologising Possibly arrests development. Living within the bounds of a biomedical, deficit model, where label and diagnosis are paramount	Living as a member of the community where societal barriers are understood as relevant to society.
Medical interventions	Removes the focus from the person with a 'problem', where a need to repair is dominant. Promotes self-acceptance. The focus is not upon deficits and fixing through medical interventions; the focus is on connection and acceptance.
Segregation, mainstreaming and alternative provision	Training and research provided for all community members, where belonging, meeting individual need, promoting choice, acceptance, culture and community are utmost.
Here and now issues, mental health and 'ordinary needs' missed	Seeks active communication and connection with individuals regardless of difference therefore accessing all parts of the human

	condition.
If the faulty self is deemed ‘fixed’, re-entry to wider community may be supported. If reparative work is considered unfinished or too difficult, permanency in exclusion will occur	Diversity is embraced. Adaption of social environment and acceptance by the wider non-disabled community is embraced. Individual choice is promoted and accepted.
Society unconsciously concurs with medical model and this perpetuates exclusion and alienation. This embodiment is observed and projected.	Society recognises the value of a social model of disability and a new phase of human evolution begins to emerge.
Adapted from Mason, 1994 and Rieser, 2000 in Reiser (2009)	

The above table demonstrates the differences in politicised views associated with disability. The medical model appears to constrict, and limit Disabled people and the social model provides a framework for growth, individualism, expression and communal responsibility towards inclusion. The social model of disability appears to place itself in a more unified position in an attempt to view the ‘whole’ rather than focusing upon medicalisation and deficit positioning.

During my time in this post, where the work was demanding and wide-ranging, I developed skills in communication and connection. I was involved in policy development; advising national organisations on the provision of accessible information and gathering data about the needs of Deaf and disability communities to produce of ‘in-house’ guides, accessible booklets; overseeing projects; staff management; development of accessible information; staff recruitment; interviewing potential candidates; volunteer recruitment; financial planning and management; presenting and speaking at national events; reporting to a board of trustees; organising conferences and

meeting with government officials.

I worked alongside a support worker who was a trainee art psychotherapist in his final year of study at university. Working with him not only aided my personal recovery, but it also inspired me to understand more in relation to therapy, the therapeutic relationship, and the use of creativity in therapy to support trauma recovery.

My anxious-perfectionist personality made this new post particularly challenging. Charitable organisations require funding from various sources, and I found this made it an increasingly pressurised environment. I found the social politics testing, since the medical model prevailed and seemed to me to be oppressive in practice. Those in power and some non-disabled medical model supporters encouraged this practice and my sense of incapacity and incompleteness grew. The environment was a fertile ground, which became muddied by medicalisation and the need for the ‘body strong’, non-Disabled to assert their power. As a result of this ‘mind-body split’ approach and after some disagreements and politicised perspective differences, my position became untenable. Furthermore, as a person in the throes of trauma recovery, being a CEO was too difficult for me at this time. Running a national charity across two sites in a personally disagreeable political landscape had become unappealing and so, after two years in this job, I left. This elicited a feeling of not being ‘good enough’. This is a familiar introject, and one in which I recognise my father’s influence.

The pressures experienced as a CEO of a national charity were compounded by a miscarriage, two harrowing episodes of surgery and other significant maternal health matters. During my recovery period and in an attempt to heal some of my wounds, I began to write more poetry. I wrote the poems in relation to infant loss and the end of a long-term relationship.

Poetry and creativity became therapeutic tools for the expression of my inner

feelings. I see these as forms of sensorimotor psychotherapy where the mind and body are used to take difficult experiences from the somatic narrative, bringing them to life through kinaesthetic activities. As Robinson observes, ‘Poetry can help enable expression of individuals' deepest unspoken concerns and may provide a means of providing spiritual care’ (2004: 32). In his model of heuristic inquiry, Moustakas describes the process of engagement with a topic – specifically the two elements of Immersion and Incubation (1990: 27-37). He defines Immersion as ‘Living it, sleeping it, dreaming it, fully engaging with it’, and Incubation as ‘allowing an inner, unconscious, intuitive working of material’ (Barber, 2002: 83). These descriptions seem profoundly poignant to me, specifically in relation to pregnancy and loss. Carrying a sentient being – ‘living it, sleeping it, dreaming it and fully engaging with it’ (*ibid*) and *incubating* a baby, then traumatically living with the reality of such loss: these are profound experiences that connected me to motherhood in a reflective, embodied and ineffable way.

3.2 Gestural performance: poetry in motion

After leaving school, I studied drama and engaged in theatre performance. My most recent full performance was at the Harrogate Theatre in 2017, where I volunteered for six months to work alongside young artistes in order to provide BSL interpretation for over one hundred performers to raise money for Shine UK.[6]

Creative writing and the therapeutic effects of this kinaesthetic activity have been widely discussed in literature regarding narrative therapy (Sarbin, 1986; Bruner, 1987; Polkinghorne, 1988; White and Epston, 1990; Foa, et. al, 1995; Monk, 1997; Crossley, 2000; Gersie 2000; Richardson, 2000;

[6] Europe's largest organisation dedicated to supporting individuals and families as they face the challenges arising from spina bifida and hydrocephalus

Robinson et. al., 2016; Williamson and Wright, 2018). A strong focus upon gesture also informs parts of my work. The use of the body is dominant in my psychotherapy practice and is important in all aspects of my work including teaching, training, public speaking, psychotherapy, supervision, and in my clinical work with Deaf clients and Deaf trainees.

This year I spoke at a Perinatal Mental Health Conference in Sheffield. I referred to my own experience of maternal infant loss and perinatal anxiety. I presented on the subject of 'Perinatal Connectivity' and in an attempt to utilise both creative writing and poetic performance, I read my poem 'Where has the time gone?' In this way I was able to share through gestural performance my experience of infant loss and carrying another baby following on from this loss. I have been told that the audience found the performance profoundly powerful. Trevarthan and Fresquez suggest 'a theory of the social psychobiology of movement that recognises that humans have a special, body-based talent for sharing in the imaginative creation of emotionally coloured life stories' (2015: 194). I have read my poem many times in private, however in this public presentation I became emotional, breathless and tearful. Breath and speech can be seen both literally and as 'life' or 'energy'; in various spiritual traditions breath is regarded as 'spirit' (Westland, 2009). The audience observed these embodied emotions and moments of breathlessness in my somatic narrative. I noted that members of the audience were moved, and many moved to tears.

I received a great deal of feedback in response to this presentation. In effect I was **observed**, the audience **mirrored** back to me my emotional expressions and in doing so I was **responded** to. Through the use of gestural performance, I experienced a way of connecting my 'bodymind' (Totten, 2014: 50) sensorimotor narrative to the narrative of others and rather unexpectedly, it was a deeply healing experience. I imagine it was perceived as powerful because of the embodied performance and the way in which this connected with the 'perinatal audience'.

> Embodied relating happens, of course, not only in the therapy room…There is a constant interplay between our relationship with other people, our relationship with our own bodymind experience, and our relationship with the world itself (Totten, 2014: 50)

Certain memories are held in the body, and through somatic gestural performance the body connects to the mind and body of others and the self. There appears to be a deep human-to-human connection occurring, where attunement goes beyond empathy, involving the deeply personal response of the hearer as well as the intent of the speaker (Stern, 1985; Erskine, 2010). Engaging with performance and expression through performance is an interesting relationally embodied way of connecting thoughts and body-held memories. What was 'heard' and experienced in the poetry reading was embodied and it appeared to become bidirectional and reciprocal in nature.

Morris (2002) and McNeil (2005) have written much regarding gesture. As Linington (2014) suggests, 'Attachment theory has shown that intergenerational transmission can mean that the relational body patterns we develop are not just found and created in the relationship between carer and infant, they are also unconsciously passed on across the caregiving generations' (Linington, 2014: 131). Armstrong and Wilcox (2002) suggest:

> Several lines of evidence converge to support the idea that gesture-based language might have preceded speech in human phylogeny: (1) paleontological evidence for human anatomical evolution: (2) primatological evidence concerning the behavior of our closest living relatives of human beings; and (3) neurological evidence concerning the organisation of the substrates for linguistic behavior of the brain (Armstrong and Wilcox, 2002: 19)

Should their findings be well-founded, then it is probable that the rhythmic

gestural performance is experienced in the expressive form of poetry in the present moment and through the ‘intergenerational body’ (Linington, 2014: 131).

Social media interest in my poetry grew, and Barbara Rivera from the Association for Prenatal and Perinatal Psychology and Health (APPPAH) requested a copy of my poem and video. In response she sent me the following message ‘Hi Vivien, I watched your video multiple times. I cried each time. Are you publicly ‘sharing’ this video? I would love to share it if you are willing. Warmly, Barbara’. The video was shared on the APPPAH Facebook page on March 11, 2018, providing an initial potential reach of 5,326 members.[7]

3.3 Clinical training: entering the realm of therapeutic studies

After leaving the charity executive position, I took time to reconsider my future direction. I had been impressed by the work of my art therapist colleague, which resonated with my own experience of the healing potential of creativity. In addition, I had experienced the use of kinaesthetic and sensorimotor work in my own therapy. As a result of these embodied experiences I applied for a university course in Psychodynamic Counselling.

The clinical training at my university and my own personal therapeutic journey made me aware that there was an element of the ‘wounded healer’ at play. In his chapter entitled ‘Fundamental Questions of Psychotherapy’, Jung states that:

> Freud himself accepted my suggestion that every doctor should submit to a training analysis before interesting himself in the unconscious of his patients for therapeutic purposes...We could say, without too much exaggeration, that

[7] Members as noted on 10/03/2018

> a good half of every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself can he hope to put right in the patient. This, and nothing else, is the meaning of the Greek myth of the wounded physician (1966: 115-116)

My maternal mental health experiences, my desire to heal and my drive to connect are dominant here. I value my longstanding experience of personal therapy and I am willing to face my own unconscious processes and trauma. As a mother and a psychotherapist, I have a desire to support my own mental health and well-being.

The university courses were very interesting and stimulating. I continued to attend psychotherapy and began to realise that therapy was a possible career that I could connect with. I also realised after completion of this training that the psychodynamic model, as taught in 2002 to 2004, in its purest form, was not a model I could fully connect with. On reflection, I believe this is associated with its apparent lack of connection to a sensorimotor narrative and the failure to use the body in psychotherapy. After all, 'every word, every gesture, every shift in voice tone or posture' (Erskine, 1999 et. al. : 32) and the experience of both the intrapsychic and non-verbal narrative are critically available in the therapeutic encounter. In addition:

> as an embodied-relational therapist, my endeavour in the therapy room and in life generally, is for a free relationality in all three dimensions: (1) contact with my proprioceptive and kinaesthetic awareness and with my embodied emotions; (2) contact with my environment and how it impacts upon my well-being; (3) contact with other people, using all the specialised sensitivities with which we have evolved (Totten, 2014: 51)

A notable moment in my psychodynamic studies training occurred when we engaged in Group Process (there were about 25 in the group). The silence

experienced in the process, rather than providing me with an interesting opportunity to observe the world of the non-verbal, instead created in me profound anxiety. I found it difficult to keep still and felt hugely uncomfortable in this process group. I think this was partly connected with my sense that others looked uncomfortable and they appeared to be holding back from speaking their truth. It was not an environment that I was fully able to trust.

This lack of trust came from both my internal world and from the external environment. The university I attended is an exceptionally well renowned establishment, but they failed to provide appropriate access for some of their disabled students. This disturbed me and did not fit with my moral position in relation to equity and access. A trainee in our cohort, who was a deaf, disabled person and a wheelchair user, did not receive appropriate access to the learning environment. The college did very little to support this trainee and often it was left to fellow trainees to support her in navigating the ancient halls and prefabricated buildings. The college did not appear to consider 'the social model of disability' (Oliver, 1990) but instead relied upon others to accommodate this trainee's access requirements, and thus promoted a dependency on other students and, in doing so, avoided taking organisational responsibility to provide independence for the student concerned.

> Common to all variants of the social model is the belief that, at root, 'disability' and 'disablement' are socio-political constructions. It is therefore the inhospitable physical environment, in concert with the negative social attitudes that disabled people encounter which result in the systematic oppression, exclusion and discrimination of disabled people' (Lang, 2007: 2)

I have embodied my early history and the discrimination that my mother's experiences embody. Totten suggests that:

> thought and language are not 'mental' qualities, which exist

> over and against the body. On the contrary, in line with holistic bodymind concept, *thought,* [action] *and language are qualities of the body itself* (italics in original) (2003: 133)

I experienced a lack of attunement in this training, due to the actions (or lack of action) of those in power in the university setting. Their apparent lack of interest in access will have no doubt affected the individual's feelings of self, her socio-political, medicalised 'deficient' disabled body and the organisational other. As Finlay asserts, 'Attunement is seen in the infant-caregiver relationship, with its rhythmic, non-verbal "proto-conversations" that move in and out of contact and synchronicity, repair and rupture' (2015: 53). There was no attempt to repair this rupture and a consistent sense of disconnect was experienced by the trainee which was mirrored in the trainee cohort. Through the influence of my early mothering experiences, a strong underlying theme in my life's work has been connection for all, which as previously stated encompasses access, equity and social justice.

3.4 Embodiment in supervision

Whilst completing a Postgraduate Diploma in Psychodynamic Counselling, I undertook two placements in two schools. My initial placement was at a primary school in South London where I received referrals from the Autistic Spectrum Department (ASD). Although challenging, I thoroughly enjoyed this placement. In providing the therapeutic narrative of each of the sessions, my supervisor noted that I had an acute capacity to 'embody' the children. He suggested that my observational abilities were keen. He described feeling as if he was in the room with the child that we were discussing, and we used this method to work with all of the children referred from the ASD. In effect I was ***observing, mirroring*** and ***responding*** to the whole-body narrative and sharing this with my supervisor. In supervision, I was using my sensorimotor and cognitive memories from each clinical hour to provide a visual non-verbal somatic narrative form and verbal account of the sessions.

Worthy of mention here are the many diverse approaches within the wider field of psychotherapy, which metaphysically embody ‘world views, beliefs and values’ (Staunton, 2002: 2).

> Language that expresses conscious meanings are perhaps less critical for psychotherapy practice than the variety of automatic implicit patterns (such as gesture, posture, prosody, facial expressions, eye gaze, and movement habits) (Ogden, 2014: 91)

Sensorimotor narrative in supervision proved to be very helpful to the child, to the supervisory process, to my work and to me. The work was presented using the somatic and verbal discourse experienced between two bodies and the bidirectional fluidity of the ‘bodymind’ (Ogden, 2014) narrative. This included visual, aural, oral, embodied, historic, cultural, transpersonal, transferential, and sociolinguistic aspects, all in a unified, whole ‘mindbody’ encounter. Totten (2003) has accurately suggested that although there is a body of psychotherapists who claim that they are only working non-verbally, this is ‘mainly an illusion’ (2003: 4).

In observing all language forms presented in clinical work, I began to feel more confident in my skills and abilities. I made assumptions about the way that other trainee psychotherapists utilised their supervision, but it was not until I shared supervision with other trainees that I realised that the sensorimotor narrative of both the client and the trainee psychotherapist was absent in relaying the sessional material. This was curious to me. Why was the somatic narrative of neither the client nor trainee shared in supervision by other trainees? In my own supervisory practice, I advise a ‘focus on the supervisee's bodily and mental processes, encouraging progress by inviting the supervisee to give himself/herself time to explore his/her sensations and response’ (Sletvold, 2014: 90) to the client, themselves as therapist and to what is held in the intersubjective space. There is now a:

> shared common interest in current psychoneurobiological data on brain/mind/body systems [which is] forging a renewed dialogue between formerly exclusively psychoanalytic models of the mind and somatic therapeutic models of the body. Both are now converging on the problem of trauma and arousal dysregulation, especially right brain attachment trauma that negatively impacts mind and body, psyche and soma (Schore, 2002: 9).

Clinical research and interest in the use of non-verbal communication is growing. This interest has emerged from more recent research into emotion and the recognition of the importance of non-verbal communication in both expressing and regulating emotion (Matsumoto, 1987; Damasio, 1994, 2000; Panskepp, 1998; Solms and Turnbull, 2002). This augmented recognition of the use of the body in the therapeutic encounter and in supervisory practice affords great potential and may elicit a sea change in current training and practice.

3.5 Major influences in the development of The Blossom Method

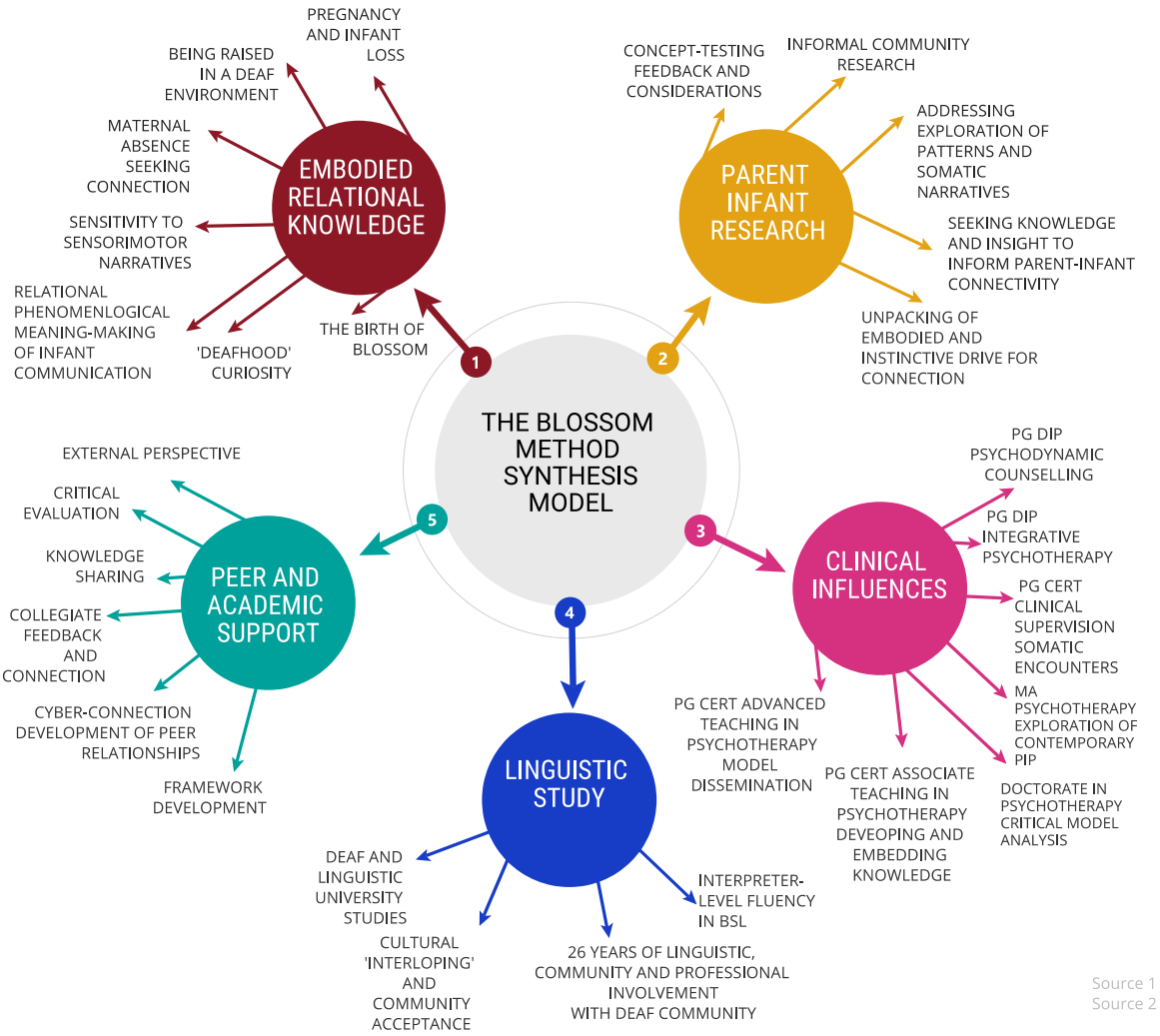
During this study period I worked part-time for a college in London. I was contracted to provide tutor and pastoral support to Deaf learners. Pastoral duties provided me with an opportunity to utilise my developing therapeutic skills and training in support of Deaf students. I was regularly exposed to the Deaf community and became more aware of the needs of Deaf people and Deaf equity in service provision.

It was at this time that I met my husband. At the end of the course I fell pregnant. This pregnancy and the birth of my daughter (Blossom) initiated further change. The undertaking of clinical training, the in-depth study in BSL and linguistics, infant loss, pregnancy, birth and multifaceted connection forms were crucial in revealing more connections to infant communication

and the subsequent development of The Blossom Method Model (TBMM).

The diagrammatic Blossom Method Synthesis Model overleaf (Vol 1: Figure 1) highlights the components within and the distinctive synthesis of these components in the development and creation of TBMM. There are five key areas: embodied relational knowledge; parent-infant research; peer and academic support; clinical influences and linguistic study. Each of these areas comprise a number of specific elements.

Figure 1 ***The Blossom Method Synthesis Model***



For further consideration of TBMM and how this can be visualised in a model form, I have provided a model (Vol 1: Figure 2). It shows the three potential ‘body-mind’ entities in a parent-infant psychotherapeutic setting and the components for consideration. It demonstrates the bio-directional quality of TBMM.

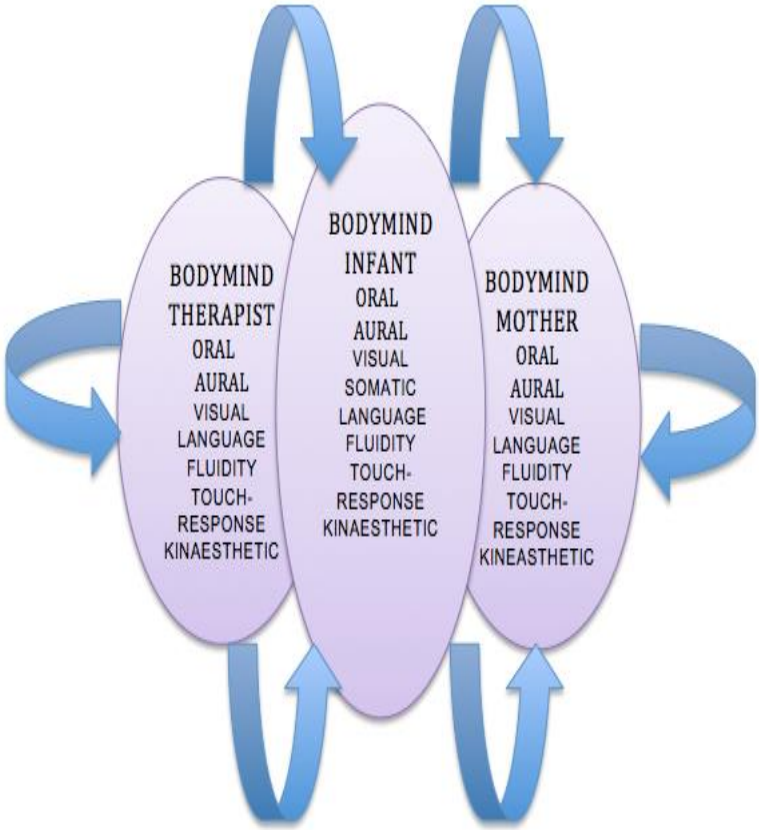


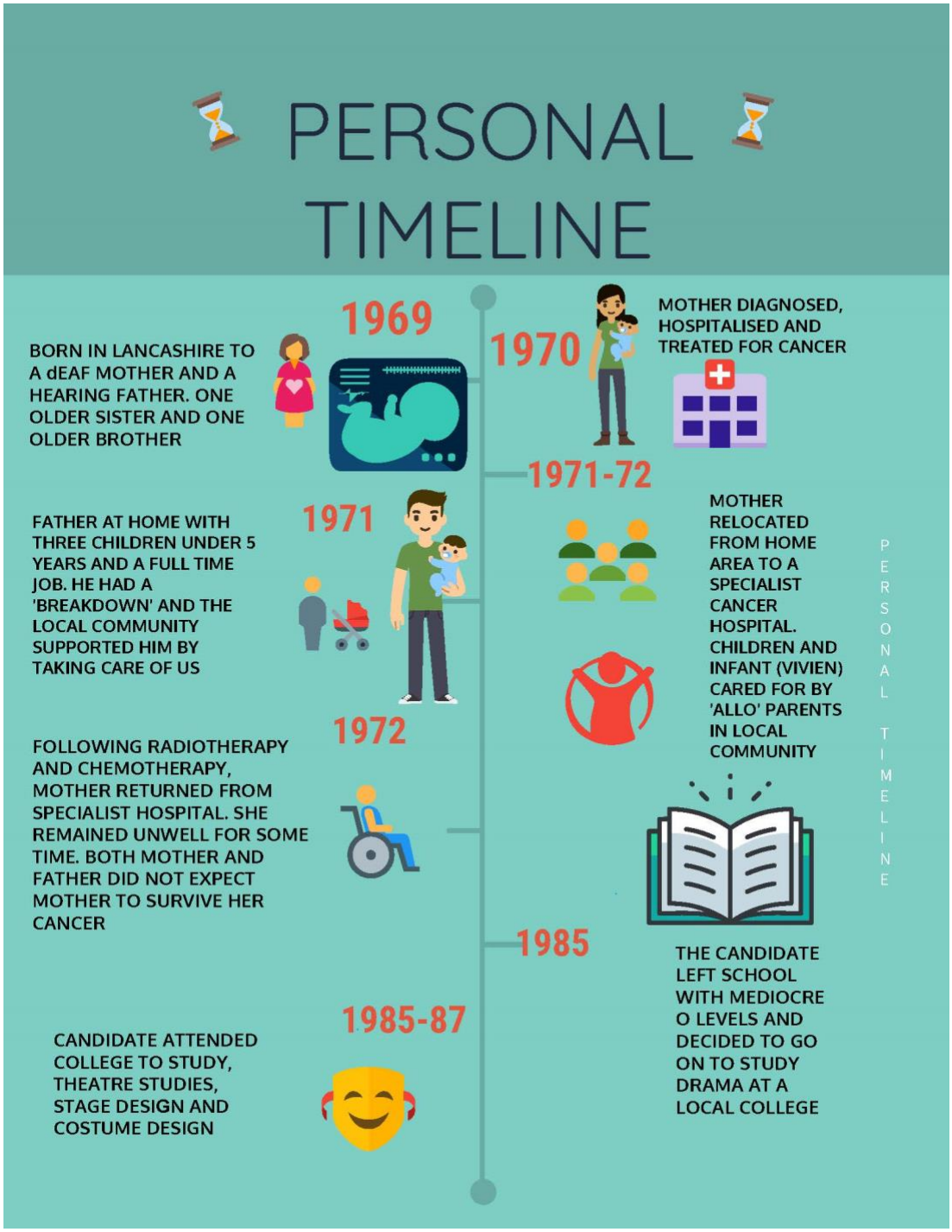
Figure 2 : Diagram of The Blossom Method

The second, educational timeline (Vol 1: Timeline 2) demonstrates my commitment to training. From 2008 to the present I have undertaken postgraduate studies in management, integrative psychotherapy, clinical supervision, associate psychotherapy teaching, advanced psychotherapy teaching and an MA Psychotherapy. Also included in this timeline are academic studies in Linguistics and BSL.

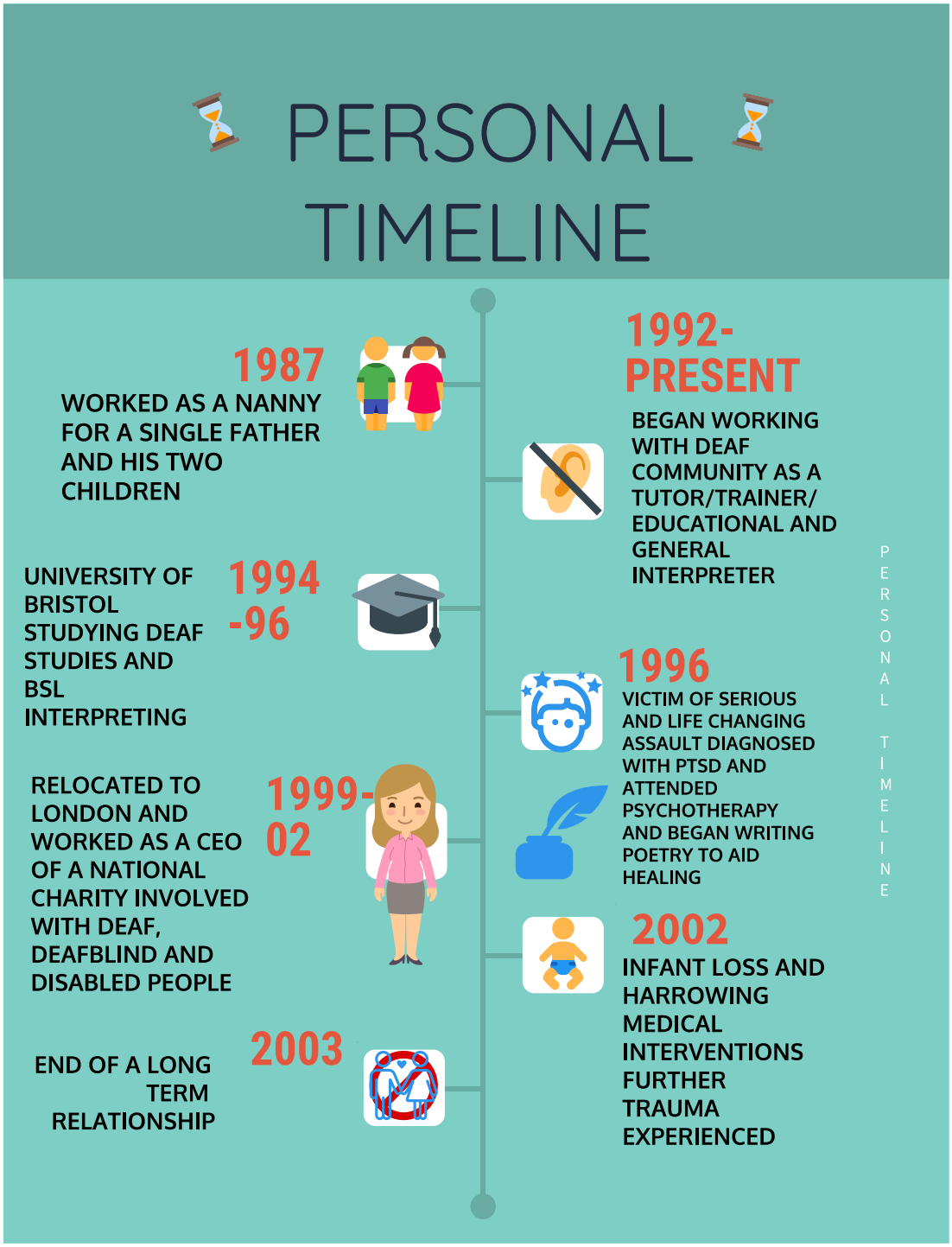
For the purpose of the context statement I add two further tables. Table 3 demonstrates my wide range of clinical experience and indicates the type of clinical practice, the skills developed, type of service user and the environment where my training and skills have been used and developed. Table 4 presents influences on the development of The Blossom Method.

The Personal Timeline (Vol 1: Timeline 1) overleaf provides significant personal information that has influenced my ‘worldview’ and maps out these details in a visual format.

Timeline 1: Personal Timeline



Personal Timeline 1 Page 1



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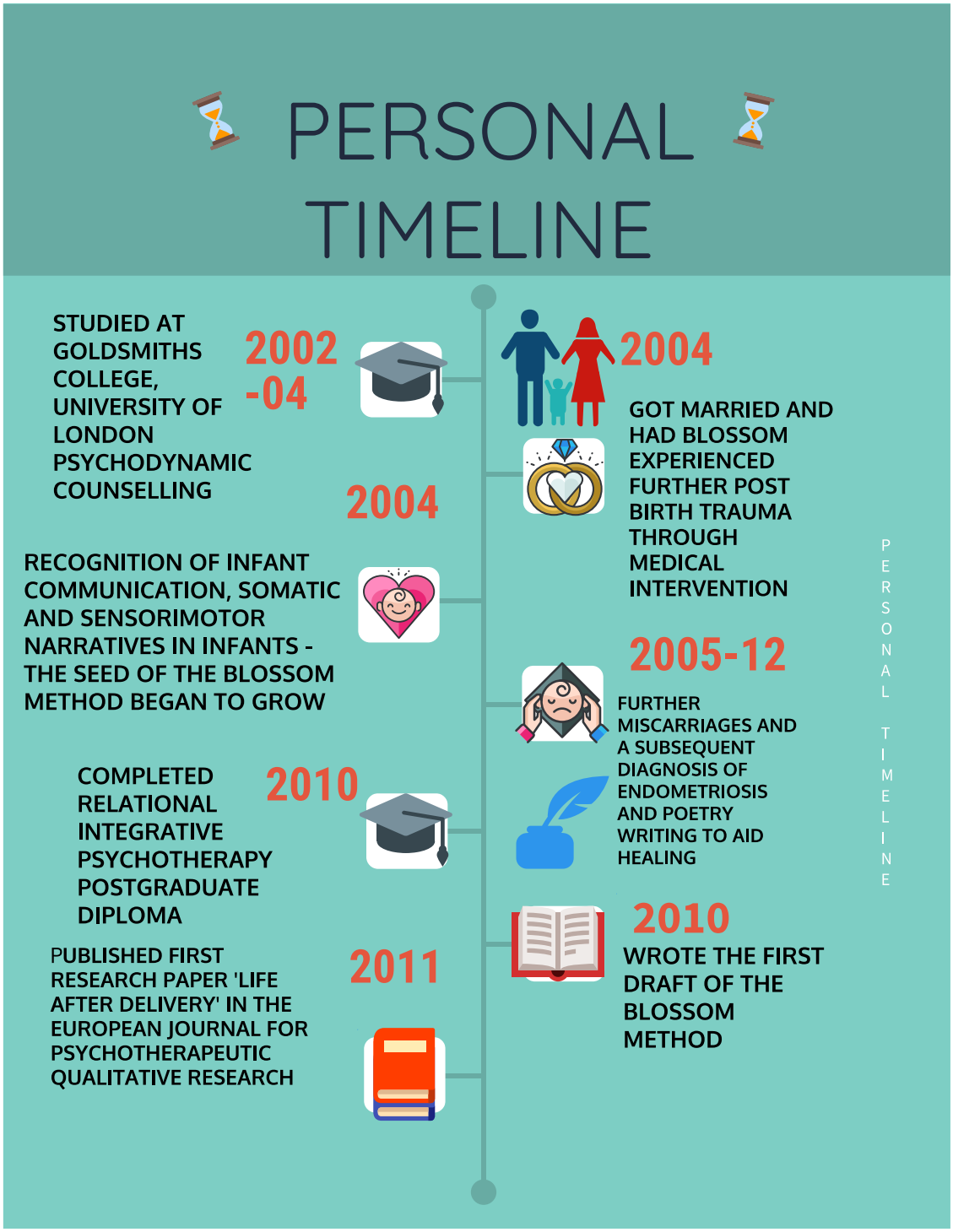

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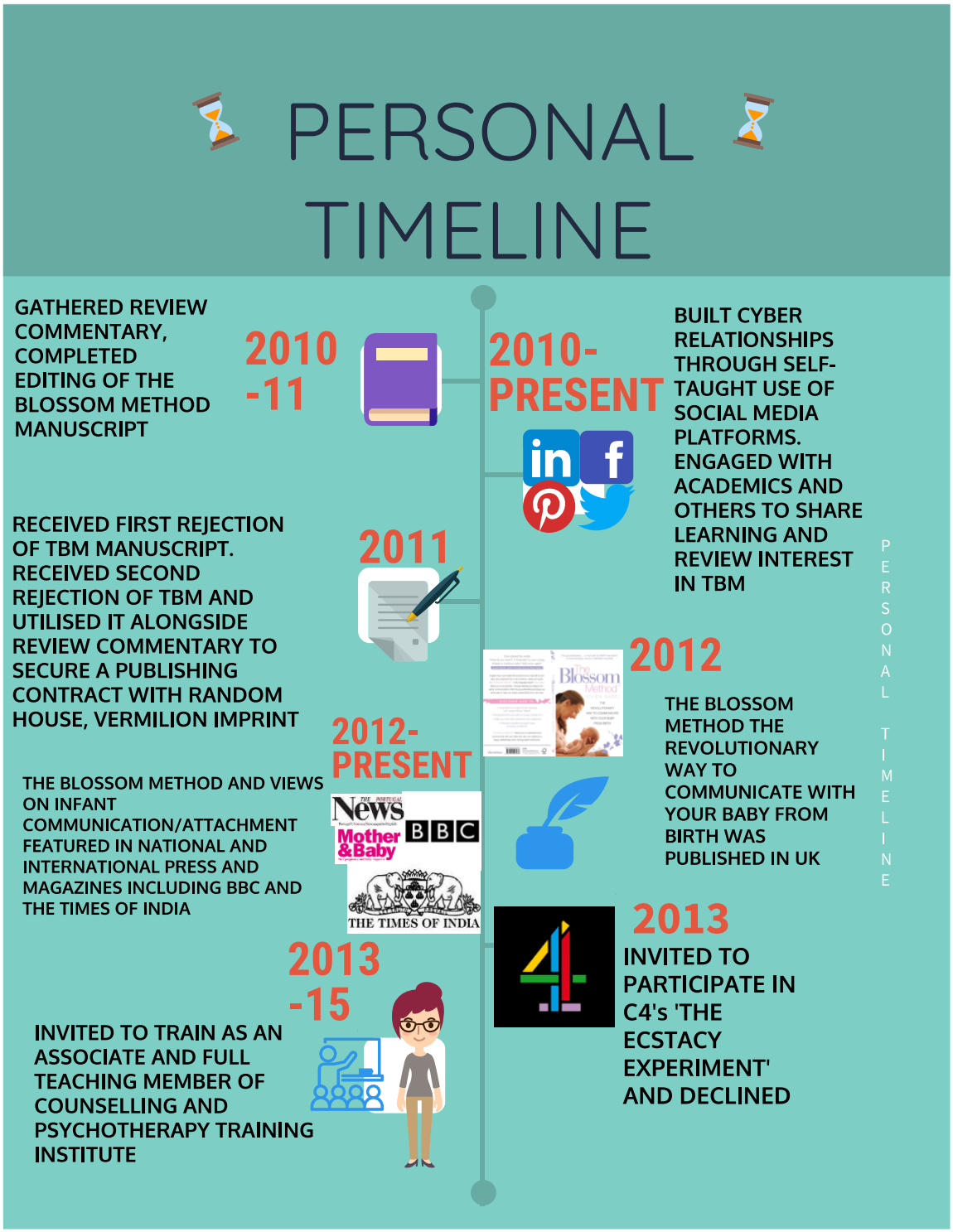

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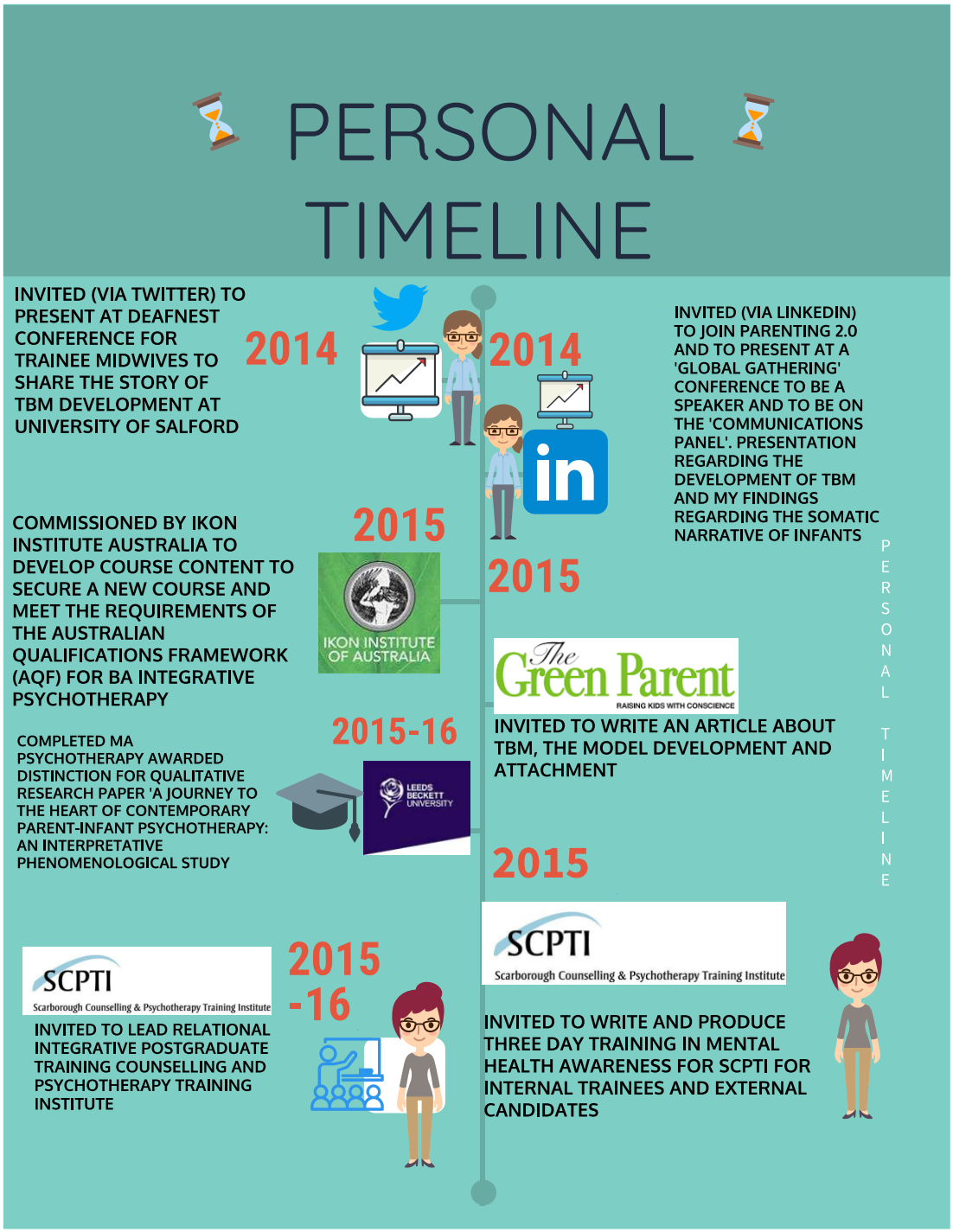

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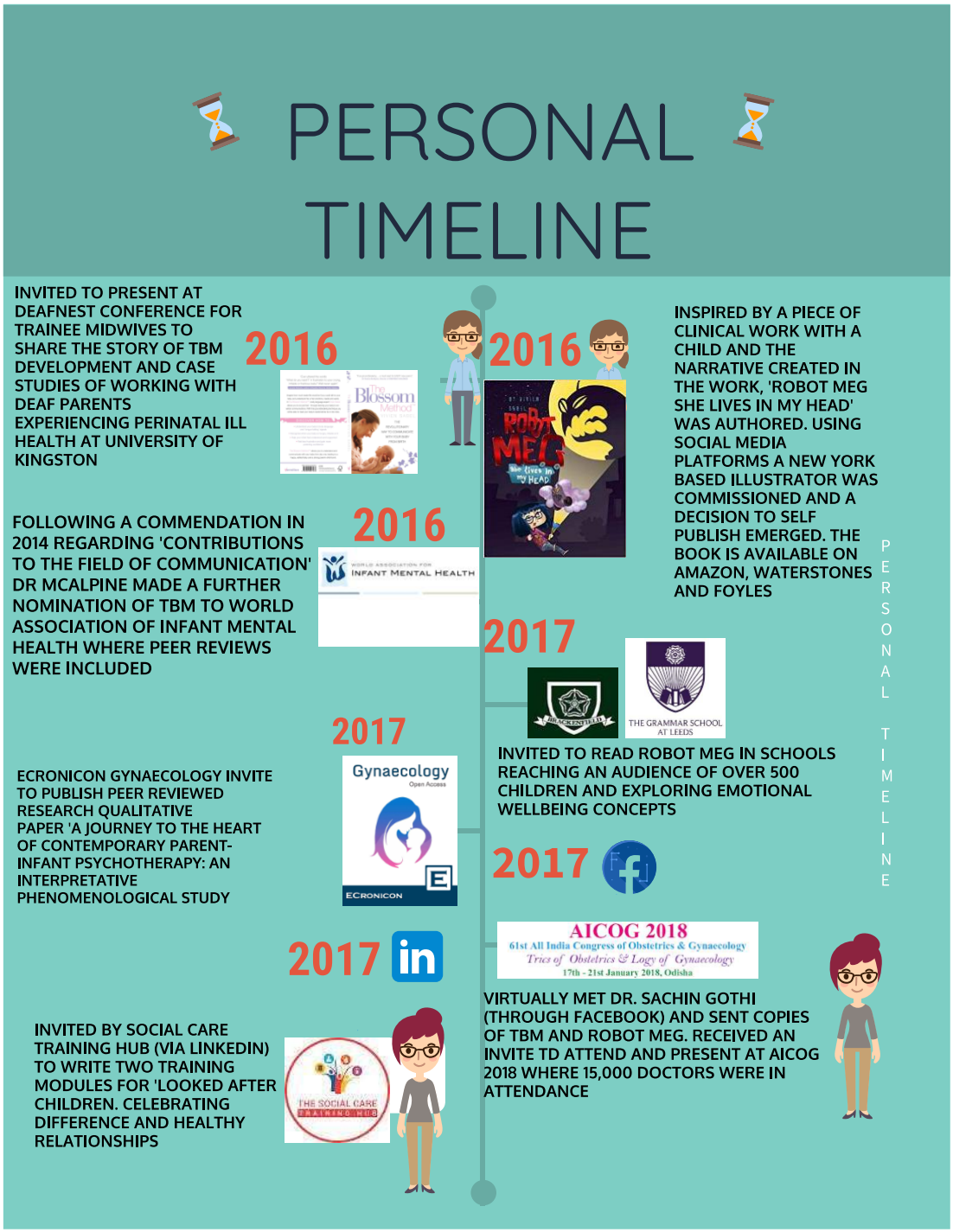

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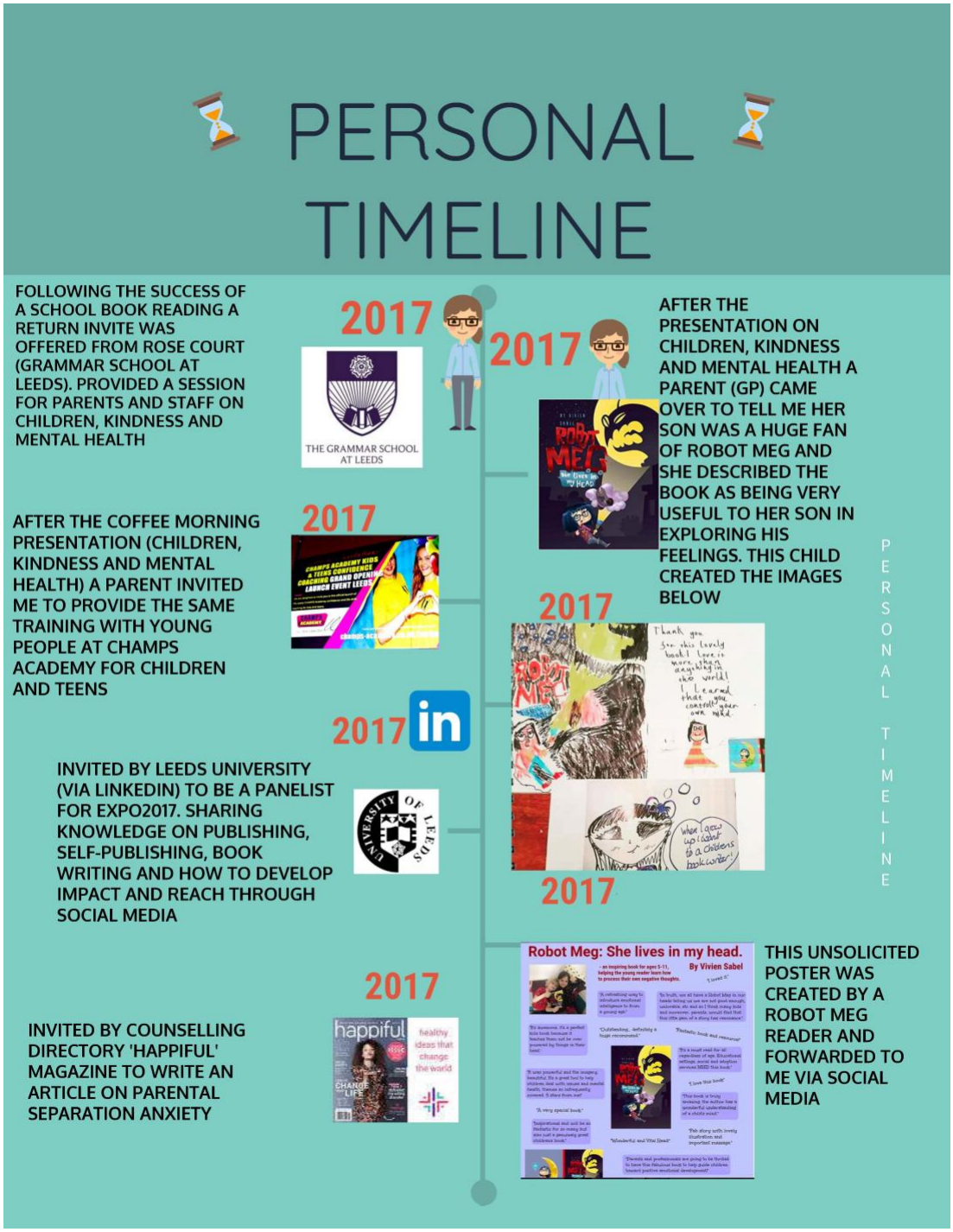

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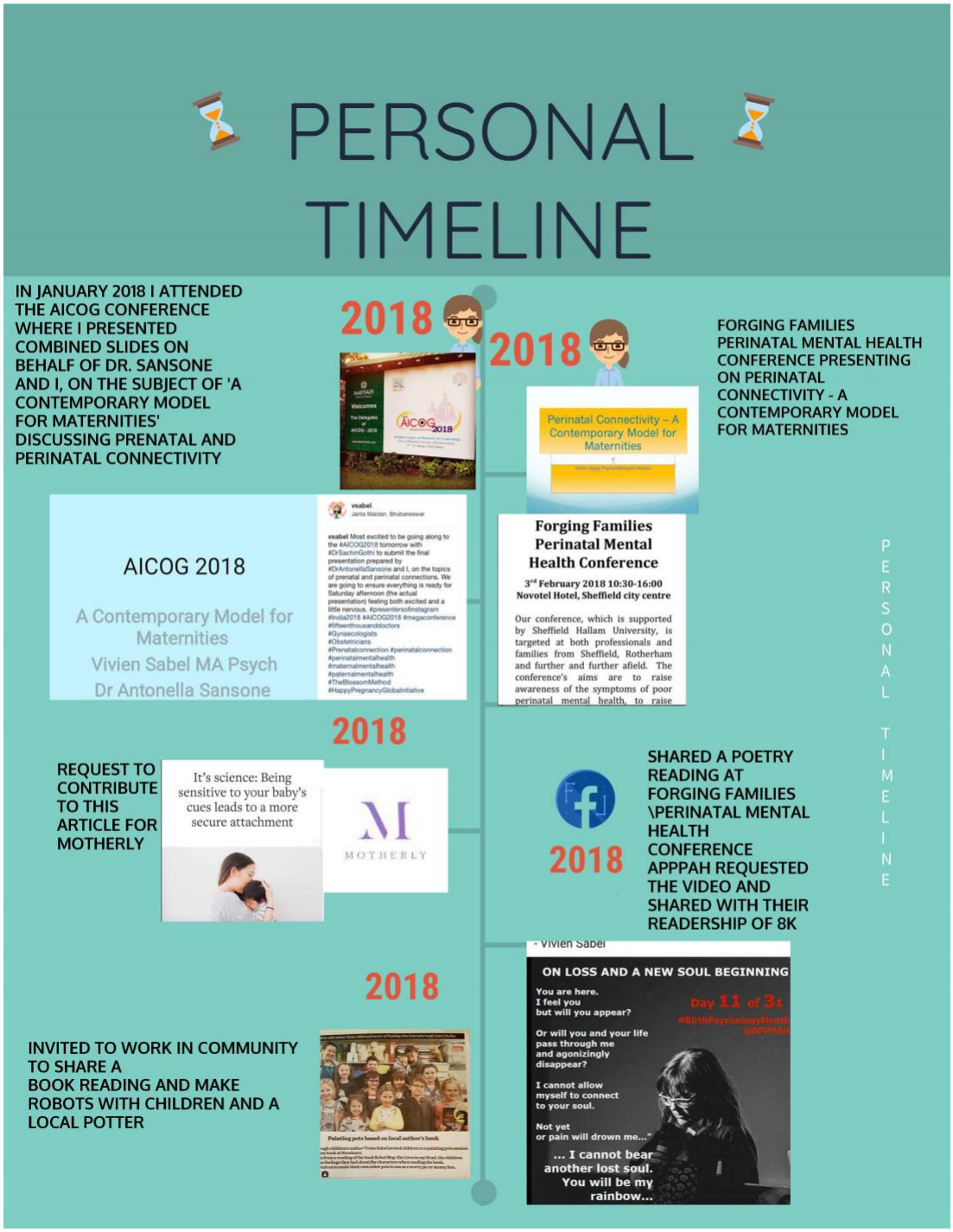
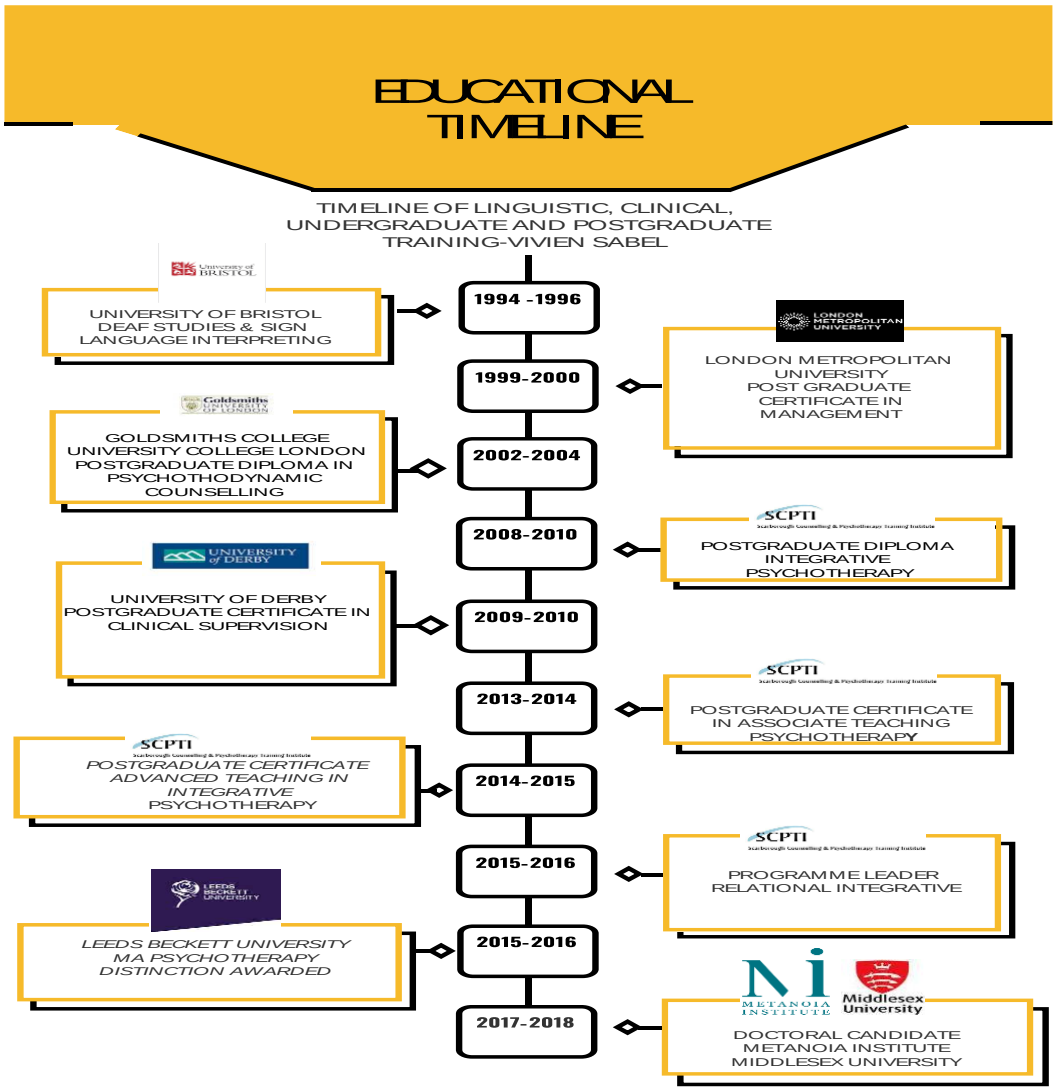


Personal Timeline Page 8

Timeline 2: Educational Timeline



Educational Timeline 2

The educational timeline (Timeline 2) demonstrates 13 years of commitment to higher education and three years of training psychotherapists in an integrative relational model. Interpreter-level acquisition of BSL has incorporated five years of linguistic study and over 26 years of contact and work with the Deaf community. Additional CPD has been consistently undertaken. The most recent CPD attended was ‘Domestic Violence and the Deaf Community’: a two-day training facilitated in BSL by a Deaf trainer involving staff from the charitable organisation with which I am affiliated.

Table 3 : Clinical Experience

CLINICAL TRAINING COMPLETION DATE	**CLINICAL EXPERIENCE**	**SKILLS DEVELOPMENT**	**PATIENT/CLIENT TYPE**	**ORGANISATION**
PG DIPLOMA PSYCHODYNAMIC COUNSELLING **2004**	COMMUNITY SCHOOLS PRIVATE OUTPATIENT/INPATIENT PSYCHIATRIC SERVICES	TRAUMA FOCUSED SOMATIC EMDR BODY WORK	DEAF HEARING DEAFBLIND ADOLESCENTS ADULTS GROUPS	SELF EMPLOYED PROJECT CONTRACT COLLEGE SCHOOL
PG CERTIFICATE SUPERVISION **2010**	SUPERVISION OF TRAINEES & QUALIFIED CLINICIANS	WORKING WITH ART THERAPISTS GROUP WORK INDIVIDUAL	DEAF TRAINEES DEAF THERAPISTS HEARING THERAPISTS GROUPS	CONTRACTOR CHARITY PRIVATE PRIVATE HOSPITAL
PG DIPLOMA INTEGRATIVE PSYCHOTHERAPY **2010**	PRIVATE CHILDREN/YOUNG PEOPLE OUTPATIENT/INPATIENT PSYCHIATRIC SERVICES	TEACHING DEAF THERAPISTS RUNNING A DEAF PROCESS GROUP LEADING DEAF GROUP SUPERVISION	COUPLES INPATIENT GROUPS CHILDREN/ ADOLESCENTS PARENTS & CHILDREN MATERNAL/PATERNAL MENTAL HEALTH	SUPERVISORY CONTRACT INPATIENT CONTRACT PRIVATE ACCIDENT/INJURY TRAUMA RECOVERY PSYCHOTHERAPY

PG CERTIFICATE ASSOCIATE TEACHING **2014**	TEACHING PSYCHOTHERAPISTS	GROUP DYNAMICS TEACHING INTERVIEWING MARKETING & RECRUITMENT	TRAINEE PSYCHOTHERAPISTS	SCARBOROUGH COUNSELLING & PSYCHOTHERAPY TRAINING INSTITUTE (SCPTI)
PG CERTIFICATE ADVANCED TEACHING **2015**	TEACHING AND COURSE LEADING	TEACHING AND LEADING PSYCHOTHERAPY TRAINING RECRUITMENT INTERVIEWING COURSE CREATION	TRAINEE PSYCHOTHERAPISTS PROSPECTIVE TRAINEES TRAINING GROUPS OF PSYCHOTHERAPISTS CONSULTATION COMMISSIONING COMPANIES PUBLICATIONS	SCPTI SELF-EMPLOYED CONTRACTOR COMMISSIONS COLLABORATION TRAUMA TREATMENT
MA PSYCHOTHERAPY	PARENT-INFANT PSYCHOTHERAPY (PIP)	PIP PRACTICE TBMM	INFANTS & PARENTS BOTH DEAF & HEARING CLIENTS NATIONAL & INTERNATIONAL AUDIENCES	OWN OFFICE COMMUNITY PRIVATE PRACTICE UK INDIA

Table 4 : Major influences

INFLUENCE	OUTCOMES
Born into a dual heritage family	Exposure to somatic and reliance upon gestural narrative from birth
Being raised by a deaf mother	Acute and heightened sense of non-verbal language Creative embodied capacity to connect and communicate non-verbally
Studying Deaf Studies, BSL, Linguistics & working with the Deaf community	Academic learning in 'Deaf Studies' Fluency in BSL and an in-depth knowledge of Sociolinguistics and Sign Linguistics
Experiencing a significant traumatic event and being diagnosed with PTSD	Heightened awareness of movement and non-verbal expression through the re-triggering of hyper-vigilance
Working with an art psychotherapist	Supported to recover well from traumatic events Provided with a 'good enough' father figure and in doing so developed more trust in males
Studying Counselling, Psychotherapy, Clinical Supervision, PIP	Developed quickly and studied to gain one undergraduate degree, two postgraduate diplomas, two postgraduate teaching certificates and one master's
Having a baby	Birthing, mothering and 'being with' Blossom seemed to ignite 'the motherhood constellation' (Stern, 1995) in a positive way to create self-knowledge and knowledge for others in relation to perinatal connectivity

These ways of working appear to hold a feminine quality and in considering this further, a feminist perspective is revealed. My approach is equitable in nature and throughout my working life my aim has been and continues to be to reach ‘the most marginalised and deprived populations first ’Equity for Children: Equity and Social Justice: A short introduction. (2013:1).

My work with a Deafblind, autistic person with additional learning disabilities, whom I shall name ‘Tom’, gave me the opportunity to practise inclusivity and develop my understanding of connection. Linington suggests, ‘People with learning disabilities can be ill-regarded, sometimes experience bad treatment from others, and be viewed as not at all suitable for psychotherapeutic help’ (2014: 125). As Napier and Leeson observe, ‘Some deaf individuals have been so socially and linguistically isolated during their lifetime they have not fully acquired either a sign language’ (2016: 149). The client was adopted in infancy and may be defined as having ‘Specialist Linguistic Needs (SLN)’ (Napier and Leeson, 2016: 149). His key worker and I have noted sign language vocabulary expansion, a development in autonomy, emotional development and a reduction in anger outbursts, all of which helped us to understand the emotional and psychological nature of the individual.

As Smith et. al. (1998) suggest, ‘touch in psychotherapy is a by-product of the mind-body dichotomy so well entrenched in the philosophical underpinning in Western society’ (1998: 4). Separatism or ‘mindbody’ dualism as suggested previously has clouded the perception of touch in therapy and the relevance of the ‘bodymind’ in psychotherapy and elsewhere. Freud, in stating ‘the ego is first and foremost body-ego’ (1924: 26) then continued to devote his time to creating a body-driven conceptual framework of the mind whilst simultaneously distancing himself from the ‘bodyself’ in psychotherapy. Goddeck spoke of his patient’s experiencing ‘betrayal’ of their unconscious bodies and the impulses within. With reference to healing touch through massage he reports ‘the patient’s changing expressions reveal hidden secrets of his soul’ (Goddeck, 1931; 1977: 236), and this is supported by Ferenczi’s theories of ‘somatic trauma therapy’ (Totten, 1998; Rothschild, 2000).

Therefore, a client who experienced limited forms of reparative touch in infancy and childhood, and who is mourning the absence of such body experience, may encounter a deficit in adult life of the egoic incidence of self-support (Smith et. al. 1998). The potential of the singular 'mind-only' cognitively driven approaches to heal embodied wounds seems improbable to me.

Consideration for positive forms of touch was carefully interwoven in the work with 'Tom'. As Staunton writes, 'In many forms of psychotherapy, abstinence from touch is seen as an essential part of containing the client's process' (2002: 90) but in consideration of a Deafblind client, touch and creativity are essential for clinical work and communication. Linington reports that, 'People with disabilities…have the same attachment needs and desires as other people in society, although these needs and desires may sometimes be communicated through different behaviours' (2014: 125). For example, the client showed me his hand and described it as being sore. I utilised this expression and through a form of 'consolation touch' (Badouk Epstein, 2014: 113) – which I believe would be better named as reparative touch – I gently massaged the client's hand. During this process the client appeared deeply moved. His eyes became moist and I asked him if he was OK. He signed 'Happy today'. Through a process of follow-on communication and somatic exchange, I utilised three signs in a combined form. I signed 'happy-tears-emotional'. The client (having never used these signs in a combined way before) returned them to me. He now uses these signs regularly if he is moved to tears in our work. His key worker says he has added these and other signs we have co-created to his general vocabulary. As Badouk Epstein observes, 'Touch can be the most powerful form of communication throughout the course of one's life, holding immense potential for use' (2014: 113).

Whilst in training I attended psychotherapy with a therapist who was 'against touch' in therapy. I was not aware of this until a poignant therapeutic moment. I recall arriving to therapy having had a 'terrible week'. I enthusiastically entered the space and declared, 'Oh I have had such an awful week! I need a

hug'. As I approached her she was stiff, unfeeling and unresponsive. I was already physically holding her, but she chose not to raise her hands to return the hold. The initial impressions and embodied residue from this experience left me feeling ashamed and wounded. My immediate sense of the therapist was that she behaved like a 'cold fish'. The embodied meanings I have derived from my own experience of being therapeutically missed is that the therapist appeared elusive, absent, rigid, slippery, and cold: above reproach, judgmental, uncaring and unfeeling. I was left feeling embarrassed, ashamed, uncomfortable, 'stupid', angry and subsequently insulted and patronised. In infancy, misattunement occurrences construct an experience of the mother as an unfamiliar person and the infant as incomplete and deficient. These experiences of misattunement may be comprehended as shame experiences which result from the sudden awareness that one is being viewed differently than one anticipated (Spiegel et. al., 2000).

I felt strongly about her lack of engagement and decided to explore my feelings with her. I have learnt to expel my anger as early as possible with the person I feel annoyed with. Gerhardt writes, 'When you suppress anger, your body and its various systems remain aroused and biochemically stimulated' (2004: 99). I believe it is imperative to express to the person your feelings in order to promote biochemical, autonomic and muscular harmony. I spoke to the therapist about my feelings and felt further discouraged by her response. She said, 'Well let's not focus upon what you didn't receive in this way but explore how you feel about not getting your needs met'. This 'shut up' technique made me feel further therapeutically missed. At this point I stated that this was not the sort of psychotherapy experience I needed or wanted to heal my early and more recent trauma wounds. I informed the therapist I would no longer be attending psychotherapy. Her attempt to explore rupture and repair using a singular, 'mind-only' approach had failed me. However, it provided me with an example of an integrative model that was valueless to me personally but that may be of benefit to others.

When considering touch in Parent-Infant Psychotherapy (PIP), a parent-infant

psychotherapist may wish to explore the following: What is the familial history of touch in the client? How does a client approach physical and emotional contact with their infant? What does the therapist hear, see, feel and embody in relation to the contact between caregiver and infant? Are there situations in which you would avoid touch? What do you embody in connection to touch and a client? Why do some clients respond favourably to touch and others seem unable to tolerate it? Why do some clients experience fear in embodied touch? What is the therapist's moral and ethical position on touch? What is the therapist's own psychosomatic experience of touch? Being in full contact with the 'bodymind' self will provide an authentic positioning for answering these questions and facilitating the work. They will inform 'connection positioning' and deepen potential awareness of all forms of connection.

As previously stated, I hold strong beliefs in consideration of disability and 'Deafhood' (Ladd, 2003: xviii). The Social Model of Disability (Oliver, 1990) was developed in opposition to the medical model and has been further developed by Disabled people. The Deaf community have developed their own cultural-linguistic model in response to the inadequacies of both the social and medical model. The diagrams overleaf outline these models.

The Forces Against Social Model of Disability model that follows (Vol 1: Figure 3) shows the number of forces that I believe need challenging in contemporary society. Without awareness, the majority will be informed by the medical model – a model which, in my opinion, promotes discrimination, limits individualism, promotes medicalisation, negates development, ignores wider needs, pathologises, is pejorative, lacks inclusivity, encourages segregation, is devaluing and discriminatory and compromises accessibility. Furthermore, it is a model built upon a landscape affiliated with the science revolution which has medicalisation at its core.

The socio-cultural linguistic model created by Ladd (2003) promotes Deaf identity, cultural connectivity, observation of linguistic minority status, BSL within and beyond the Deaf community, accessibility, comprehension of need

and involvement in policy.

Figure 3 : Forces against the social model of disability

Table 5 : Cultural linguistic model

ANTI-MEDICAL MODEL Hearing-impaired Deficit discourse Problems of deafness Ethnocentrism ANTI-GENETIC ENGINEERING Science intervening to end the deafness gene ANTI-COCHLEAR IMPLANTS Cochlear implant surgery as a matter of choice when the infant ages and can self-elect ANTI-MAINSTREAM Education in mainstream settings for Deaf children can be very isolating	PRO BSL MODEL Deaf community seeking linguistic recognition, not further promotion of oralism LINGUISTIC MINORITY Deaf people viewed as a linguistic minority & linguistically oppressed PRO DEAF SCHOOLS Deaf children being educated in BSL MORE DEAF PROFESSIONALS/BSL INTERPRETERS More Deaf people in visible professional roles and in the media DEAF VISIBILITY More BSL on TV, in films, in the music industry	DEAF CULTURE Collective culture Include the teaching in linguistic/language studies BSL TEACHING IN SCHOOLS Promotion and education in BSL via the national curriculum DEAF CLUBS Collective Deaf History Deaf Humour, Deaf Theatre, Deaf/BSL Poetry, Deaf Performance COLLECTIVE TRANSPERSONAL DIMENSION Collective spiritual issues

CHAPTER 4: THE BLOSSOM METHOD

Conclusions drawn in relation to human existence appear to be more connected with impulses and other inexplicable unconscious factors rather than with conscious will and well-meaning rationality (Jung, 1966).

4.1 What is The Blossom Method?

The Blossom Method has been developed in response to my life experiences, clinical training/work, academic insight and directly from my experience of becoming a mother to my daughter, Blossom. It is a relationally embodied method for communicating with and understanding the somatic narrative of an infant.

> The social engagement system is usually built upon a series of face-to-face body-to-body interactions with an attachment figure who regulates the child's autonomic and emotional arousal; it is further developed through attuned interactions with a primary caregiver who responds with motor and sensory contact to the infant's signals long before communication with words is possible (Ogden, et. al. 2006: 42).

Babies are sentient beings with a drive to bond with their parent(s). Papousek and Papousek suggest that, 'learning how to communicate represents…the most important developmental process to take place in infancy' (1997: 35). That said, infants do not speak the verbal language of adults. Much like the Deaf community, they have their own methods of communicating. They communicate and attempt to connect using their bodies, mouths, and other non-verbal cues.

In my drive to connect and with an innate interest in working with the different language forms, I noted many expressions in Blossom that I assumed would be similar in other infants. For example, in Chapter 4 of my book *The Blossom*

Method (Sabel, 2012), there are specific references to various and variable tongue movements in infants that I have defined as ‘tongue-talking’ (Sabel, 2012). My research for the book showed what appeared to be similar movements and expressions in the other infants observed. The presentation might be slightly variable (as accents in spoken languages vary), but the presence of these movements developed my curiosity about the language of infants and I believe that ‘body language, facial expressions, tongue-talking’ (Sabel, 2012) may aid understanding between parent and infant.

I do not see the presence of expressions in infants as random. I believe they are emerging forms of communication and precursors to speech and language development which can be understood through responsive, attuned and sensitive parenting. They provided information to me as the observing care-giver about matters in relation to hunger, discomfort, wind, constipation, tiredness, frustration, over-stimulation, need for comfort, and possibly signs of illness. The following illustrations are taken from *The Blossom Method* and aim to provide a visual reference of some of these findings.

Figure 4 : The hungry tongue – protruding in and out of an infant’s mouth (Sabel, 2012)

Figure 5 : The hungry ‘O’ shape mouth (ibid)

Figure 6 : The searching tongue moving from side to side (ibid)

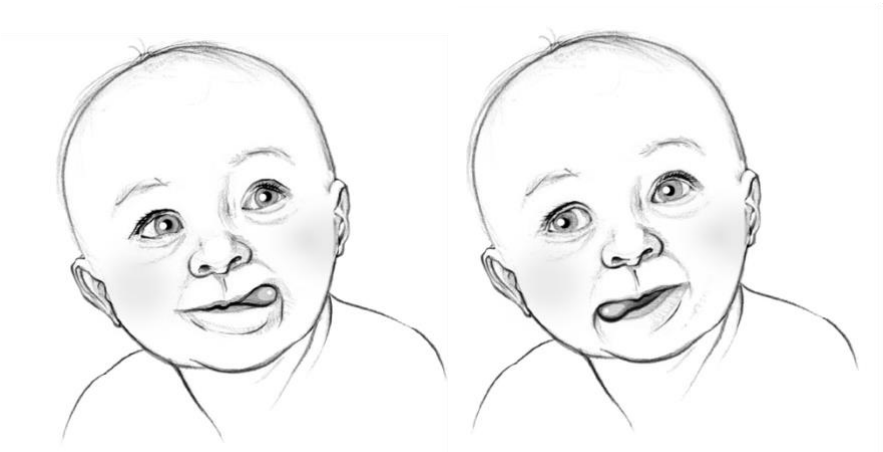


Figure 7 : The windy tongue/expression (ibid)

Figure 8 : The bowel movement and urinating expression (ibid)

The Blossom Method (2012) advocates reactions to this 'tongue-talking': **observation (I have seen you)** of expressions, **mirroring back (I am listening)** and **response (I will provide you with what you need)** to the infant. In addition to 'tongue-talking' (Sabel, 2012) *The Blossom Method* refers to other forms of somatic narrative, including fist clenching, arm movements, leg kicking, taut tummies and arched backs, self-soothing, eye gaze, head movements, body wriggling and changes in infant breath. As suggested previously, supplementary information in relation to signs of infant illness (Vol 1: Appendix 5), birth trauma, wind, constipation, breast avoidance guided by infants, mastitis, causality of maternal physiological conditions through maternal somatic narratives, implicit processes, mother-infant connection, sleep, infant communication, non-verbal communication, therapeutic relationship, and language development were discovered through this research. During an extended breast-feed I recall Blossom avoiding my left breast. She would normally move between the two with ease. On this occasion she refused. Two days later my breast became very sore and I was subsequently diagnosed with mastitis. When I recovered from the mastitis, she returned to the left breast. As Sansone (2004; 2007; 2018b) suggests, an excessive increase in tension may alter the muscular form of the breast, which may result in mastitis, thus inhibiting the capacity to breastfeed. This could be a somatic response to a client's own embodied maternal history. I

gathered similar stories from other mothers in relation to infants informing their mothers through their somatic responses (Vol 1: Appendix 4).

The drive for connection with my baby was embodied and intense. I discovered more about attunement, somatic narratives, reciprocity, mutuality, awareness and emotional resonance in attachment (Cozolino 2010). These discoveries supported my original findings, deepened my knowledge and made me determined to illuminate this area in the wider field of psychotherapy and elsewhere.

4.2 The Birth of Blossom and The Blossom Method

Blossom was born at home as planned and we enjoyed a wonderful home-birthing experience where medical interventions or drug assistance were not required. We used 'HypnoBirthing' (Mongan, 1998) as an aid to a more relaxing birthing experience.

Whilst pregnant with Blossom I held embodied a previous pregnancy loss. After a traumatic miscarriage and subsequent gynaecological surgeries, the birth of Blossom was quite a relief. As Bager-Charleson suggest, 'We can delude ourselves, perhaps, that we can "bracket"' (2012: 134) these somatic and cognitive references, but they will emerge in our mind and body as these 'traumatising events cannot be extricated from the psyche' (Sabel, 2017: 138) and therefore I imagine I carried my anxiety and my lost infant into my pregnancy, the birth of Blossom and in raising her.

During Blossom's life in the womb and following her birth, I felt she was communicating with me. 'Rudimentary embodied **mirroring** fostered by mother-baby interactions may play a role in child development and emotional attunement with their mothers long before birth, and even affect our capacity to empathise' (Murray, et. al. 2016; Ammaniti and Gallese, 2014 in Sansone, 2019). From the point of conception, the womb and wider environment signals 'all the way down' that the child is loved and welcomed (Emerson, 1997; Meany, 2010, in Sansone 2019). In engaging with Blossom *in utero*, I felt deeply

connected to her. I recall during the third trimester experiencing Blossom's 'in the womb' hiccups. It was such a strange yet reassuring feeling to know she was hiccupping inside me. These little rhythmic movements and her other sensorimotor actions reassured me in relation to infant loss and the lives of my unborn children. I constantly connected through touch and verbal communication throughout my pregnancy. I would talk to my baby and bump and rub my belly.

'Psychophysiological attunement' through 'touch and sound are already sources of pleasure in the womb' (Sansone, 2007: 112). My husband did the same, and he played his guitar throughout our pregnancy. Interestingly, Blossom's sense of musicality is profound. She has been singing since infancy. She sings when she is happy, and it is in the absence of singing we are provided with clues to her wellbeing and mood.

Once Blossom appeared the midwife placed her on me. She completed her own 'breast crawl' where she fed and slept in equal measure for many hours. We marvelled at our miracle baby. It was only a matter of hours before I recognised her non-verbal forms of infant communication and her somatic narrative. This was further enhanced when I was injured and left with limited mobility for approximately six weeks. It was during this period that I became particularly aware of Blossom's non-verbal narrative and the phenomenology of 'tongue-talking'.

In support of attuning to the somatic narrative of infants, the key principles of The Blossom Method, in its original form, are **observation**, **mirroring,** and **responding** to the non-verbal language of infants. In developing this method, I did not ignore the verbal expressions, but initially (and instinctively) my primary consideration was the somatic non-verbal narrative. However, in addition to the non-verbal narrative, I embodied my experiences of her verbal narrative too.

> *Communicative Musicality* explores the intrinsic musical nature of human interaction. The theory of 'communicative musicality' was developed from ground-breaking studies showing how in mother-

> infant communication there exist noticeable patterns of timing, vocal timbre and melodic gesture. Without intending to do so, the exchanges between a mother and her infant follow typical rules of musical performance, with distinct timing and melodic narratives (Malloch and Trevarthan, 2009: 1)

As Sansone observes, 'The emotional dynamics of the mother-infant dyad and their rhythmic interactions are certainly fundamental to linguistic and cognitive development' (2004: 218).

The Blossom Method Model and Literature

The following section outlines relevant literature and The Blossom Method Model (TBMM), and reports upon its usage and considerations as a contemporary model with clients in parent-infant psychotherapy (PIP). Like Winnicott, amongst others, who initiated parent and child consultation in 1931 (Acquarone, 2004) I have used contemporary connectivity methods (video, Skype, social media) and face-to-face consultation to gather anecdotal evidence involving parents and infants locally and globally. This research stemmed from becoming a mother and gathering sensorimotor data through my own original experiential testimony. These works in The Blossom Method (2012) highlight specific discoveries in relation to my personal observations of the somatic narratives of infants and attachment connectivity between infants and their caregivers.

In consideration of infant mental health, Winnicott (1953; 1964; 1971a; 1971b; 1971c), Bion (1962a; 1962b) and Bowlby (1944; 1951; 1969; 1973; 1980; 1988) addressed infant mental health and the relationship between caregiver and infant that spanned decades. Bowlby suggested that 'in order to reach optimum mental health' (Sabel, 2016a) 'the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment' (Bowlby, 1951: 13). Here Bowlby emphasises the availability of the mother, however I am drawn to consider an opposing position where maternal 'absence' is experienced in

infancy, and the impact of such loss. Absence of the primary caregiver as a result of maternal/paternal death, birth trauma, perinatal depression, postnatal depression, postpartum psychosis, PTSD, or potentially absence through being flooded or engulfed by the intersubjectivie infant and other causes are likely to have a significant impact on the developing infant, the mother, the mother-infant dyad, the wider family and subsequently the wider community (Vol 1: Appendix 6).

Boukydis suggests, 'Infant mental health is a relatively new and important field that has, as its core, practices involved with nurturing the parent-infant attachment relationship' (Boukydis, 2012:1). Boukydis (2012) further states, 'One basic assumption of infant mental health practice is that to the extent mothers are well supported and emotionally healthy, their infants will receive the essential nurturing and emotional sustenance they need for healthy development' (2012: 1).

In PIP the clinician aims to support the caregiver to develop the infant-parent relationship and enhance the attachment relationship 'by targeting the mother's view of her infant, which may be affected by her own experiences, and linking them to her current relationship to her child, in order to improve the parent-infant relationship directly' (Barlow, et. al., 2015: 14). It provides an opportunity to observe the 'interpersonal communion' (Stern, 2004: 148) between parent and infant. In regulating the infant and in consideration of the infant's mental health the importance of the role of caregiver has been noted (Beebe, et. al., 2010; Tronick, 1989; Tronick and Weinberg, 1997;). Wholly observing, mirroring and responding in the caregiver-infant dyad in PIP may support the parent to understand more of how their habitual ways of thinking about the self (caregiver) and other (infant) may need to be considered 'with the re-emergence of psychic material from the past (such as memories, desires, disappointments)' (Schore, 2010: 1 in Baradon, 2010).

If the maternal figure is present, the processes of mutual regulation are neither simple nor straightforward (Tronick, 1989). This is likely to be a result of a mother experiencing 'a unique form of *double identification*…' (Brazelton and

Cramer, 1991: 15; italics in original) where ‘dual identification transpires in relation to her mother *and* fetus. The re-emergence of the relationship to the new mother’s own mother is a very intense process. [It may transpire] in a rapprochement to the mother, therefore igniting the ‘motherhood constellation’ (Stern, 1995).

Thomas et al. discuss how, ‘A major conclusion of the last decade in developmental neuroscience research is there now is agreement that the infant brain is designed to be moulded by the environment it encounters’ (1997 in Schore, 2001). ‘Evidence suggests that early parent-infant attuned interactions lay an important foundation for the child’s later emotional, social, cognitive and neurobiological development’ (Sabel, 2016b: 23). An environment sensitive to the infant will be shaped accordingly. However, ‘those who study interpersonal neurobiology believe (and research supports) that any meaningful relationship can reactivate neuroplasticity processes and alter the structures and biochemistry of the brain’ (Cozolino, 2014: xviiii).

In 2014 a collaborative report produced by London School of Economics (LSE) and Centre for Mental Health (CME) stated that the costs associated with perinatal mental health in the UK alone amount to £8.1 billion each and every year (See Vol 1: Appendix 5 for full findings table). As Bauer et. al. describe, ‘NICE and other organisations involved with the treatment of perinatal and postnatal mental health provide clear strategies but, [disappointingly], current provision can be described at best as patchy’ (2014: 5).

Observation of the somatic narrative in relation to infants and TBMM are works that requires right-brain to right-brain communication (Schore, 2010) through ‘hemispheric’ connectivity. In PIP, ‘the story told by the ‘somatic narrative’ – gesture, posture, prosody, facial expressions, eye gaze, and movement – is arguably more significant than the story of words’ (Ogden and Fisher, 2015: 13).

The original TBMM concentrated upon the three main areas of **observation (O), mirroring (M)** and **responding (R)** (OMR) to an infant with the main focus upon a somatic and sensorimotor narrative exchanged between a caregiver and

infant. These core components provide a form of interconnectivity, a neurodevelopmental feedback loop between the developing infant and caregiver.

The following section delves into the model and explains through example the further perceived value of these considerations. The three components of OMR each hold a number of possible internal and additional considerations. They include the ‘somatic attachment’; transpersonal, intersubjectivity, relational, transferential, intergenerational, sensorimotor positioning; and cultural-linguistic psychotherapeutic factors. For the most part I will refer to case study examples taken from three cases: one of these studies with a hearing mother and her infant, the second with a D(d)eaf mother and her two-year-old infant and finally the third with a Deaf mother regarding her sense of motherhood.

In parent-infant psychotherapy ‘the therapeutic passage is a very physical process. Often what is most essential is experienced first in the body’ (Mann, 1997: 182). This said, there are two (and in the case of PIP three) bodies present in any psychotherapeutic encounter. Therefore, the observation of implicit and explicit processes of all bodies is available as a resource to the therapist and client. In using TBM the therapist is attempting to connect, through the process of embodied relational ‘whole-bodymind’ connectivity, the ‘bodymind’ of the client to the ‘bodymind’ of the infant via the ‘bodymind’ of the therapist. Kurtz suggests mindful observation ‘of non-verbal clues or ‘indicators’ that provide behavioral cues’ (Kurtz, 2010: 127) and a link to attachment history, trauma, client history, and the ‘bodymind’ story may aid therapists in formulating a client’s ‘hypotheses’ (Ogden, 2014). Frank and La Barre (2010) recognise the controversial nature of the usefulness of developmental theory in conceptualising the adult experience; and like Mitchell, (1993) and Stern (2010) they are mindful of how interpretation of the infant experience needs much consideration.

Questions arise regarding how a therapist experiences the presence of a client and infant. At point of contact, what was observed? What does the ‘bodymind’ of the client(s) elicit somatically in the therapist? Is the verbal language presented

congruent with the sensorimotor embodied language observed? What does the therapist observe in relation to levels of attentiveness in the parent? How attuned does the parent appear in relation to the infant? How responsive is the infant to their caregiver? Is the caregiver able to tolerate eye gaze with the infant or therapist? Is the infant seeking eye contact with the parent? How does the parent hold their infant?

Boukydis suggests a 'L-O-A-F' approach:

Listen (always listen)
Observe (the mother and baby, as well as your own felt sense)
Allow for silence (respect the mother's internal processing)
Feel curiosity (about the baby; about the mother's experience and wonder out loud sometimes) (Boukydis 2012: 150).

In the period from Blossom's birth until the present, I have undertaken local, national and international anecdotal research with mothers, fathers and primary caregivers. Bright and Harrison assert that, 'The question of who is involved in research is an essential consideration' (2013: 107). I had naively imagined it might be possible for me to undertake long-term infant-mother somatic narrative and sensorimotor observational studies in a hospital setting with mothers and their infants. Securing ethical approval within a medical setting was possible, but it would have been a difficult and lengthy process. My understanding of the mother-infant dyad means I have some reservations about face-to-face intrusion upon caregivers and their infants at the point of birth. However, I recognise the potential that this approach has for ground-breaking observations and trials. Ethically, 'matters of vulnerability, power and interrelationship' (Bright and Harrison, 2013: 107) are important to me. Smith et. al. note that, 'Most research requires some form of ethical approval' (2009: 105) but in consideration of the new mother and infant, I imagine it would be at the least intrusive and for some potentially overwhelming. Returning to the primary maternal experiences at the point of pregnancy and birth may increase the anxiety of the new mother (Sansone, 2007). Yet in some of my work with newborns and parents I have been surprised by the openness to and interest in engaging with TBMM. In

consideration of ‘human sciences’ and the impact of maternal mental health, I feel it is important to consider the statistics below.

Table 6 below estimates that 284,890 women are affected by perinatal illness in England each year. This figure does not consider paternal mental health. Nor does it include those who do not seek assistance during or post birth. As Bauer et. al. note, ‘A high proportion of cases of mental ill health during the perinatal period go undetected’ (2014: 27).

Table 6 : Perinatal mental illness

Estimated number of women affected by perinatal mental illness in England each year		
Numbers affected	Type of Mental Health	Symptoms/Descriptors
1,380 2/1000 Maternities	Postpartum Psychosis	Serious Occurs usually shortly after birth Symptoms include hallucinations, paranoia, delusions & confusion
1,380 2/1000 Maternities	Serious, Chronic Mental Illness	Chronic e.g. Schizophrenia & Bipolar Likely to occur in the perinatal period or experience a reoccurrence and/or deterioration in mental health during or post pregnancy
20,640 30/1000 Maternities	Severe Depression	Serious & persistent. Symptoms likely to affect functionality and included insomnia, irritability, loss of

		interest, hopelessness etc.
20,640 30/1000 Maternities	Post-Traumatic Stress Disorder (PTSD)	Anxiety Disorder caused by extreme events May be experienced as frightening, anxiety may increase with shifts in mood and capacity May experience flashbacks and intrusive thinking
86,020 100-150/1000 Maternities	Mild-Moderate Depressive Illness & Anxiety States	Symptoms include fatigue & persistent low mood/sadness, disinterest and changes in appetite May have an anxiety constituent
154,830 150-300/1000 Maternities	Adjustment Disorders & Stress-related Mental Health	May not significantly impair function but can be experienced as a result of changes and adjustment difficulties in the pregnancy or perinatal period

NB There may be some women who experience more than one of these conditions. Adapted from source: Estimated using prevalence figures in guidance produced by the Joint Commissioning Panel for Mental Health in 2012 and ONS data on live births in England in 2011.

As an adjunct and in support of families in the ‘fourth trimester’, I engaged ‘mothers and others’ through extensive use of social media platforms. I issued a summary of the manuscript and provided a rudimentary questionnaire. I therefore avoided invasive immediate post birth face-to-face interactions but

offered information in relation to TBMM prior to the birth of infants and met where possible new parents and infants at suitable locations and agreed times.

A snowball sampling method ‘which amounts to referral by participants’ (Smith et. al. 2009: 49) was deployed and I also garnered local support in order to meet with parents and infants in the Yorkshire region. I filmed one mother and infant, gathered photographic evidence, and interviewed parents – taking a relational phenomenological stance. I initially wrote extensive case notes with this method in mind. Upon completion of further postgraduate studies in Integrative Psychotherapy, I had gathered enough data to consider publication. Securing a publishing deal with Random House (now known as Penguin Random) was profoundly satisfying. The Vermilion Imprint of Random House is the biggest publishing house focusing upon parenting and baby-related global publications.

The Blossom Method research began in 2010 with a leaning toward interpretivist methodology in that I was seeking to review the somatic and pre-verbal phenomena discovered in relation to Blossom from my own individual perspective. I was seeking to investigate the experience I had had with my daughter, in consideration of her language forms and the dance of communication between us. Yet it is important to note, in the original draft of TBM I was specific in relation to parents viewing their findings with regard to their individual infants and their communication forms with a phenomenological eye. I was not prescriptive. My aim was to promote sensitive and responsive parenting. Additionally I was seeking to promote active attuned parenting. I was informed during the editorial process and for the purpose of producing a parenting guide it was necessary for me to write about the somatic narrative of all infants as an expert. However, as new layers of understanding are uncovered the specific linguistic phenomena experienced in communication exchanges with parents and their infants I am less inclined to be explicit in relation to interpreting meaning to the language forms of all infants as this appears over simplistic. At present it appears that phenomenology is at the heart of this research but that there is a pluralistic open-ended methodology to consider, with diverse inference and explanations from those utilising TBMM. Nonetheless, the findings from caregivers in relation to using TBMM appear to offer justifiable and credible

accounts that can be used by others in PIP, general psychotherapy and parenting.

Braud and Anderson observe that, **'**Many of the most significant and exciting life events and extraordinary experiences – moments of clarity, illumination and healing – have been systematically excluded from conventional research' (1998: 3). The reasons for exclusion and the people responsible for the exclusion have informed much discussion. Traditional science appears resistant to the concept of exploration of the human experience. Historically and preceding the 'scientific research revolution' (Kuhn, 1962, 1977), Cartesian dualism (initiated by Descartes) promoted a rigorous scientific positivism-driven methodology which generated a paradigm shift in scientific spheres. This 'scientific revolution' was deemed valuable to traditional science, but dualism failed to consider the possible impact upon human sciences or 'mind works'. This occurred because human sciences have not been measured in the same traditional, analytical, scientific way. I experienced an intuitive understanding regarding the findings uncovered in the somatic narrative of infants and I believed that further exploration would be useful. In a sense an 'embodied known' manifested itself and as a result a need to discover more materialised. 'In every learner, in every person, there are creative sources of energy and meaning that are often tacit, hidden or denied' (Moustakas, 1990 in Hiles, 2001). Ignoring these findings was impossible for me.

Heuristic inquiry within the context of my own experience is the way this research has developed. This began with 'wait[ing], watch[ing] and wonder[ing]' (Cohen, et. al. 1999) whilst 'empathically dwelling' (Finlay, 2011: 78) with my findings. Curiosity and openness informed my methodology. In undertaking a form of heuristic inquiry, my drive was to connect with my infant and latterly enable others to connect with the narrative of the body with their own infants.

As Secunda, 1993 suggests most mother-daughter studies have been framed from the perspective of the mother's critical role in providing her daughter with advice and support (Hutchinson et. al., 2003; Luepker et. al., 1996; Perry et. al.,1998; Wood et. al., 2004). Mothers are their daughters' role models, their

biological and emotional map (Secunda, 1993). This said, I wonder what the reciprocal influence has been between my mother and me and more recently between my daughter and me. Other experiential studies are considering the potential reciprocity within the bounds of the mother-daughter relationship (Pinquart and Silberstein, 2004; Aronowitz, et. al., 2005).

4.3 Heuristic inquiry: Introspection and The Blossom Method

> Human science seeks to know the reality which is particularly our own, the reality of our experience, actions, and expressions. This realm is closest to us, yet it is most resistant to our attempt to grasp it with understanding. Because of the success we have had knowing the world around us, the human realm has expanded its power to such an extent that we can act to create wellbeing and physical security and comfort and to inflict untold suffering and destruction. Serious and rigorous re-searching of the human realm is required (Polkinghorne, 1983: 280-1).

Understanding the reality of my experience and the aspiration to know more in relation to parental connectivity with infants, sensorimotor narratives, the use of cognitive and somatic narrative in an integrated unified mind-body combination in psychotherapy practice, sensorimotor connection and the unfolding significance of the mother-infant relationship has seen me immerse myself intensely in these explorations. A consideration of my life's experience, the language of the individuals I meet, in particular the somatic narratives of infants and their parents, but also those encountered in psychotherapy practice, maternities and elsewhere has been explored. Finlay describes how 'Infants are seen to gain a positive sense of self and to be understood by having an attuned caregiver who mirrors and mediates emotions' (2015: 53). Attunement in psychotherapy is often discussed (Macaulay et. al. 2007; Erskine, et. al. 1999) but unpacking the meaning and the tasks involved in attunement in psychotherapy practice is an area where The Blossom Method has strength and potential in psychotherapy training.

Heuristic inquiry is a very demanding process, involving self-commitment, a disciplined approach, rigorous searching and reflection, and ultimately a submission to the process (Hiles, 2001). My work, my life experiences, higher education, and becoming a mother are important in this thesis. No one factor is more important than another and they all bring together a unique immersion and embodied experience, the narrative of which appears to have provided an understanding in relation to phenomenology in infancy, 'parent-infant' connection, and the potential to 'lend support to the intimate connection between non-verbal affect attunement and attachment security across the life span' (Håvås, et. al., 2014) in all forms of psychotherapy, and in other spheres.

> According to Moustakas (1994) in heuristic inquiry the researcher is both a source of data and intimately involved with the process of data analysis.'It facilitates deep reflection and allows findings to emerge via tacit processes' (van Ooijen, 2016: 173).

Seeking to comprehend and research what is often tacit, hidden and denied is not an easy task. Important in heuristic inquiry is the identification of an examination (Moustakas, 1990) and here, in an attempt to corroborate The Blossom Method, I am endeavouring to delve deep into it.

Heuristic inquiry is a method that has attracted the interest of researchers working in counselling, art therapy and psychotherapy (Braud and Anderson 1998, West, 2001, Etherington 2004). Moustakas (1990) suggests that six core processes and six basic phases are involved in heuristic inquiry. The following section will critically evaluate my heuristic inquiry made to date, demonstrating the complexities encountered and any accomplishments.

For demonstration purposes Table 7 below displays the six core processes of heuristic research proposed by Moustakas (1990: 27-32). The left-hand section provides the individual phases and the right-hand section illuminates the stages in connection to this study.

Table 7 : Phases of heuristic inquiry

PHASE	EXPLANATION
Initial engagement	The Blossom Method: What is it? How has it been developed? What are the potential uses of this model in clinical practice and elsewhere?
Immersion	Model development through academic, clinical and experiential learning Anecdotal research completed prior to publication Initial model written about and published as a semi-academic parenting book
Incubation	Manuscript written in 2010. Book initially published in 2012 Feedback received and suggestions to consider a more academic volume suggested MA Psychotherapy in PIP completed and highlighted further potential for The Blossom Method.
Illumination	Through the process of retreat and distancing from the original model, variable uses emerged
Explication	Through the developments in neuroscience, psychobiology, and the rise of sensorimotor and somatic narrative psychotherapy, what was originally more tacit knowing has appeared extensively in literature relating to neuroscience. These academic findings appear to connect firmly with the original and further developed insight into The Blossom Method Model
Creative Synthesis	Through the process of this research there is an attempt to bring together the tacit knowledge, learning (academic and experiential), and involvement in clinical work with many individuals with ‘different’ communication needs, and to create an academically viable unified model for use in psychotherapy and elsewhere

As previously intimated, The Blossom Method is a model originally created with reference to understanding the sensorimotor primal language of infants and communicating with infants; however, the three core principles of the method, **observation, mirroring** and **responding** have been written about separately in psychotherapy theory and practice (Bowlby, 1958; 1960; Ainsworth and Bowlby, 1991; Erskine et. al., 1999; Frank, 2009; Ogden, 2007; 2009; 2011; 2013; Ogden and Minton, 2000; Ogden et. al., 2006; Ogden, 2014; Ogden and Fisher 2015; Sansone, 2004; 2007; 2018; 2018b 2019; Schore, 2000; 2001; 2002; 2009, 2010). I am not aware of any other psychotherapeutic model that specifies the concepts of The Blossom Method in the same way, but I do recognise the components within it. It is the ability to draw on embodied, amalgamated experiences that has aided the formation and execution of these works. I hope to realise the rebirth of The Blossom Method to engender new learning, possible applications or interpretation.

Frank (2001), Frank and La Barre (2010), Ogden (2014), Ogden and Fisher (2015), Sansone (2004; 2007; 2018; 2018a; 2018b; 2019) amongst others have for many years placed value on non-verbal communication in somatic and sensorimotor psychotherapy. However, the territory of implicit non-verbal communications and bodily-based affective states has been undervalued or discounted by mainstream psychoanalysis, which has overemphasized unequivocally verbal representations (Schore, 1994). The main focus of body psychotherapies has most often been connected with sensorimotor manifestations of psychobiological trauma and attachment. However, body psychotherapists are now considering a more interdisciplinary approach. Psychobiologically speaking, trauma has a profound impact on both the body and the central nervous system and ‘traumatized individuals are somatically driven’ (van der Kolk, McFarlane and Weisaeth, 1996). This paradigm shift and the use of sensorimotor approaches are worthy of greater consideration by traditionally trained psychotherapists regardless of psychotherapeutic orientation.

4.4 The expansion of The Blossom Method

In my recent MA Psychotherapy study ‘A Journey to the Heart of Contemporary Parent-infant Psychotherapy: An Interpretative Phenomenological Study’, I was able to expand upon my original Blossom Method and provide a more in-depth model. The following information is taken from the Vol 1: Appendix 7 of this original research.

In consideration of the merging of Schore’s Affect Regulation Theory and The Blossom Method I have taken key components of Schore’s model of affect regulation and right-brain development (Schore, 2010: 24-27), and similarly The Blossom Method (Sabel, 2012) in an attempt to demonstrate a contemporary bidirectional ‘right-brain’ to ‘right-brain’ to ‘right-brain’, Parent-Infant Psychotherapy paradigm/model.

Bowlby’s Attachment Theory (Bowlby, 1969) suggests that an infant develops a preference for caregivers who are able to regulate and calm them. Internal models of self and others through the subtle co-regulatory system exchanges between caregiver and infant are essential for the developing infant (Brazelton and Cramer, 1991; Stern, 1995; Sroufe, 1996). Synchronicity and disconnection in these interactions are experienced from birth in the caregiver-infant relationship. Through the process of co-regulatory engagement, the infant and subsequently the child develops awareness of the availability of the caregiver to soothe distress and of their presence, availability and attunement. The central nervous system of the infant will be developed and imprinted with these attunements, misattunements and reparation of misattunements (Tronick, 1989).

4.4.1 Schore’s Model (2010)

> Dominant in the right hemisphere of the brain is processing of non-verbal and spatial visual information. It is stimulated in emotional processing and is triggered and actuated by vocal tone and non-vocal facial expression (Westland, 2009)

I have addressed Schore’s model of affect regulation and right-brain

development by considering 1) right-brain affect processing 2) right-brain regulation and 3) right-brain communication processes (Schore, 2010: 24-27).

Schore identifies a regulated response and in doing so he suggests the following:

Right-brain affect processing

In order to regulate response in an infant, when an infant is feeling positively aroused, the mother provides a warm verbal and non-verbal response which matches the 'infant's affect and positive arousal' (Schore, 2010: 24).
In consideration of 'negative affect processing' (*ibid*); the way in which a parent experiences a 'not so happy' infant and the provision of a regulated response to 'a fussy, moody affect' which is expressed freely, the mother is able to tolerate her own negative feelings and participate in interactive care through the process of mutual attuning (*ibid*).

Right-brain regulation

In consideration of interactive regulation, an infant expresses and recognises affective facial expressions, vocalisations and gestures and the infant seeks out the mother to co-regulate their inner state. The mother does this by responding with arousal/regulating facial expressions, vocalisations and gestures. The mother therefore seeks to affect the infant's inner state of being. Each member of the dyad (the mother and the infant) responds to the other's facial expressions, vocalisations, and gestures, which is providing a right-brain to right-brain connection. Here the mother and infant, through interaction, seek attunement. In terms of 'autoregulation', the infant may seek to self-soothe and the mother may engage her own self-calming behaviours whilst each member of the dyad remains calm and regulates individual states of being (Schore, 2010: 24-27).

Right-brain communication processes

In consideration of right-brain communication processes, Schore (2010) suggests three areas: 1) visual/facial expressions 2) vocal tone and rhythm 3) gestural and postural response (Schore, 2010: 24-27).

4.4.2 Sabel's The Blossom Method (2012)

I posit the use of The Blossom Method in parenting, in psychotherapy practice and elsewhere. The Blossom Method is based upon three simple components, 'observation, mirroring and responding' (Sabel, 2012) to the infant (or client/patient) in order to provide a 'right-brain' to 'right-brain' connectivity in both parenting and psychotherapy

PIP 'right-brain' to 'right-brain' therapy

In terms of a PIP paradigm/model with a 'right-brain' to 'right-brain' connectivity, I posit that the above can be used in a therapeutic relationship where the parent-infant therapist supports affect processing, affect regulation and 'right-brain' regulation by using the sensorimotor narrative, non-verbal and verbal connectivity in their work with parent and infant. The therapist would (1) **'observe'** the dominant non-verbal and verbal discourse of the mother (2) reflect and **'respond'** verbally and (3) '**mirror'** non-verbally to demonstrate that they are actively listening to the whole sensorimotor narrative providing a dyadic visual-affective arousal regulator, and dyadic auditory-effective arousal regulation or, put simply, a 'mirroring' which matches the dyadic tones and rhythms of the dyad. The therapist's body language (gestural and postural) would further match the dyadic rhythm whilst containing any personal response to the clinical work and sharing these responses with the 'm'other-infant at an appropriate time in the therapeutic work (Schore, 2010; Sabel, 2012).

The image below describes work with a mother and her ten-month-old infant. Here I am demonstrating 'hands-on signing': a sensorimotor-positive touch technique combining vocalisation and simultaneous 'hands-on signing' to soothe an infant who may be tired or in need of comfort. Initially, through demonstration, I aim to connect the right-brain of the psychotherapist to the right brain of the infant whilst the mother receives a right brain infant response, which stimulates a right-brain response in her. Subsequently a right-brain mother-infant bidirectional connection, through the right-brain guidance of the therapist, is possible. A short video clip of this is contained in the film produced for the final registration panel.

Figure 9 : Hands-on signing

I posit a right-brain (therapist) to right-brain (mother) to right-brain (infant) way, with a psychodynamic fluidity and bidirectional possibility of undertaking parent-infant psychotherapy as most useful in contemporary PIP. The clinician would be 'wholly-observing' the infant-parent connectivity and would be 'mirroring' these observations and 'responding' through their visible facial expressions, vocal tone, rhythm and gestural and postural responses, whist 'therapeutically-holding' the parent-infant relationship (Schore, 2010; Sabel, 2012; 2017). 'A sophisticated therapist may use this processing in a beneficial way, potentiating a change in the patient's state without, or in addition to, the use of words' (Meares, 2005: 124). In order to attain our full personality capacity, we need stimuli – we need to experience attunement, mirroring and to feel emotionally held in interactions with other people, as this develops neuro-emotionality and individual potential (Bentzen, 2015).

4.5 Distinctive features of TBMM

The process of the DPPW has been to ***independently evaluate/argue alternative approaches*** in an attempt to ***accurately assess/report on my own and others' work*** in order to ***justify evaluations as constituting bases for improvement in practice.*** The development and augmenting of knowledge gathered will serve to strengthen TBMM. The knowledge held tacitly and

relationally embodied can be evidenced in the work of others such as Sansone, (2004; 2007; 2018; 2018a, 2018b; 2019) Frank (2001), Frank and La Barre (2010), Ogden (2007; 2009; 2011; 2013), Ogden and Minton (2000), Ogden et. al. (2006), Ogden (2014), and Ogden and Fisher (2015). Producing the film has been invaluable to this journey as it has refined the capacity to demonstrate key findings in relation to phenomenological meaning-making in infant communication and the capacity of connectivity in the parent-infant dyad. This process is continually encouraging ***evaluative reflections***.

Sansone (2004; 2007; 2018; 2018a, 2018b; 2019), Frank (2001), and Frank and La Barre (2010), make specific reference to similar PIP approaches. Frank's background in dance and movement training and Sansone's yoga practice, dance and mindfulness training appear to have influenced them profoundly in connecting with sensorimotor stories of adults and infants. They 'emphasize [the importance of] movement in parent-infant interactions during the first year of life because nonverbal behavior is never more evident than at this time' (Frank and La Barre, 2010: 1). I am informed through conversation and embodied in the works of Sansone (2004; 2007; 2018; 2018a; 2018b; 2019) with newborn infants, mothers and infants, and adults. Latterly Sansone is placing a strong emphasis on the importance of human connection in utero, is undertaking a second doctoral study and is publishing two forthcoming books, *Cultivating Mindfulness to Raise Children Who Thrive: Why Human Connection from Before Birth Matters* (forthcoming, 2019) and *Gems of Primal Wisdom: From Before Conception Through Pregnancy, Birth and Beyond* (forthcoming).

Like all practitioners in the field of parent-infant psychotherapy who bring their own unique experience of the somatic, sensorimotor and kinaesthetic, I have my own embodied experiences. These experiences and embodiments have supported the development of TBMM, where observation of micro movements and early language forms in infants have been assigned phenomenological meaning. However, with any sensorimotor model and approach I am aware of the controversies regarding interpretation, through reformation and reconstruction of the infant experience (Frank and La Barre, 2010; Mitchell, 1993; Stern, 2010). My view is observation of infant 'language', dual

sensorimotor engagement and phenomenological meaning-making in support of parent-infant connection could further enhance the connectivity and communication between parent and infant. My hope is that through engagement in 'sensorimotor play' and learning more about the somatic narrative the attachment relationship will be enhanced. It may support mental wealth and body-mind connectivity. In follow-up conversations with research participants, they report a reduction of anxiety in the 0-3-month period. Lowering anxiety in parents supports a better connection which in turn is mirrored back to the infant (Sabel, 2012). Following the introduction to and use of TBMM, parents have consistently reported more confidence and understanding of their infants. TBMM could prove useful in PIP both as a tool for facilitating and by offering a simple model for parents to follow. In the making of my film a participant suggested she not only has learned more about her daughter's non-verbal cues; she and her baby have had 'a lot of fun' engaging in mirroring. She said she thought her daughter is 'even more smiley' as a result.

The advanced linguistic study undertaken, academic training and insight, and primarily the significance of being raised by a deaf mother have culminated in the creation of TBMM. Frank and La Barre (2010) have studied at doctoral level and base their perspective on years of experience working in various settings, including [and not dissimilarly], working with parents and infants, couples, individual adults and training and supervising psychotherapists. Sansone, in addition to her Doctor of Psychology, has studied infant observation, and researched with African indigenous cultures, in particular the Himba. She has a special interest in pre and perinatal connection and mental health, where the integration of primal wisdom and science, psychosomatics, and mind-body approaches are understood to be paramount. Like Frank and La Barre (2010) and Sansone (2004; 2007; 2018a; 2018b; 2019), I have attempted to define and provide meaning for specific infant movements and apply a form of *'foundational movement analysis'* (Frank and La Barre, 2010: 3). This is based primarily on the non-verbal cues of both parent and infant and utilisation of these cues non-verbally to model baby-led communication and promote connectivity between parent and infant. My clinical training has informed TBMM but in an aim to reach a wide and international audience the model in its original form was aimed at

parents.

TBMM has three specific orderly components, ***observation, mirroring*** and ***responding*** **(OMR)** to the sensorimotor language of infants.

Observation

In Stern's developmental model (1995) he states that in order to understand fully the 'whole child', consideration of both the 'observed infant' and the 'clinical infant' is essential. Mallach and Trevarthan (2009) refer to observing noticeable patterns and exchanges between infant and mother that they recognise as musicality of a communicative nature that provide melodic sensorimotor stories. Finlay (2015) in describing attunement refers to adjustments to the other in a synchronous harmonious way. Sansone (2004) suggests these rhythmic interactions are dynamics of emotional exchanges between infant and mother: she defines these observations as fundamental to neurodevelopment and linguistic prowess. Beebe, et. al. 2010; Tronick 1989; Tronick and Weinberg,1997), Sroufe (1996) and Boukydis (2012) note the importance of observing and supporting a mother in order to ensure emotional nourishment is available for healthy infant development. Kurtz (2010) suggests purposeful observation of the sensorimotor and somatic narrative of the parent in order to identify possible behavioural clues in relation to attachment patterns and traumatic history in order to support the potential of formulating clinical hypotheses (Ogden, 2014). Brain development is promoted through caregiver and infant engagement (Charura and Paul, 2015). Frank and La Barre (2010: xix) remind us of the value of understanding observations of the sensorimotor narrative and recognise how the 'nonverbal lexicon' combined with the theoretical frame aid all psychotherapeutic work. As stated elsewhere, I recognise the value of the somatic narrative not only in psychotherapy but as fundamental to all successful communication whether in the therapeutic encounter or not.

Mirroring

Affective attunement to the infant's non-verbal cues through mirroring supports the infant to organise emotional and physiological experiences which leads to

reflective functioning (Greenspan and Shanker, 2004). Sansone reminds us that infants are capable of specific imitation of 'mouth movements, tongue protrusions' etc. and suggests that the 'infant's cyclic responses to the mother's expressions are frequently and unconsciously mimicked' (2004: 189). Finlay (2015) describes how sympathetic, embodied mirroring may be required more for some clients than others. Although I recognise that some clients may be more sensitive than others to non-verbal mirroring I appreciate the value of 'somatic echoing' regardless of client sensitivity to the non-verbal narrative. In this statement I am not ignoring the need for cognitive attunement: there is simply a desire to include both the sensorimotor mirror and, where it is deemed relevant, any cognitive observations. In TBMM I am suggesting following the infant's communication. Mimicking through mirroring the infant's non-vocal and vocal expressions as a way of embarking upon infant-led communication. In doing so a parent/therapist develops awareness of these mirroring processes, and a deepening of understanding of the language forms of an individual infant is developed in the mother/father-infant dyad or infant-parent-psychotherapist triad. Furthermore, through the development of this early communication and by including these matters in the training of psychotherapists there is recognition that the somatic narrative and embodied sensorimotor processes and understanding of them could aid the work of all therapists. Westland (2009) reminds us that the brain's right hemisphere is dominant in processing non-verbal and spatial information. Schore (2010) in his theories of *right-brain affect processing, right-brain regulation and right-brain communication processes* suggests affective processing, regulation and communication can be facilitated by a developing understanding of non-verbal and vocal arousal between parent, infant and psychotherapist. These present-moment intersubjective caregiver-infant exchanges do appear to hold value for those in PIP and in parenting.

Response

Recognition and responding to an infant's somatic narrative is a 'right-brain to right-brain' (Schore, 2010) activity which supports infant development and appears to support parental/infant attunement. However, the parent who is fundamentally uncomfortable with their own felt sense or embodied feelings may find it problematic to manage effectively the feelings of their infant (Pawlby et.

al., 2018; Speier, 2018, in Leach, 2018).

Kennedy and Underdown note that ‘Parents and infants both thrive when they are able to enjoy getting to know each other, to read each other’s signals, and to develop together’ (2018: 225, in Leach, 2018).

In creating a film for my final registration panel, I met with a three-week-old infant and his mother. During the film I was able to demonstrate through observation my perception of an infant’s needs and feelings of discomfort as a result of wind. My response to his non-verbal repertoire was to suggest the infant was experiencing wind. This was demonstrated by the discomfort observed in the infant through jerky movement of the limbs and raising of his knees, with a slight intermittent kicking motion. The mother suggested she would have automatically placed her infant on her breast but following my intervention and response to these observations she decided to wind her baby instead. This resulted in a calm, comfortable and restful infant response and no further breast-feeding was required. Kele, a fourth time parent, in the film, describes herself as an ‘earth-type mother’ and recognises herself as an experienced parent. At the beginning of the film she spoke of the value of understanding the somatic narrative of her new baby, in order to reduce the need to be continually breast-feeding. After the intervention she suggests there is significant value in sharing infant observations, TBMM with parents in pregnancy and post-birth.

Frank and La Barre’s model encourages *foundational movement analysis* (2010: 3; italics in original) ‘a conceptual framework that emphasizes a phenomenological approach to observing and understanding interactive movement patterns within psychotherapy’ (Frank and La Barre, 2010: 3). TBMM – with its recognition of infant language forms and specifics in relation to phenomenological meaning-making of the language of infants – attempts to promote connectivity for all parents and infants both within and outside of the psychotherapeutic encounter. Sansone in her work with mothers and infants and her studies in infant observation suggests the somatic narratives of both parent and infant are valuable to understanding the traumatic past and present blockages to the success of the parent-infant relationship. All of us are ‘here and

now' and 'there and then' clinicians and all of us are working towards improved connection in the parent-child relationship. Our emphasis and the linguistic choices made to describe and demonstrate our findings vary but it is apparent we are all seeking to promote infant mental health and parental well-being.

Reaching out to Dr Zack Boukydis, a pioneering perinatal clinician, supported my understanding that many clinicians and academics in the field are trying to promote connectivity albeit in different ways with different leanings as we are all attempting to make sense of the information available to us.

Like Sansone's *Mind-body Integration Model* (2007) and Frank and Le Barre's *foundational movement analysis* (2010:3; italics in original),TBMM promotes the story telling of how parents organise and experience their embodied psychological tensions (i.e. muscular) in their holding, expressions, gestures and interactions with their infant. It teaches us to pay attention to the non-verbal narrative that governs parent-infant interactions, while simultaneously supporting parents to become aware of the sensorimotor story and somatic narratives involved in caretaking with their infant. In addition, it provides examples of specific repetitive 'kinetic patterns' (Frank and La Barre, 2010: 3) and encourages the mirroring of these expressions back to the infant. There is a useful example of this in the film created where I engage in TBMM and the thirteen-week-old baby beams with delight and appears to enjoy this form of sensorimotor play and subsequent connectivity. The way in which Frank and La Barre (2010: 3) have created *'foundational movement analysis'* is very helpful and TBMM would benefit from the formalisation of these somatic references in providing further specific information on 'identifiers and descriptors' (Frank and La Barre, 2010: 4). I would probably adopt this approach in addressing tongue and other movements in TBMM in any future publication associated with TBMM.

TBMM, like Frank and La Barrre's *foundational movement analysis* (2010: 3) and Sansone's mind-body integrative approach, fosters both sensitivity and reflective functioning in parents as its focus is upon both mental and bodily processes. We know that sensitivity and reflective functioning are fundamental abilities that promote attunement, which is foundational in fulfilling secure

parental attachment and optimal infant development. Affective attuned responses to the infant's non-verbal cues supports the infant to organise his or her emotion and physiological experience, leading to reflective functioning (Greenspan & Shanker, 2004).

TBMM is focused upon present moment ongoing interactions rather than parent's representations of the infant - mentalising or past experiences. This model allows the psychotherapist to detect parental difficulties in synchronised responsiveness, which could be a reflection of the parent's disconnection from their body self and the body self of their infant, which is often displayed in the traumatised parent (Sansone, 2018a; 2019).

The careful use of TBMM through observation, mirroring and responsiveness supports parents to connect with their infant and to build confidence in their own parenting. It encourages – through observation, mirroring and responsiveness – connection through the present moment interactions, and supports the parent to gain awareness of their own embodied trauma and the sensorimotor story within, which will expose impasses and moderate the effects of intergenerational transmission of trauma and mental ill health (Sansone, 2018a; 2019).

TBMM makes specific reference to the body cues of the infant e.g. tongue patterns, fist clenching, kicking, arching backs, eye gaze, leg raising, rhythmic patterns etc. and like Sansone (2004; 2007; 2018a; 2019) Frank and La Barre (2010) treats these as communicative meaningful events and considers the infant as an active participant in the therapeutic and analytic process. These 'here and now' moments, interactions, and non-verbal language exchanges are potentially an important resource to aid healing for both infant and parent. The careful reflections of these sensorimotor exchanges are able to influence the parent's perception and view of their infant as well as healing their own past traumatic experiences.

In support of sharing TBMM and the making of my film for the final viva I met with a new first-time mother and her eleven-week-old infant. I noticed that post feeding the infant raised her arm rhythmically and her legs repetitively as she

showed signs of gastric discomfort. Although the mother sought assistance from the health visitor and attended an infant osteopath appointment, they did not provide her with any clues as to the problem. The health visitor described this somatic response as ‘normal’ infant behaviour. The mother started to think it was an intolerance of some kind. In exploring this with the mother she said, ‘it happens all the time and it doesn’t just occur post feeding’. Later in the film she said she had attended a midwife-led training on breastfeeding. She has been informed by the midwife trainer that ‘if you breastfeed your baby there is no need to wind them’. The mother followed this advice and my interpretation of this somatic response was that it was possibly a ‘hang up’ from the first two weeks of not being winded. In the baby’s movements she appears to attempt to self-wind to relieve discomfort. After the film was made I advised the mother to consistently and constantly provide ‘winding’ actions (back-rubbing/tapping) whilst holding her baby in an upright position. The mother said she would try this with her baby and at the same time withdrew dairy from her own diet. She immediately noticed the benefits. We do not know whether the actions suggested, or the lack of cow’s milk protein and soya helped in this scenario. The mother herself is happy with the results. Not only did these actions reduce the discomfort in her baby, it also reduced the anxiety in the new mother, which was once again experienced and mirrored back to her by her infant. Through **observation** of the in the moment somatic narrative of this eleven-week-old infant and **mirroring** of this discomfort in the facial expression of the mother-researcher/film-maker dyad and gathering data in relation to the infant a two-pronged approach **response** to recovery from this somatic dynamic was implemented.

In filming with the same mother, I suggested an **observation, mirroring responding** reaction to a tired infant through the mirroring of their infant’s *sleepy eye expression*. In following this up with the mother she said, ‘Oh yes I have mirrored her ‘sleepy’ eyes. If she is not over tired when I start it works a treat. If she is too tired, then she is too busy moving around to even notice me.’

Here the client’s past experience is not the focus – rather in utilising TBMM the present and body narrative become the object of observation and contact.

In using TBMM a sense of presence is promoted in parents, which is a fundamental ability to respond to the infant's cues, needs and wants, as the infant is fully embedded in the present. The accessibility of TBMM may aid traumatised parents by providing a simple framework to follow, thus thwarting the potential of intergenerational trauma transmission.

Furthermore, considering the relevance of TBMM and the components therein – **observation, mirroring** and **response** – to parents accessing maternity services and the importance of mindfulness in relation to TBMM for clinicians, I believe there is value in the teaching and training of TBMM to medics, maternity clinicians, psychotherapists, and potentially others. In response to a question I asked in relation to the possible value of training those involved in maternities including GP's being trained in the observation, mirroring back and responding to people non-verbally, one of my film contributors said, 'Sales people do that [receive training in the importance of the somatic narrative], and that's nowhere near as important as people's health' (Carla, mother to an 11-week-old infant).

4.6 Critical evaluation of intersubjectivity in PIP

Understanding how infants and their parents influence each other in relationship (intersubjectivity or the sharing of another's individual or dyad experience) is a necessary prelude to the understanding of developmental difficulties and recommendations for any applicable clinical treatment. Gallese (2003) proposes that our capacity to understand others, far from being exclusively dependent upon mentalistic and linguistic abilities, is grounded in the relational nature of our interactions with the world (Sansone, 2019). As the parent-infant relationship develops new movement capacities emerge and form alongside the existing repertoire of co-created interactions. The early patterns remain embodied in both parent and child (Frank and La Barre, 2010).

Intersubjectivity is at the core of our experience of self. From early life, sharing with our conspecifics, multiple states that include actions, sensations and emotions – an implicit pre-reflexive form of understanding of others (Sansone,

2019). Gallese (2003) names the richness of these shared experiences *manifold of intersubjectivity*, which makes it possible for us to recognise other human beings as similar to us and to establish intersubjective communications and understand others' intentions (Sansone, 2019). Gallese argues, 'that the same neural structures that are involved in processing and controlling executed actions, felt sensations and emotions are also active when the same actions, sensations and emotions are to be detected in others' (2003: 171). He defines these as 'mirror matching mechanisms' (Gallese, 2003: 171). These action mechanisms are embodied; we are always using our well-practiced repertoire to operate in the here and now, making the past recurrently part of the present (Frank and La Barre, 2010). Sansone's 'research and observational study of mothers and infants from pregnancy and beyond led to the finding that the woman's body self-awareness during pregnancy, labour and birth not only shapes the quality of her holding and interactions, but also of how she talks to her baby' (2004: 321; 2018a, 2018b, 2019). For some parents there may be difficulties in engaging fully in the movement exchange between the parent and infant; this may prevent the infant from being able to express and expand their range of movements. Frank and La Barre suggest that, 'If this is so, the outcome for the baby may be a limited and inflexible movement repertoire' (2010: 80). Infants embody their parents handling and caretaking attitudes. Personified and embodied historical experience will materialise in the caretaking and parental choices; it will further emerge and powerfully impact in the handling of an infant.

Offering a personal example, I have embodied my mother's presence, and the care received from the 'allo parents' (Nitsch et. al., 2014) who cared for me in her absence. In birthing Blossom these primary relational intersubjective embodiments will have moved to the forefront and as a result may have augmented our experience of connectivity.

The context of parent-infant psychotherapy offers a rich world of non-verbal language exchanges – gestures, facial expressions, posture, movement (e.g. whether watchful or mechanical, jerky, tense or flowing), rhythm of speech, laughing – which puts our deepest human nature in touch and facilitates mind to mind connectivity and reflective functioning (Sansone, 2018a; 2019). Without the

non-verbal (which governs parent-infant intersubjective communications) it would be hard to achieve the empathic, participatory and resonating aspects of intersubjectivity (Stern, 2004). Essential to PIP is its aim to understand the implicit world of communications between parent and infant so as to connect with it and understand the maternal inner world; including her views of her infant, her own experiences and how these affect the current interactions and relationship with her infant. By paying attention to this implicit substrate of intersubjectivity, the parent-infant psychotherapist can connect with the parent-infant dyad, providing a mirror of attentive listening and compassion, which benefits both parent and infant intersubjectivity and creates a rich web of shared experiences. Through this cooperative engaged work and by understanding the dyad of intersubjectivity, the psychotherapist can improve the parent-infant relationship directly and the parent and infant's mental health (Sansone, 2018a; 2019).

The desire to physiologically connect with others and to read and share the feelings and concerns of others had to evolve before language, and as such provides the foundations for the evolution of cooperative behaviours. This mutual drive towards interdependence and connection is a biological necessity and the very foundation of intersubjectivity and the capacity for empathy (sharing and understanding of other's experience). Primary non-verbal communications (intuitions, images, emotions, gestures) are rapid and precede reflective awareness (Dorpat, 2001). An implicit pre-reflective form of understanding between parent and infant precedes reflective awareness within this relationship and between the psychotherapist and the dyad. The parent-infant psychotherapist can provide an inspiring mirroring by fostering healthy intersubjectivity between parent and infant (Sansone, 2018a; 2019).

Before language there was something else, in a way more primitive, and with unequalled power in its formative potential, that propelled us into language. Something that could evolve slowly and incrementally, but suddenly gave rise to the thinking processes that revolutionised mental life. Something that (unfortunately) no fossil remains can show us. That something else was *social engagement* between humans. The link that can join one person's mind with the

mind of someone else – especially, to begin with, emotional links – and as early as before birth, is the very link that draw us into thought. The capacity for social engagement is manifested first at the level of affective sharing and later at the level of explicit teaching and learning (Sansone, 2018a; 2019).

In contrast to other primates, the human infant does not have to acquire first-hand all knowledge and experiences necessary for survival. Instead, the infant needs to develop the skills for sharing affective evaluations and intentional states with others. This, and as a result of the development of the social brain and its plasticity, allows the infant to participate in the cultural learning processes of human society and be neurologically shaped. The context of parent-infant psychotherapy promotes this learning process by improving parent-infant communications and intersubjectivity directly, thus promoting secure infant attachment and optimal development. At the time Bowlby (1958; 1960;1969) was writing, little was known about the capacities of the very young infant for establishing intersubjective communication with a caregiver. Modern studies on infant development (Trevarthan and Aitken, 2001; Ammaniti and Gallese, 2014; Sansone 2004; 2007; 2018; 2018a; 2018b; 2019; Frank, 2001; Frank and La Barre, 2010; Ogden, et. al. 2006; Ogden, 2014; Ogden and Fisher, 2015) and parent-infant psychotherapy acknowledge this earliest human ability, which makes an infant an active co-operator and contributor in the relationship with his/her parent and the therapeutic process (Sansone, 2018a; 2019).

The intersubjective in the therapeutic endeavour is also noteworthy. Mitchell defines intersubjectivity as ‘the mutual recognition of self-reflective agentic persons’ (2001: 58). In Clarkson’s observation of intersubjectivity she professes, ‘the work lies in the creative space between, in the relationship’ (2003: xvi). How therapists view the ‘intersubjective’ will be dependent upon their own transpersonal, proprioceptive, kinaesthetic and embodied viewpoint. Their intersubjective considerations may be associated with interrelatedness and the human drive for connection or the contact and connection interplay between therapist and client (Carroll, 2014). The ‘intersubjective’ encapsulates for me, the ‘space between’ two (or more) ‘bodyminds’ of consciousness: a fertile, yet elusive ground for *observation, mirroring, responding,* attunement,

misattunement, presence, connection, disconnection, embodiment, rift and return. A space for symbolism – 'bodymindedness', bio-resonance, bi-transpersonalism and other unknown possibilities. The interpretation of intersubjectivity is in itself intersubjective. What materialises between two 'bodymind' entities will transpire in each therapeutic or non-therapeutic encounter. Therapists and clients with their 'bodymind' presence will consider meaning and potential for themselves. How the 'intersubjective' therapeutic window is utilised in psychotherapy will be variable dependent upon both perspective and context (Paul and Charura, 2015).

4.7 Critical commentary on endorsements of TBMM

The first and most profound critical commentary received from Dr McAlpine was both insightful and significantly helpful. As previously mentioned Dr McAlpine was one of the first readers of TBM. I did not know Dr McAlpine: she was a connection on LinkedIn. I forwarded the original manuscript to Dr McAlpine and other connections (including academics, those involved in professions associated with parenting, psychologists and others deemed relevant to the concepts of TBMM). As a result of her interest, support and subsequent instruction I completed a full edit of the original manuscript. Her assistance and encouragement made a huge difference in that following her advice and my edit, she agreed to take the revised manuscript to Sydney University Press. The feedback received from the Editor read as follows:

'Dear Vivien,
Susan has finally read your manuscript, we've discussed and we've decided that unfortunately we will not be able to publish it. It is a FANTASTIC manuscript with ground-breaking ideas that will go on to sell millions of copies. Unfortunately, we are a small operation and are unable to do it justice. We are not set up to deal with books with such mass potential. In fact, it wouldn't be fair on you if we were to publish it. It needs a publisher of a different calibre and massive marketing and distribution divisions...' (See Vol 2: Evidence 44 for a full copy of the email).

This email and the short reviews gathered from members of the social media

platform LinkedIn were utilised to contact Random House. The then commissioning editor of the parenting literature department (Vermilion Imprint) received the documents via email and she responded to me on the same day, inviting me to submit my manuscript. Dr McAlpine's helpful editing suggestions, the rejection email from Sydney University Press and the review commentary supported my securing a contract with Random House to publish with Vermilion parenting publishing imprint. The commissioning editor then advised that additional anecdotal evidence for inclusion in the manuscript itself could benefit the final publication. This exercise was not only helpful in further revising the manuscript; it aided my understanding of both the perceived relevance of TBMM but also as a result of working closely with parents and their infants I began to see the relevance of the model in working psychotherapeutically and elsewhere. The study and case material matters were subsequently published in the final print of TBM. The initial review comments were inserted in the published copy.

Prior to publication and subsequently, I have considered through feedback the need for additional academic study; a deepening of knowledge in the field of PIP, the sensorimotor narrative, parent-infant connectivity and the role of the somatic narrative in wellbeing and mental wealth. I have gathered this from numerous sources including academic endeavours, article writing, social media posts, research with parents, co-working/presenting and working in the community. However, Dr Erlendsson (Vol 2: 23) like Dr McAlpine (Vol 2: 13, 15 and 16) had both been instrumental in my application to join the MA Psychotherapy programme at Leeds Beckett University. They were keen to see me have my work on TBMM validated through studies undertaken in higher education.

My attendance at Leeds Beckett University emerged following attendance at a workshop organised whilst working as an integrative programme lead. Dr Divine Charura (Vol 2: Evidence 33) had been invited to provide a seminar on 'Equality and Diversity' and at the end of his seminar he mentioned the MA Psychotherapy 'top up' degree at Leeds Beckett. Although there are many academic supervisors for the course, I was fortunate to receive supervision from the Programme Lead Dr Divine Charura. Dr Charura knew of The Blossom

Method and his critical commentary on my final paper assisted me in the further development of TBMM. It was during this research that I began to identify the relevance of the work of Schore (2000; 2010) and I merged his 'affect regulation' theory with TBMM, creating a more robust bidirectional right-brain to right-brain PIP paradigm. Upon completion of the MA Psychotherapy I was delighted to be awarded a distinction. This boosted my confidence in TBMM and personally in my capacity to produce academic work. I remained in contact with Dr Charura as I wanted to publish the paper in an international journal. We had also considered writing a joint paper. Our busy lives took over and my mother-in-law became very unwell. Our plans for co-writing were placed on hold.

In the meantime, I was contacted by ECronicon (via LinkedIn) to publish my MA paper in their international journal for gynaecologists. In order to publish this further editing was undertaken and an edited version was published in September 2017.

It was during the graduation ceremony that my family and I spoke to Dr Charura again. We spoke of DPPW and Dr Charura spoke positively about the potential relevance of this route to a doctorate and presenting my Public Works for submission. I made my application to Metanoia Institute for DPPW after our meeting at the MA graduation ceremony.

In my role as course leader in a psychotherapy institute, I learned that the trainees were particularly open to learning more about parent-infant connectivity, TBMM and these elements were brought into the institute and in general were well received. However, one trainee stated she was disappointed that I had not included academic references to the works of others in my TBM manuscript. I was pleased she had raised this as I was able to inform her that all of these references were placed in the original manuscript, but I was asked to remove them all prior to publication and write TBM as a 'parenting expert'. TBMM has reached parents worldwide, however as previously mentioned in both the justification and context statements its lack of academic context, references, and style has seen it fail to reach some of my peers – though other academics have been very accepting of it (see Vol 2: 13-16; 20-24; 28, 30; 32-36; 41; 45). As part

of my learning through the DPPW, I am inspired to write a further individual book and in doing so take a more rigorous and academic route to publication.

The two years spent training and working as an associate and full teaching member of a psychotherapy institute and the subsequent year working as the relational integrative lead significantly supported my learning and development. This training and the subsequent leader role provided a platform to share my public works and as a result an arena to receive feedback from those involved in psychotherapeutic training and teaching.

The WAIMH nominations in both 2014 and 2016 have encouraged further analysis and the need to provide an academic theoretical framework for TBMM. Dr Erlendsson, Dr McAlpine, Dr Sansone, Dr Boukydis, Dr Gothi and others have supported my Public Works. They connect with the importance of perinatal connectivity, understanding the somatic narrative of infants and the potential for deeper connectivity during the perinatal period.

4.8 Case Studies: The Blossom Method in action

An example of previously unpublished, original work for a case study has been included (Vol 1: Appendix 6 - removed). This includes a reflexive account of my clinical notes undertaken in the initial session between Cat and her baby Sebastian. Although this was previously unpublished, Cat signed a slightly different agreement that provided authority for the content to be utilised in connection with TBMM works (Appendices 8 and 9). In addition to some reflections on my work with Cat and Sebastian, two anonymised further case study examples are provided, ‘Mothering Martha’ and ‘Demi’s sense of motherhood’.

Cat and Sebastian: strong mothers and embodied loss

The result of these observations demonstrated Cat’s determination and desire to be a ‘rock’ for Sebastian just as her mother has always been a ‘rock’ for her. Even though Cat’s mother lost her husband and Cat lost her father when she was only four years old she had internalised her ‘good enough’ mother and

regardless she was determined to continue the legacy of strong and determined mothering. Sebastian's cries and distress mirrored his mother's ill-ease and discomfort throughout our first meeting. Each time Cat discussed her traumatic birth and the loss of her father, Sebastian mirrored ill-ease and discomfort in his body. Furthermore, I gathered and interpreted this as his somatic narrative in relation to constipation which mirrored his mother's holding of her trauma in relation to her birthing experience and the loss of her father. Post-meeting and at the appropriate moments we reflected and discussed my finding during our work together. They highlighted further the somatic awareness previously considered but not to the depth demonstrated in The Blossom Method itself. Post our work; Cat described herself as 'more confident in her mothering'. She said she was 'delighted' to have engaged in these works and was 'fascinated' by our discoveries in relation to the somatic narratives and specific infant language of Sebastian. She described with confidence the relevance of Sebastian's non-verbal language and suggested through our work she had become much more somatically and non-verbally linguistically attuned.

Mothering Martha: a dual linguistic approach

In the case of Mariella and her baby Martha, a client whom I had been seeing for psychotherapy as a result of complex early trauma became increasingly concerned about her infant. She was worried that her infant would not make eye contact with her when she asked her to. Mariella, as a deaf mother, needed to have eye contact in order to read her daughter's lips. Her underlying concern related to Autism in the family of her partner Mike. I asked Mariella to bring Martha into clinic where I observed them in action.

Mariella, a loving mother, struggled with feelings of inadequacy and connectivity. She was fiercely protective and feared 'not getting it right'; she appeared to experience some immobility in her play with Martha. Kinaesthesia is concerned with movement and behaviours of movement. Proprioception relates to positioning. It considers where your body is in time and space. 'As bodies begin to relate, each body's significance takes up residence in that of the other, providing each participant with an inner felt sense of the other's posture (Merleau-Ponty, 1962)' (Rumble, 2010: 132). Her chronic, traumatic history did

not support her in finding her inner, lost child and the linguistic choices from birth seemed to be further impacting upon her relational contact with her infant. Mike, who was profoundly deaf, had not, as a child, been encouraged to use or learn BSL. He was sent away to a hearing boarding school and encouraged to join his community of hearing peers, where he was both isolated and determined. He describes his early years as 'horrific'. Mariella, who was born hearing, and for no medical reason developed profound hearing loss from her teens, was not a native BSL user. Mariella concluded her deafness relates to her complex trauma. Both Mike and Mariella use mainly speech in their home and both of them appeared to 'fall between' cultures. As a result, their sense of cultural belonging was compromised. They felt their hearing child would want to develop her speech and in doing so they were inadvertently isolating themselves from the world of their child. This appeared to promote a sense of disconnect in their infant Martha. After a short period of observation, I noted Martha was verbally responding to her mother but as a result of her mother's deafness, Mariella was unable to hear her. I further noted a lack of confidence in using sign language. Additionally, the 'affect' of any form of language presentation should be considered. What effect is the presentation having upon the therapist? Is the affect noted providing 'a microcosm of the person's world and habitual ways of being' (Finlay, 2015: 17) or does it represent an image or verbal ('bodymind') expression of anxiety or otherwise? In recognising that 'involvement cannot be facilitated without risk' (Ferenczi and Dupont, 1988; Erskine et. al., 1999) I decided to raise my observations and share my reflections of this 'whole 'bodymind' narrative'.

Mariella's voice was strong and her signing she deemed as less so. *Observation* of clients' fluid changes in their sensorimotor positioning is worthy of much consideration as 'there is meaning and certitude made by and expressed [in their] posture, actions and affects' (Tronick, 2007: 16). Teyber (2000) suggests that 'In order to work with the process dimension, the therapist must make a perceptual shift away from the overt content of what is discussed and begin to track the relational process of how people are interacting as well' (2000: 15). In order to model an age appropriate, dual-linguistic approach I asked Mariella if Martha and I could engage in some play. I wanted to see if she would lift her

head and engage with me. In playing with Martha I utilised both sign language and speech. Initially she responded with speech only but after a short time of using speech and sign language Martha began to mirror my signs and use her voice simultaneously. She raised her head and engaged fully in our play. She seemed to benefit from a dual-linguistic approach. Mariella, like Mike, was unsure about using sign language and it was through this exploration we discussed a dual linguistic approach. As a result of Mariella's complex childhood and late onset deafness and Mike's early experiences and discouragement around sign language, being first time parents, and just trying 'to do the best' for their child they lacked confidence in their own linguistic parenting choices. This said, 'once specific indicators are observed and named, explicit exploration' (Ogden and Fisher, 2015: 40) is available to the therapist. The implicit and explicit, *observed* multi-layered language forms would provide the therapist-parent dyad or the therapist-parent-infant triad with further opportunities for exploration.

Demi's sense of motherhood: Deaf mothers in hearing maternities

In the case of Demi, a married Deaf mother who was referred to me for psychotherapy, I discovered a latent (undiagnosed) perinatal depression which was further exacerbated through birth trauma and remained undiagnosed until our meeting some 10 months after the birth of her son, Ben.

This client was deeply wounded by her experiences of maternity services and hearing clinicians. This work was highly complex in that Demi did not in any way identify with her depression. Initially, her story related to 'feeling disappointed that she had not given birth to a baby girl'. In therapy, verbal or signed utterances against the framework of the 'unspoken' sensorimotor narrative may sometimes appear incongruent. Additionally, the 'affect' of all language forms in an individual presentation should be considered.

In a specific therapy session with 'Demi', whose preferred method of communication is BSL, I noted in her signed language anxiety and anger in relation to a recent birth surgery and lack of accessible, culturally related follow on support. Throughout her session she signed 'frightened', 'anxious',

‘concerned’ ‘worried’ and ‘nervous’. Her facial expressions further suggested significant frustration and anger. The client’s visual gaze instinctively directed toward the surgically impacted area. She engaged in self-soothing (hair-stroking, rubbing of her thighs with her hands, wrapping her arms around her body etc.). It appeared as if she used these self-soothing actions in her anger and distress. I believe her creative adjustment techniques promoted a ‘disconnect’ from her wounds, but I also experienced a disconnection from her embodied anger and frustration. In an attempt to self-disconnect from her own physicality, she recoiled her back. The themes of terror and fear emerged. The client’s fear-driven anxiety embodied her. What affect was the presentation having upon me as her therapist?

Demi had told me she felt discomfort and dis-ease about talking to any professional, especially a hearing clinician who ‘wouldn’t understand Deaf cultural and linguistic matters’. I am curious if her anger was connected to her experience of a lack of access. BSL interpretation was not provided with consistency at her maternity review appointments (therefore potentially thwarting her psychological positioning of her own pregnancy and subsequent recovery). Her access needs had failed to be met and as a result she doubted her own capacity to be fully present in her mothering. Furthermore, she doubted every hearing professional and their capacity to understand her current position and her embodied sense of ‘deafhood’ (Ladd, 2003: xviii).

The client who was very low in mood, deeply angered by her lengthy wait for her referral, and overtly angry as a result of having to repeat her story again, recovered from her wounds through using TBMM to aid her reconnection with herself and her baby. At the end of our work she became pregnant again.

Reflections

In 1937, Todd suggested ‘For every thought supported by feeling, there is a muscle change’ (Todd, 1937: 1) and whilst we cannot verbally record these somatic muscular memories ‘the body keeps the score’ (van der Kolk, 2015). These ‘subverbal’, embodied memories will be found in the sensorimotor narrative: the somatic attachment history, ‘especially during early childhood [but

also] from the cradle to the grave' (Bowlby, 1979: 129). It is the job of the therapist, using TBMM through active 'bodymind' *observation*, *mirroring* and *responding*, to consider the attachment history in all forms: including how the body is presented and experienced in the clinical work by both client and therapist. Throughout each therapeutic encounter I posit a need to consider 'permanency', fluidity and 'moment-to-moment' shifts in 'bodymind' narrative. The capacity of the therapist to **observe** and then to reflect (***mirror* and *respond***) to these expressions will enhance therapeutic connectivity, which can stimulate neural pathways and improve the attachment relationship between client and therapist, and therapist and infant. The therapist has the potential to deepen their knowledge of the somatic attachment of the client and infant. For further consideration is the understanding of the somatic attachment history of the clinician and how this may influence the 'bodymind' of the therapist and client in the therapeutic encounter. In addition to any vocalisations, I believe there is value in exploring these imperative, 'psychobiological' components. As Totten suggests, 'our theory of the therapeutic relationship needs to be remade from the ground up as a fully embodied account – not just of body psychotherapy but of *all* psychotherapy' (2015: xviii).

Finally, for consideration is the elusive nature of the transpersonal. The transpersonal dynamic in psychotherapy has been defined by Clarkson (2003) as, 'The timeless facet of the psychotherapeutic relationship, which is impossible to describe, but refers to the spiritual, mysterious or currently inexplicable dimension of the healing relationship' (2003: 20).

The Blossom Method rebirth

In addition to the triad model posited above specifically for PIP, I further recommend the use of whole-body observation, mirroring and response to non-verbal communication in therapy training, psychotherapy, supervision, maternity units and elsewhere.

These implicit (non-conscious) bidirectional right-brain/body non-verbal communications also occur within the therapeutic relationship (Schore, 1994; 2003). Meares describes how:

> Not only is the therapist being unconsciously influenced by a series of slight and, in some cases, subliminal signals, so also is the patient. Details of the therapist's posture, gaze, tone of voice, even respiration, are recorded and processed (2005: 124)

By considering this unified, non-hyperspecialistic approach, through observation, mirroring and responding to the body and all forms of communication, the active observer/listener will receive all that is available to them. They will comprehend more in the relational embodied exchange; they will be a receptive listener and as a result will elicit presence in the other. Active attunement and attending wholly will provide a strong foundation for connection in any sphere.

CHAPTER 5: COMMUNICATING THE METHOD

> The creation of something new is not achieved by intellect in isolation but by the play instinct acting from an inevitable inner calling. The imaginative mind plays with the objects it loves (Jung, 1969).

5.1 Hyper-specialism versus universality

Ortega y Gasset (1988) suggests: 'In order to make progress science required men of science to become specialised: the men of science that is, not science itself. Science is never specialist: otherwise *ipso facto* it would cease to be true' (1988: 108). This process of specialisation has led to 'the man of science becoming more and more limited, limiting himself to an increasingly narrower field of intellectual occupation' (Ortega y Gasset, 1988; Giordano, 2006). With reference to specialisation, Ortega y Gasset (1988) concludes that it leads to an impasse where limits, restrictions and impossibilities appear.

To be clear, when individuals work in a hyperspecialistic way, they create an approach in which each professional involved focuses on the individual perspective of their own profession. 'The barbarity of specialism' (Ortega y Gasset, 1988: 108) argues against a phenomenon whose effects today are as visible as ever and that we call by the ugly name of 'globalisation' (Giordano, 2006). Cross-fertilisation and a broad-use model, like TBMM, may support innovation and promote further shared learning. Furthermore, one could argue that sharing information via academic papers and academic routes is not necessarily the most accessible way of disseminating knowledge. For example, whilst I was attending the AICOG 2018 conference (Vol 2: Evidence 6, 20, 22) in India it became abundantly clear that the abbreviations, jargon, and specialised medical terms were not accessible, and for me access has ethical considerations. The more hyperspecialistic the work or presentation, document, model, or method, the more disconnection will be experienced from the

community or from the wider interconnected communities. Specialist-dominated practice may see service users connecting with a number of different clinicians and as a result further disconnection may be experienced.

The Blossom Method Model is not hyperspecialistic and is defined as a more unified model that holds potential for broad use. As a result, the method could be taught, and theory shared in advancement of supporting a compassionate, attuned, empathic model for psychotherapies, maternities and potentially in other area such as social work and teaching.

Using The Blossom Method Model as a method of connecting and communicating with 'mothers and others' could relieve anxiety in the clinician/worker, infant and caregiver. It may further promote unconsciously and subliminally a model for connection between a parent and their infant.

In considering my own position with reference to hyper-specialism, I have purposefully chosen to train in psychotherapy, but have consistently diversified to expand my skillset, vary my workload, inform my practice and broaden my reach. The resulting works include: the publication of a therapeutic children's book *Robot Meg She Lives in my Head* (Vol 2: Evidence 7); the writing, publication and performance of poetry (Vol 2: Evidence 37-40); working on an international basis with IKON, Australia, to provide course material for a new Bachelor in Integrative Psychotherapy (Vol 2: Evidence 8); public speaking engagements (Vol 2: Evidence 5; 6; 9; 35; 36); being a panel member at a Leeds University event for students involved in creative writing studies; writing articles for national and international press (Vol 2: Evidence 10) and more.

5.2 Reach and impact of The Blossom Method

Reach and impact are seemingly defined differently depending on the user and the audience. Penfield et. al., (2014) suggest that there is a difference between academic impact and broader socio-economic impact beyond academia. In the UK, the evaluation of academic and broader socio-economic impact takes place separately. Impact has become the term of choice in the UK for research

influence beyond academia (Penfield et. al., 2014).

The Oxford English Dictionary defines impact as a ‘marked effect or influence’. However, defining impact, reach, benefits, value and returns is not as simple as providing book sales figures. Book sales offer an idea of purchasing; however, this may not fully reflect information on impact or reach. Global distribution may appear to reflect sales, but copies sold may not reflect reach and impact.

As previously stated, *The Blossom Method* is available worldwide, in the UK, New Zealand, Australia, India, USA, Canada and South Africa. The rights have been sold to a South Korean publishing house for distribution in South Korea and to a Mexican publishing house for the Spanish edition to be distributed in South America. Despite this international success, it has not apparently attracted the attention of those engaged in the British psychoanalytic community – or at least those engaged in ‘Infant Observational Studies’ such as the Tavistock Institute. However, it has reached the worldwide press (Vol 2: Evidence 11) and as a result I have been asked to contribute to magazines, newspapers, articles, journals, books, training, radio and podcast recordings (Vol 2: Evidence 8; 11; 15; 17; 18). Furthermore, I have received feedback from individuals who have shared with me their findings in relation to The Blossom Method (see Vol 2: Evidence: 1-3; 12-14; 20-24).

5.3 Social media: connection in cyberspace

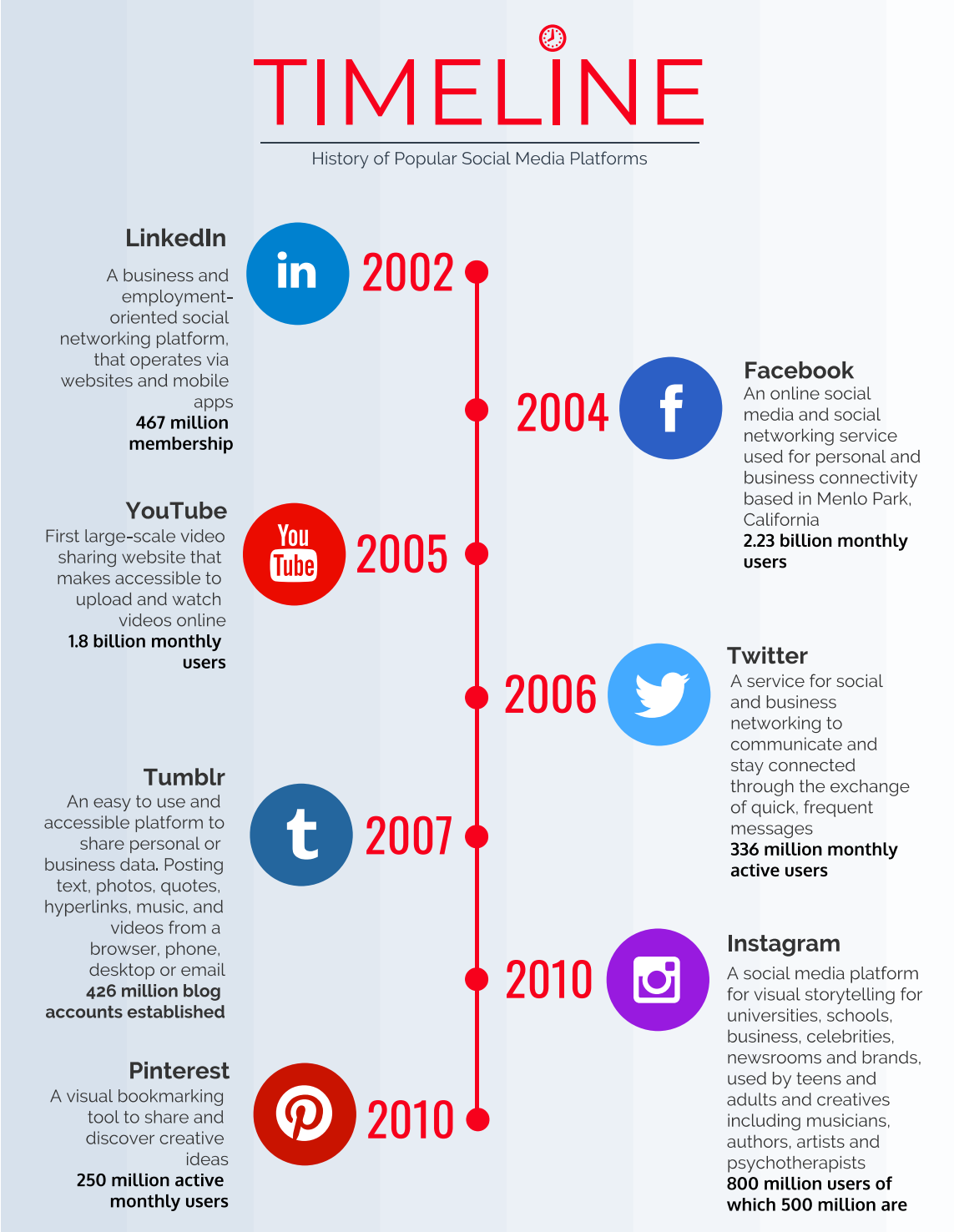
Social media is an inevitable source of connection, yet this in itself holds an oxymoronic quality. The contradiction of social media and connection may not be seen at first glance, but I am curious about users of social media and connection. Are those who engage with social media already isolated and therefore seeking to fill a void in themselves via cyber space? Does the use of social media create increased social isolation? Are social media platforms and time spent on them encouraging an absence of authentic face-to-face social experiences? Are social media platforms promoting feelings of exclusion by showing images which are carefully curated? (Primack et.al., 2017). This said, all forms of social media have provided and continue to provide much-needed

sources of sharing and promotion of learning. For me, what may have started as cyber relationships have become real relationships with real people, resulting in collaboration, joint working, joint presenting, publication, requests to develop material, speaking engagements, 'expert' requests and invitations to present both in the UK and internationally (Vol 2: Evidence 5, 6, 8-10, 13, 15-18, 20-33). These relationships have opened platforms central to my work and dissemination.

Timeline 3 provides information in relation to social media platforms and specifies historical information and statistical data[8] in relation to active membership/monthly users of the most popular platforms.

[8] Data gathered via Google in September 2018 and reported via each of the platforms listed

Timeline 3: History of Social Media Platforms



Timeline 3

Instagram, established in 2010, is a popular social media platform. The figure below (Figure 10) explains in an accessible way how engagement can be achieved and how impact, connection and reach materialise on this platform. It also provides suggestions on how to improve upon reach and impact.[9]

The features of the model such as ‘tagging’ and ‘hashtagging’ relate to behaviours utilised to engage others, including influencers and micro-influencers, in order to improve reach and engagement. These tools have been utilised by the candidate in order to disseminate, connect with relevant professionals, develop relationships, improve knowledge, reach and impact upon parents and professionals. They have been used to improve the likelihood of finding connections and interested users through search methods.

[9] The infographic figure data overleaf was gathered from Venn gage Infograph Company on September 2018. This model has been revised from their original.

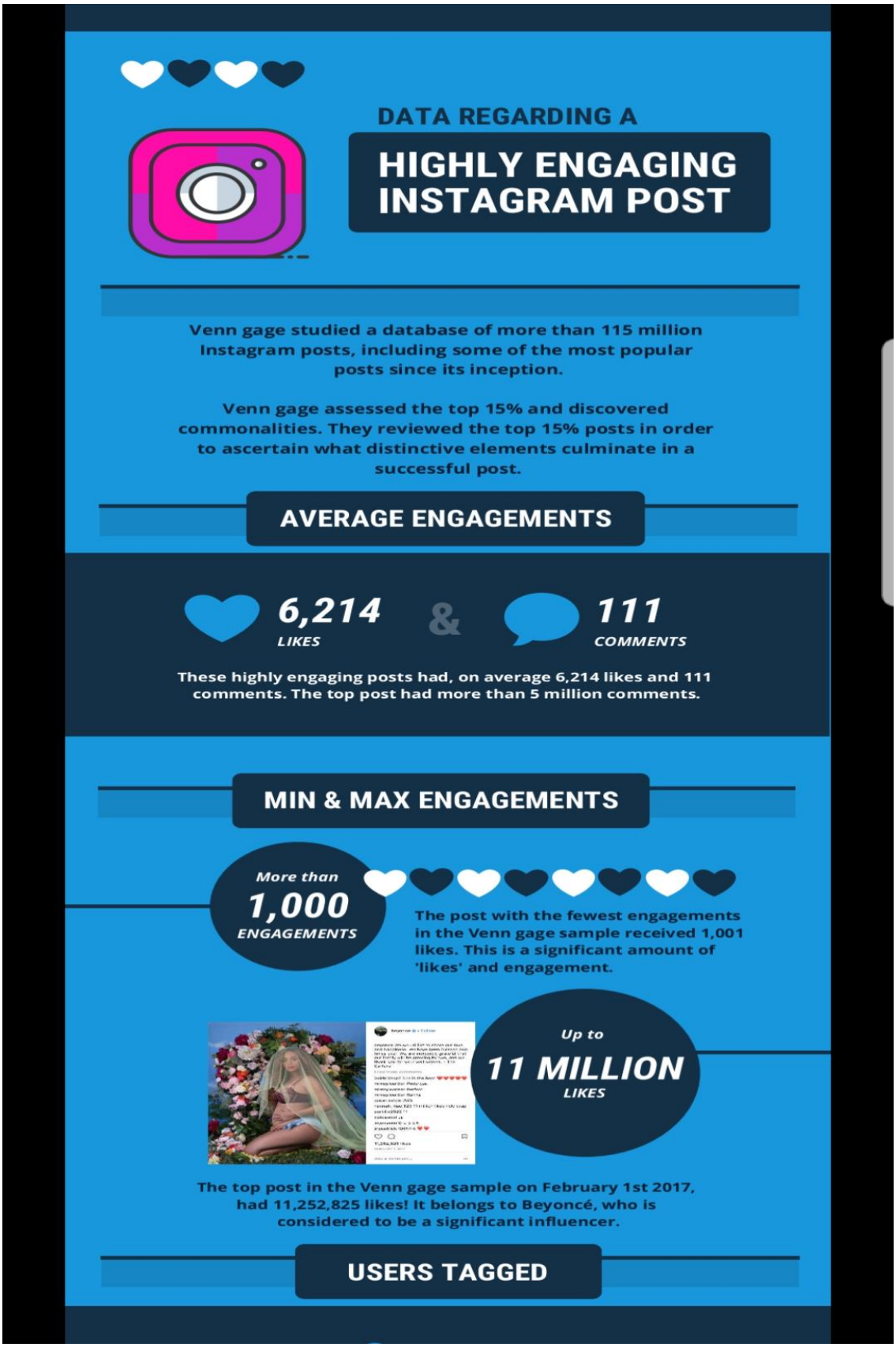


Figure 10 Instagram engagement

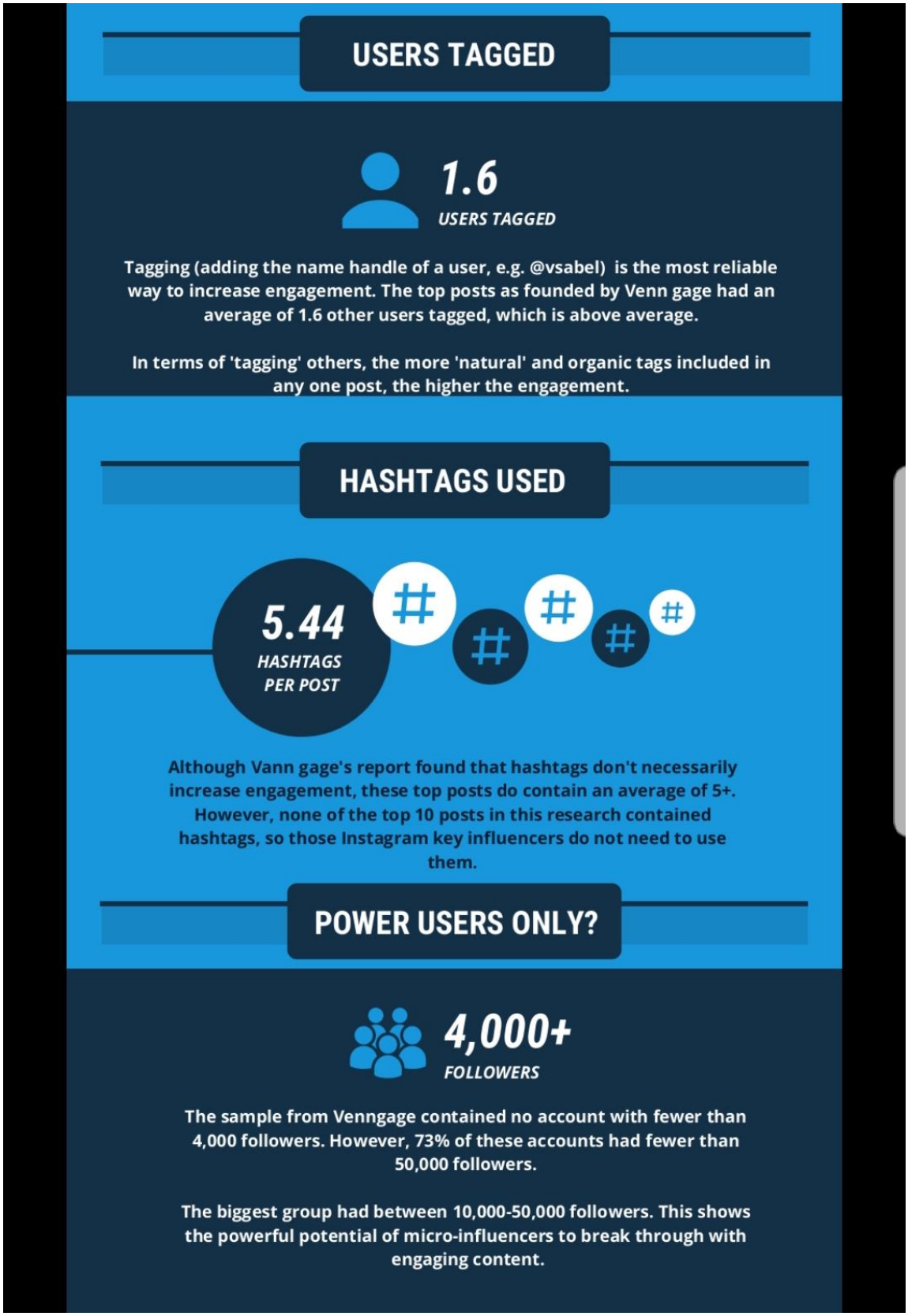


Figure 10 Instagram engagement continued

Figure 10 Instagram engagement continued

The following table demonstrates the type of social media used by the candidate, the connections made and the outcomes of building social media connectivity in terms of reach and impact

Table 8 : Social media connectivity

PLATFORM NAME	REACH	IMPACT	RESULTS
TWITTER 	9,518	Connection with authors, publishers, baby/parenting experts Built profile as an 'expert' in the field of infant communication, infant mental health and parent-infant mental health Developed relationships with parent-infant mental health clinicians and others in similar fields Built cyber relationships which have become	Gathered quotes/praise for *The Blossom Method* & *Robot Meg* Requests to be quoted in press, radio interviews, publications, to produce blogs, posts, articles, attend conferences and speaking engagements Through developing a relationship with a charity, an organisation working with families who have experienced infant loss, I raised over £660 (2018) Member of the 'All

		collegiate, supportive and concrete Met up with others in the field to share work/learning with each other and wider audiences	Party Parliamentary Committee' (APPG) to support with Parent-Infant Mental Health in UK Invited to be interviewed for PIP UK Conference
LINKEDIN 	4,551	Cyber and real connection with individuals in similar fields Relationship building Sharing findings Guidance and shared learning Global connections developed Followed up with connections and subsequently met and presented with some Relationship building has resulted in requests for radio/podcast interviews reaching international	Invited to present at Global Parenting 2.0 Conference 2014 and subsequently have been invited to India and Australia for follow on Parenting Conferences with this international group Honoured with the title of Global Presence Ambassador as a result of participation and communication panellist duties Invited to publish my MA Paper with E.C. Gynaecology

		audiences Request to attend multiple conferences Multiple requests to share material produced.	International Journal (2017). Request to submit more research in E.C. Gynaecology in 2018 Received feedback from academic peers regarding publications Sharing of publications and public work globally Use of my unpublished work in psychotherapy training and mental health support requested Invited to attend and present at DeafNest Conferences 2014 & 2016 Invited to attend Leeds University to be an author panellist in 2017
FACEBOOK (PERSONAL)	35	Continued connection with colleagues in UK	Invited to participate in 70/30 campaign and work

		and internationally Relationship building Sharing of new projects Building relationships and as a result being connected to others via their networks Keeping abreast of new research, training and opportunities	as an ambassador for this campaign to reduce childhood abuse by 70% by 2030 Invited to attend and speak at the largest global gathering of gynaecologists and obstetricians (AICOG, 2018) in India 2018. Invited to contribute to Happy Pregnancy Global Initiative with a following of 4.7K Connected to Association for Prenatal & Perinatal Psychology and Health (APPPAH) with a 5.3K membership and shared my first public reading of unpublished poetry and published research

			Invited to present on Perinatal Connectivity and present poetry at Forging Families Perinatal Mental Health Conference in Sheffield (2018) Engaged in supportive groups in Birth Trauma and PhD Support Groups Invited to write press and other journalistic material
FACEBOOK (BUSINESS)	323	Building and engaging with followers Sharing relevant research and articles Sharing personal articles, blog posts, journal pieces and research in relation to infants and parents and psychotherapy	Gathered local, national and international participants for The Blossom Method research Gathered evidence of prenatal & perinatal connection Disseminated related material to evidence findings in relation to infant mental health

INSTAGRAM 	610	Audience building therefore increasing reach Sharing views on psychotherapy, infant mental health, mothering, infant loss, pregnancy etc	Received personal commentary and feedback from readers and users of The Blossom Method Sharing articles to promote further awareness of attachment, infant communication etc
PINTEREST 	394	Developing & connecting with those in the field of psychotherapy, infant mental health & child mental health	Disseminations of public works and sharing the public works of others. Relationship building Shared boards with others therefore building collaborative relationships
OTHER	Unknown	Recruited a New York based illustrator for *Robot Meg*	Designs & illustrations produced for *Robot Meg*

Table 8 offers the reader an opportunity to ascertain the broad use and perceived value of social media in terms of information sharing, realising cyber connections, reach, impact, relationship building, and the production

and promotion of material for both national and international audiences. In embarking upon developing skills in the utilisation of social media, I was unaware of the potential for growth, reach and impact. Having had no formal training in any element of social media, I utilised my innate drive to connect and share to reach others. I initially began by using the LinkedIn platform and then Twitter.[10] Most of my initial reach was established through Twitter (launched in 2006). I created tweets using the maximum character count (140 characters) by copying carefully chosen text from the pre and post publication copies of TBM book. These quotes generated interest in the content and concepts of TBM and engagement, reach and impact increased. Virtual and real relationships began to flourish. It was through relationship building with one of my Twitter connections that a request was made to secure an email address for the Random House[11] parenting editor. I pursued this lead, and this resulted in me securing a publishing deal with Vermilion Imprint at Random House. The editor I emailed became my editor for *The Blossom Method.*

The power of social media cannot be underestimated. It was through the use of Facebook and connecting with the founder of The Happy Pregnancy Global Initiative Dr Sachin Gothi, (whom I met via Facebook) (Vol 2: Evidence 6, 20, 22) and through my contact Dr Antonella Sansone (Vol 2: Evidence 14, 45) (whom I connected with via LinkedIn) that I came to be invited to attend and present at ‘the world’s largest conference for Gynaecologists, Obstetricians, Surgeons and others involved in maternities’ in Bhubaneswar India in January 2018 (Vol 2: Evidence 6, 20, 22).

This said, the journey to publication was stressful and sometimes

[10] Twitter is an American online news and social networking platform on which users post and interact with messages known as "tweets". Tweets were originally restricted to 140 characters, but on November 7, 2017, this limit was doubled for all languages except Japanese, Korean, and Chinese.

[11] Random House is now known as Penguin Random House. Bertelsmann and Pearson merged their respective trade publishing companies (Random House and Penguin Group) in 2013.

experienced as difficult and discouraging; a journey not for the faint-hearted or those lacking in self-belief. The first submission of my manuscript did not go well. I was given a contact email for a major publishing house. I eagerly forwarded my manuscript and awaited a response. I received a rejection email. The editor's feedback suggested that as an 'unknown', non-famous person, there would be little interest in my personal and familial history. To me this seemed in some ways logical. The backstory (however much it lacked structure and finesse) to publication did to me seem to be relevant to the reader. The editor suggested the content could be included in an information pamphlet type publication. This was a disappointment but one that did not hinder its future publication. I saw it as an opportunity '***to make adjustments to my project design'.*** Interestingly, at the initial registration, a panel member suggested further information relevant to my 'backstory' to publication would be of value in the final submission and I wonder if this has been resisted as a result of this early rejection.

The way in which I write is influenced by both my early years and my immersion into the Deaf community. A traumatic early life left me disinterested in schooling and resistant to authority figures. My 'intercultural interloping' (Napier and Leeson, 2016: 63) means words in print are only half the story and in isolation do not provide a full account. They limit my capacity to express and compromise what is embodied. As Frank states, 'My wish has been to articulate through words what I am able to so easily articulate through the language of my body' (2010: 18). To this end and in the hope that I can fully express myself, I have submitted a short film for the final presentation that includes personal historic data, and theoretical and parental evaluation of TBMM. It will include video and photographic evidence of TBMM in action and critical commentary associated with it. I hope this will aid the observer to recognise ***'the potential usefulness of {TBMM} to specific audiences'*** and ***'the creation and interpretation of new knowledge'*** that is relevant to parenting, psychotherapy, and parent-infant psychotherapy.

LinkedIn was the first social media networking platform I engaged with. Here I 'virtually' met former Professor of University of Sydney, Dr Rosina McAlpine (author, Australian-based, director and founder of Win-Win Parenting) who was so impressed with *The Blossom Method* manuscript that she took it to University of Sydney Press, who chose not to publish it, but offered the most wonderful rejection email (Vol 2: Evidence 44). Dr McAlpine has been a keen supporter of my findings in relation to The Blossom Method and has as a result made two nominations (2014 and 2016) for an award with the World Association of Infant Mental Health (WAIMH) (Vol 2: Evidence 14). She asked me to contribute to a second volume of *Inspired Children: How the Leading Minds of Today Raise Their Kids* (Volume II) (Vol 2: Evidence 15). I provided her with a chapter for this publication. Dr McAlpine has interviewed me for her Blog Talk Radio programme (Vol 2: Evidence 13).

In addition, I contacted the late Dr Zack Boukydis and asked him to review my original manuscript. He kindly offered feedback and a quote for me to use in relation to his perspective of my works (Vol 2: Evidence 34). In re-reading this email exchange I am able to identify his generosity and compassion. I regret that we failed to meet and share more in relation to parent-infant mental health.

The relationships that have developed are valued and nurtured. They are encouraging and supportive for all involved. They are reciprocal in nature. Hobhouse referred to reciprocity as 'the vital principle of society' (1906: 12) , and Becker (1956: 1) denoted humans as '*homo reciprocus*'. Simmel documented equity in social forms and unity and suggested it could not subsist without 'the reciprocity of service and return service (1950: 387).'

Amongst others and as previously mentioned, I am in communication with: Dr Antonella Sansone (Doctor of Psychology, prenatal and perinatal psychologist, author, published researcher); Dr Diane Speier (director of Birth, Growth and Healing Ltd, UK published researcher, doula and director

of Digital Doula); Dr Sachin Gothi (India-based, award-winning gynaecologist/obstetrician and founder of The Happy Pregnancy Global Initiative); Deborah McNelis (US-based author of *Neuronurturing, Brain Packets*, and panellist at the Parenting 2.0 international conference); Consultant Psychiatrist/Medical director Dr Haraldur Erlendsson and Elly Taylor (former counsellor, Australian-based, author and 'Becoming Us' course developer). I met all of the above through social networking and social media sites. We share our learning, actively promote each other's work, and pass requests to the most relevant person. For example, following a journalist's request, Elly contacted me as she felt the article entitled 'It's science: Being sensitive to your baby's cues leads to a more secure attachment' for Mother.ly (Vol 2: Evidence 17) would be more specifically my area of expertise.

> As a result of this 'bottom-up marketing' (Karpinski, 2005) we are supporting each other to meet a wider global audience. This bottom-up marketing occurs because 'billions of people create trillions of connections through social media each day' (Hansen et al., 2011: 3). These connections build relationships that result in a vast social network, tapping into a consumer marketplace where marketers would never be allowed to tread (Hanna, et. al. 2011: 2-3).
>
> Exchange partners build social capital through repeated acts of immediate, voluntary reciprocity that demonstrate their trustworthiness, their regard for the partner, and their willingness to invest in the relationship (Molm, et. al., 2007: 215).

These relational investments are crucial to dissemination and information sharing.

5.4 Beyond The Blossom Method: Domains of influence

In writing a second book and considering both traditional and non-traditional publishing methods, I utilised social media to connect with other children's books authors (both self and traditionally published), publishing agents and publishing houses. After careful consideration and accessing information regarding self-publishing, I decided to pursue a non-traditional route to publication. It was a contact via Twitter who put me in touch with an author who self-published and also supports others to reach their printing goals.

In considering a second publication, I engaged a UK-based company to print the original and second print runs of *Robot Meg: She Lives in my Head* (Vol 2: Evidence 7). Since March 2017, I have self-published, promoted and sold 450 copies of *Robot Meg.* This book has over 87 five-star reviews and one four-star review on Amazon (Vol 2: Evidence 19). The information and statistics gathered from social media and other online platforms such as Amazon regarding *Robot Meg* have been sourced in order to attempt to secure a publishing deal for the book in the US and Canada. Through social networking sites I was offered peer reviews of both publications (Vol 2: Evidence 3, 13, 14, 19-30, 33 and 34) and they have been applied in marketing, influencing, disseminating and network building.

Through Facebook I was asked to facilitate a Deaf Awareness and Introduction to BSL course for young people completing their Duke of Edinburgh Award. The Facebook connection was previously unknown to me, but she knew of my work as a psychotherapist, my involvement with the Deaf community, my deaf mother and my BSL skills through social media and my Public Works. We developed our contact and connection through social media and I began teaching this course to five young people and three of their mothers in December 2017. We had a Deaf person who joined the group and shared her experiences of losing her hearing in her teenage years and the impact of her loss. The twelve-week course was completed on 17th

April 2018. The training material and course facilitation has been successful. The participants provided their feedback, which can be located in Vol 2: Evidence 31. This course (according to feedback) proved to be worthwhile and helpful not only in basic BSL acquisition but in matters associated with Deaf culture and the Deaf community. In addition to the course, which was one hour per week, we established a 'private' Facebook group to share learning, videos, and relevant literature to aid the training and learning experience.

Learning to understand the reciprocal mutuality and the social customs expected in the cyber world is vitally important. Much of my learning has been gathered through the process of trial and error. On reflection, this type of learning has provided me with insight beyond textbook learning. Corcoran (2009) in Hanna (2011) divides networking into three media types (1) media owned (controlled by the marketer; e.g., company website) (2) paid media (bought by the marketer; e.g., sponsorships, advertising), and (3) earned media (not controlled or bought by the marketer; e.g., word-of-mouth, viral). Li and Bernoff (2008) segment active participants in the spheres of influence based on five different types of social behaviours: Creators (e.g., publish, maintain, upload); Critics (e.g., comment, rate); Collectors (e.g., save, share); Joiners (e.g., connect, unite); and Spectators (e.g., read). (Hanna et. al. 2011: 4).

In order to reach individuals and communities, it is logical to participate in *cyber networking* – maintaining curiosity, interest in the other, courage, self-motivation, belief in product/service, and resolve, which are useful skills to have and develop further. Social networks are about the experiential (Wyshynski, 2009). The creation of these experiences occurs when marketers blend 'reach, intimacy and engagement through interconnectedness' (Hanna, et. al. 2011: 5). For further consideration are consistency in connectivity and an ability to maximise output with multiplatform connectivity and use.

Building a social media network is time-consuming and requires significant attention and effort. Connections do not want to receive spam;[12] they are seeking to engage in mutuality and interconnectedness.

Vol 1: Appendices 1, 3 and Vol 2: Evidence 2, 3, 4- 6, 8- 23 provide examples of engagement, influence, reach and connection.

[12] Spam equates to unsolicited messages received (generally in bulk) via social media platforms.

CHAPTER 6: FINAL REFLECTIONS

Follow that desire and that inclination which experience
confirms to be your own (Jung, 1973).

6.1 Public Works: Lessons, Learning and Considerations

As a psychotherapist, supervisor, author, student, researcher and public speaker the perception held is, the journey to date has been neither simple or straightforward, the results I hope will bring great potential for change in the way connection and communication are viewed in psychotherapy and elsewhere.

Creating TBMM and re-evaluating the core principles of the model means I have revisited the three core elements of ***observation, mirroring and response (OMR),*** in addition to the language produced by infants themselves. In adopting the three values (OMR) I am able to note there are other theorists (Bowlby, et. al., 1956; Bowlby, 1958; 1960; Ainsworth and Bowlby, 1991; Erskine et. al, 1999; Frank, 2009; Ogden, 2007; 2009; 2011; 2013; Ogden and Minton, 2000; Ogden et. al., 2006; Ogden, 2014; Sansone, 2004; 2007; 2018; Schore, 2000; 2001; 2003; 2010; Ogden and Fisher, 2015; Papousek and Papousek, 1997; Murray, et. al., 2016; Sansone, 2004; 2007; 2018; 2018b; 2019; Cozolino, 2010; Malloch and Trevarthan, 2009; Boukydis, 2012; Stern, 1995, 2004, 2010; Beebe, et. al., 2010; Tronick, 1989; Tronick and Weinberg,1997; Sroufe, 1996; Frank, 2001; Frank and La Barre, 2010) whom amongst others, consider these elements important in infant mental health. Additionally, the work of Schore (2000; 2003; 2005; 2010) promotes understanding the somatic narrative of the infant using a right-brain to right brain system of communication through ‘hemispheric connectivity’ (Sabel, 2018).

Acquiring knowledge has been and remains a constant in the journey to creating TBMM. One of the most significant lessons in TBMM development is that academic rigour and academic approval requires significant effort. I had found the MA Psychotherapy at points a very stressful training but engaging with the DPPW has also been quite a journey. Living and developing TBMM has facilitated a deeper understanding of the language of infants and the complexities of model development. The focus of the DPPW has promoted a deeper exploration of tacit, a priori, a posteriori, explicit, propositional and non-propositional knowledge gathered from heuristic, reflexive research and contact with parents and infants, whilst attempting to marry developed theories alongside research already concluded.

By undertaking academic studies in psychotherapy and in particular an MA in Psychotherapy (researching contemporary PIP) in addition to DPPW, I hope to demonstrate a continual commitment to assessment of acquired knowledge and to re-evaluate TBMM theory and practice. As previously stated and following the production of my draft of TBMM I became aware of the work of Ruella Frank and Antonella Sansone. Their works have added to my knowledge and in some ways mirror some of my findings. The model in its latest form has been generated and ***proposes new approaches*** and demonstrates my capacity to ***identify and appropriately use an extensive range of sources and knowledge of data in ways that are applicable to practice.***

In 2004 when Blossom was born, I had undertaken my first clinical training in psychodynamic counselling. In initially discovering more in relation to the somatic narrative of Blossom, I knew nothing of the works of Schore (1994; 2000; 2001; 2002; 2003), Frank (2001), Ogden and Minton (2000), Sansone (2004), Erskine, et. al., (1999), and van der Kolk, McFarlane and Weisaeth (1996). I knew only of my somatic history, the value I placed on somatic information and the sensorimotor narrative of my infant. At this point I had

completed my academic training in Deaf studies and sign language interpreting, but I then began to consider the similarity to other works.

In sharing my findings with my husband, I discovered he too could see and experience the somatic narrative of Blossom in the same way. His experience was gathered through my discoveries, but he knew quickly that Blossom's forms of communication held messages regarding her needs: hunger levels, comfort, discomfort, energy levels, constipation, toileting experiences and signs of illness. I had naively thought other parents gathered information in the same way (Sabel, 2012). The belief I held and still do in relation to somatic accounts in infancy has been paramount to bringing this project to life. Not only was I inspired by the joyous infant we held, I was further encouraged by 'mothers and others' and their interest in the somatic narrative of their own infants. I had inadvertently and passionately discovered a platform to engage mothers in connecting with their infants in the way we connected with Blossom. In doing so I felt sharing this information and ***participating in consultation in an informed empowering and accessible way*** could support parents to connect more fully with their infants.

I began my informal reflections in 2004 with mothers and fathers in a local mother and toddler setting. I had befriended these parents and engaged them with gentle observations and curiosity. I then spent the next six years observing infants and sharing my story of these findings. By 2010 I had then completed further clinical training in relational integrative psychotherapy, and this training and study cemented my belief in the value of parent-infant connectivity. In 2010, after I had finished drafting my first manuscript, I came across the work of Frank (2001) and Sansone (2004, 2007). These findings proved to be exciting and affirming. During 2008-2010, in undertaking my Postgraduate Diploma in Integrative Psychotherapy I shared my findings with my peers. They appeared interested and deemed it as relevant to ***professional practice contexts.***

I recall sharing something about transmuting my personal history and my personal experiences of parent-infant connection with my then tutor into a model of practice in psychotherapy and elsewhere. She advised me to consider writing a paper on how my personal, academic and embodied history are relevant to ***the profession as a whole.*** I worked tirelessly and in a way that did not support a good work-life balance. This resulted in the production of the original manuscript. A former trainee colleague agreed to grammatically check it for me. I worked on an old laptop using open office with a spell checker that did not function. At the end of this process I lost the entire manuscript but with the support of professionals I rediscovered an earlier draft, but not the original 40,000-word draft.

I utilised social media and the cyber connections I had developed to discover more about publishing and to secure my publishing deal. Simultaneously I was fortunate to connect with Dr Rosina McAlpine (Vol 2: Evidence 13-16) who was very encouraging of both my findings and my manuscript. I was delighted when she agreed to review it for me. Her generous and consistent support has been of significant value. Once the manuscript had been edited Dr McAlpine offered to take it to University of Sydney Press (Vol 2: Evidence 13, 44). It was Dr McAlpine, like Dr Erlendsson (Vol 2: Evidence 23), who then suggested I pursue a more academic route to validate my findings and The Blossom Method. It is following their advice and the advice of Dr Divine Charura (Vol 2: Evidence 33) that has seen me engage with the DPPW and in fleshing out my original TBMM findings with further academic rigour and a theoretical framework. Respecting the valuable feedback of supervisors and advocates I utilised this opportunity '***to make adjustments to my project design'.***

Model creation demands ***critically evaluating advanced professional knowledge.*** Many hours in email and telephone contact with Dr Antonella Sansone have supported the further development of TBMM. This and other forms of collegiate exchange have been evidenced (Vol 2: 45 and 16). I have

considered commentary from parents, students, academics, psychiatrists, advisors and professors and as a result have made further advancements in TBMM. During my MA Psychotherapy studies, I applied Schore's affect regulation work (Schore, 2010) to the theory of TBMM and in doing so recognised similarities in his work and the work of clinicians such as Frank, La Barre, Ogden and Sansone. There are references to observation and specifically in the work of Frank and La Barre 'six fundamental [sequential] movements' are identified as 'yielding, pushing, reaching, grasping, pulling and releasing movements' and it is suggested that 'a baby communicates what he wants and needs from his parents and expresses how he reacts to what his parents want and need from him' (Frank and La Barre 2010: 21). Eye gaze and the inclusion tongue-talking patterns form part of TBMM. Sansone suggests 'pre-verbal mouth and tongue movements, cooing vocalizations, gestures, and postural and facial expressions are precursors to verbal language' (2004: 192) or proto-conversations (Bateson, 1975). Ontogenetic discourse suggests, that infants not only communicate before speech development but that they already have developed social-cognitive knowledge; with capacity to grasp meaning, engage with intentionality. They appear to exhibit skills in observational meaning-making and display comprehension capacity (Tomasello, 2008). I would further suggest there are emerging symbolic communication forms manifested in infancy to express need, well-being, parental requests, mood, comfort, discomfort, connectivity and disconnection.

Others have worked over many years to address communication with the complexities of humans and are utilising the non-verbal, sub-verbal and verbal in their areas of specialisms. Nind and Hewett (1994), Nind, (1996), Hewett & Nind (1998) focus on the fundamentals of pre-speech communication for example, shared attention, eye gaze, facial expressions and vocalisations. Where the quality of each non-verbal or sub-verbal interaction is deemed as significant (Nind, 1999). They began their PhD research projects in 1987 in the field of communication, in an attempt to

communicate with people who are difficult to reach. The research saw the development of the ‘Intensive Interaction’ approach by undertaking live study in an educational environment designed to support people at early levels of development, people who have severe, profound or complex learning difficulties and people who have autism. Firth (2008) and Firth and Barber (2011) have considered the dual aspects of the Intensive Interaction model and have researched this with persons with social or communicative impairment. Falck-Ytter et. al. report, the study of eye gaze and absence therein which may further illuminate the existence of underlying conditions like autism. Eye gaze tracking may support the characterisation of autism, where early intervention may improve outcomes for those diagnosed with autism in infancy and early childhood (2013).

Caldwell (2006; 2007) and, Caldwell and Horwood in their work in the field of autism and intellectual disabilities discuss the concept of learning the individual’s language and describes imitation as a way of seizing attention, and a way to enter the central innermost realm of embodied communication (2008).

In addition and further worthy of note is ‘Adaptive Interaction’: the work of Ellis and Astill (2008; 2010). Adaptive Interaction is described as an approach to communicating with people with very advanced Dementia, where all behaviour is viewed as communicative and an individual’s communicative repertoire is observed through intensive interaction. Learning about the repertoire of an individual with Dementia has supported the observer to note specifics including, ‘vocalisations, movement, facial expressions, eye gaze, turn-taking and initiation’ (Ellis and Astell, 2008).

In TBMM the author is suggesting, the caregiver regards the infant’s presentations ‘as-if’ it is purposefully communicative (Newson, 1978). In doing so the infant reciprocates and co-created communication emerges (Vygotsky, 1978). This communication is primarily non-verbal but mutually

meaningful (Papousek & von Hofacker 1995) and as a result intersubjectivity – awareness of other and self is experienced (Trevarthan, 1993). In the infant-parent dyad communication skills are developed through imitative interactions (Tomasello, 1992). Feedback suggests that the concepts of TBMM are perceived as valuable in that they offer 'a deeper level of embodied [therapeutic] connectedness' (Ogden and Fisher, 2015: 22). TBMM draws the therapist's attention to a client's somatic embodiment and the 'bodymind-bodymind' connectivity held in the therapeutic encounter. Restricting practice to the verbal expressions of clients may 'limit clinical efficacy' (Ogden and Fisher, 2015: 24) and therefore the encouragement of a 'bodymind' model may see improvements in both client experience and in day-to-day practice. As Håvås, et. al. suggest their 'findings regarding nonverbal attunement lend support to the intimate connection between nonverbal affect attunement and attachment security across the life's span' (2014: 2). In training trainees with TBMM, the author highlighted specifics in relation to the non-verbal language of clients in order to draw attention to congruence and incongruence between spoken languages, 'visio spatial' language, somatic narratives, kinetic precedents and sensorimotor accounts in psychotherapy. This resulted in a more generous consideration of the 'somatic whole' in psychotherapeutic exchanges.

This said, not every non-verbal cue is an indicator' (Ogden and Fisher, 2015: 38), although I would argue that every movement and the way it is actioned and embodied is worthy of note. I would further suggest that this takes much observational practice and subtlety in action. The personal experience I hold with somatically embodied, immersive and academic knowledge of the sensorimotor does not guarantee perceiving the entirety.

There appear to be themes in relation to my commitment to sharing TBMM and *Robot Meg* and other of my Public Works: they include tireless working, determination, being driven and working always with a dogged tenacity (Vol 2, Evidence 13-16 19-32). These efforts have meant that I have had to

consider carefully my ongoing responsibility for self-care and need to consider wellbeing as an important element of my professionalism (UKCP Code of Conduct and Ethics, 2009). I tend to plough into things without consideration of the implications on family life. Striving for a healthy work/life balance is challenging for me but as maturity in practice has developed, a more mature approach to this has been reached. The BACP ethical framework promotes 'keeping a healthy balance between work and other aspects of life' (2014) and perhaps the completion of this doctorate will finally place my 'I'm not good enough' fears to rest.

Deaf, deaf and hard of hearing clients are included in sharing knowledge of The Blossom Method, but I am acutely aware that registered blind parents may struggle with the components of the method, nonetheless I am open to learning more from the sight loss community and am interested in how the method could be translated with partially sighted and visually impaired community members. Parents with dual sensory loss are to be further considered too. I firmly believe this is 'doable' but as, yet I have been unable to consider in depth the requirements of dual sensory loss parents and sight loss parents.

In practice I work with many disabled clients: always following their lead on terminology used and perspectives embodied. If a client defines as hard of hearing I will use their terminology, carefully and respectfully ascertaining their position and following their linguistic lead. If an individual defines as 'mixed race' I will mirror their chosen expression and not offer other terminology in place of theirs. These matters need to be carefully observed and respected. In working with transgendered clients, I have found myself in uneasy positions when I have failed to understand preferential pronoun usage. Thankfully individual transgendered clients have been clear in their positioning and language. They have taken time to explain any preferences and with respectful and careful consideration, clients are observed in their predilections.

Although the focus of this research has in the main been engaged with the sensorimotor story in psychotherapy, I do not wish to diminish the words selected by clients in psychotherapy. I find myself 'struck' by verbal expressions such as 'dumfounded', 'at a loss for words', 'no words can describe' 'it breaks my heart' 'it was such a blow' and similar commentary discovered in sessional work. In his work in relation to the forgotten narrative and legacy of trauma works, van der Kolk describes the expression of "speechless terror" (van der Kolk et. al.,1996: 317; Ogden and Fisher, 2015: 24). Expressions like these I believe will further benefit from verbal and non-verbal exploration of the somatic and linguistic narrative.

6.2 Conclusion

In the writing of this thesis, the 'transition from description to the reflexive and critical analysis…was difficult' (Stevens, 2016: 44) for me. Yet, the encouragement 'to re-story' and 're-evaluate' these achievements' (du Plock and Barber, 2016: 26) with the presence of my academic advisor has aided me, I hope, to attain a balance of the descriptive, reflexive, and analytical components required for the Doctorate in Psychotherapy by Public Works. Therapeutically speaking, engaging in this process has personally supported me to 'open up and find healing' in some of my 'forgotten' embodied wounds. This process also recognises my embodied drive to transmute and breathe life into what may be described as intense, uncommon in combination, experiential learning involvements, developing them into a model that may support parent-infant psychotherapy, infant mental health, parental attunement, psychotherapeutic attunement and which may encourage a socioeconomic cost reduction in the £8.1 billion[13] currently spent in the UK as

[13] Perinatal depression, anxiety and psychosis together carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK (Bauer et. al., 2014: 4; London School of Economics (LSE) & Centre For Mental Health (CMH))

a result of issues arising from the perinatal period.

This said,

> ‘The research evidence has not changed in therapy for fifty years: the factor that matters most in successful psychotherapy is the bond between the client and the therapist’ (Miller, 2012: 209).

Although I have said little overtly in relation to the therapeutic relationship, connectivity, the bond in the therapeutic relationship and the alliance are important to me. I see these as crucial in all therapeutic encounters. It is the connectivity between two bodyminds that is the essence of all relationships, including author-reader and therapist-client, and which eludes the confines of verbal expression, an ineffable quality of connectedness that is not learned from reading, study or writing but that is experiential in nature (Ogden and Fisher, 2015).

This ‘efficient and intense route to gaining a doctorate’ (Anthony and May, 2016: 201) has proved to be a powerful and deeply personal journey. It has enabled me to recognise the components of TBMM in the works of others and identify a ‘leading edge’ (Anthony and May, 2016: 201) model for use in parent-infant psychotherapy, and where a dyad or triad exists, potentially elsewhere. Of unique interest are the particular findings in relation to the specifics of infant language. My desire and allegiance to these findings have encouraged TBMM to ‘seemingly take on a life of its own’ (Anthony and May, 2016: 202). In order to illuminate these findings, I will ideally go on to research the language of infants in more depth.

Sharing TBMM nationally and internationally with audiences involved in psychotherapy, staff in maternities, social work, in teaching and beyond is something I feel passionate about. My work with young people, in schools and elsewhere, has proved to be stimulating and exciting for those involved: I am currently meeting with schools to engage in more training with them, not only TBMM but possibly workshops in Deaf Awareness, BSL and Poetry and

Emotional Wellbeing. A drive to diversify and a need to reach and impact upon many remains a driving force for all of my works.

Like Jung in 1933 (2001: 76), my sense of mind-body dualism remains the same. The perception of a dichotomy of mind and body is artificial, and one I believe is based upon intellectualism rather than the true nature of human beings (Jung, 1933; 2001:76). Regardless, and as one of my former research participants suggested:

> At the end of the day we all just want to feel felt and get gotten and that's what were supposed to have experienced in that parent infant experience is that, you get me, I get gotten by you and the world makes sense because you make sense of it for me and you reflect that back ('Elisa 646-653' in Sabel, 2016c: 44).

If TBMM and other of my Public Works assist parents, clients, children and infants to 'feel felt and get gotten' then I will be satisfied with contributions brought to the field of psychotherapy and elsewhere.

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APPENDICES

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Appendix 1 - Impact Table Removed

Appendix 2 - Sign Linguistic Considerations in Britain

The complexities of sign language and the derivatives therein are worthy of explanation. As 90% of deaf children are born to hearing parents (Mitchell, 2004; Mitchell and Karchmer, 2004; Schein and Delk, 1974 in Morere and Allen, 2012: 233), the likelihood of hearing parents being knowledgeable in languages of the deaf is slim. The first professional parents are likely to meet in relation to their deaf child will be an audiologist. Audiologists are likely to be hearing and each individual audiologist may have their own view regarding what may be most appropriate for a deaf child.

As 50% of my clinical work is undertaken with the Deaf community, I have considered the importance of sign language and the possibility of exclusion. Deaf people in my practice report experiencing oppression through a lack of cultural, linguistic and community insight. Psychotherapy and other services may need to develop their knowledge and insight into the world of the Deaf Community and in particular the Deaf parent.

Inclusion of Deaf people in both service advisory matters and service provision of psychotherapy ought to be considered. Four babies are born deaf every day in the UK (data from Newborn Hearing Screening Programme, 2008). For further consideration are the ten percent of Deaf parents raising both hearing and Deaf children. 90% of all deaf children are born to hearing parents. These 90% of Deaf children will be born into families where little if anything is understood in relation to the Deaf Community ‘The traditional medical construction of deafness…implies that deafness is a biological disorder or deficit that should be corrected’ (Sheridan, 2001: 19-20). Some Deaf people might see themselves as a cultural and linguistic minority. They may hold ‘the notion that [they] are members of a bilingual-bicultural minority group’ (Parasnis, 1998: p xi). There is a need to include the ‘voice’ of not only hearing people but of

members of the Deaf community.

When a Deaf child is born into a Deaf family the familial sign language will most likely be BSL. When a deaf child is born into a hearing family who are open to the possibility of sign language the family are likely to attend BSL classes and the child will probably enter into a deaf school environment. If a child is born into a hearing family who are interesting in developing their child's deaf identity, there is a likelihood that the family will choose to learn BSL. Hearing family members who learn BSL generally use Signed Supported English (SSE) as their communication of choice with their children. The reason behind this is associated with the parental language of origin; if they are hearing and reside in the UK, many will use English as a first language. Therefore, they are likely to use English word order in the signing used. The child is likely to use a combination signed language that may be alternated from BSL to SSE. SSE uses BSL signs in an English word order. Oftentimes SSE is utilised by people who use English as a first language and is most likely to be utilised with non-native BSL users and family members. A child will likely 'code switch' from SSE to BSL in communicating with their Deaf peers. If a deaf child is born into a hearing family who are in some ways resistant to their child's deafness they may opt for surgery and have their child undertake cochlear implant surgery. Parents who choose this route for their infants are taking the decision to try to correct their child's hearing through significant surgery, usually in the hope that they will recover some useful hearing. This is not always possible but the parent's desire for their child to not be deaf has many implications in childhood and in later years. These children will probably not be encouraged to learn BSL and they may be sent to speech therapy. As a result, they may struggle with their identity and sense of belonging.

Appendix 3 – Doctoral Descriptors Table - Removed

Appendix 4 - Data from TBM: Signs of infant illness quotes

Below are extracts taken from The Blossom Method content from anecdotal research with 'mothers and others' prior to publication and included in the final publication.

'I always knew when Jack was ill. He had a different smell about him.' – Karen and her seven-week- old baby boy (Sabel, 2012: 110).

'I remember this smell on my baby's breath with my first born but it never happened with my other baby. It was easy to know with my eldest that she was under the weather.'– Jane, mother of two (Sabel, 2012: 66).

'My baby's breath smells different today. It usually smells of milk but today it smells weird. I wonder if he's going to be ill?' – Aisha and her four-week-old baby boy (Sabel, 2012: 66).

'My baby's breath had the characteristic sweet/sour smell of milk most of the time, but when he was under the weather his breath smelt like glue. I could always tell when he was going to be ill by the scent of his breath.' – Juliet and her 14-week-old baby boy (Sabel, 2012: 66).

Appendix 5 - The Costs of Perinatal Mental Health Problems

Key Findings
Perinatal depression, anxiety and psychosis together carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK
Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother
Over a fifth of total costs (£1.7 billion) are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion)
Other costs include loss of earnings/impact on someone's ability to work and quality of life effects
The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child
Perinatal anxiety (when it exists alone and is not co-morbid with depression) costs about £35,000 per case, of which £21,000 relates to the mother and £14,000 to the child
Perinatal psychosis costs around £53,000 per case, but this is almost certainly a substantial under-estimate because of lack of evidence about the impact on the child; costs relating to the mother are about £47,000 per case, roughly double the equivalent costs for depression and anxiety

TABLE 1 designed from data in Bauer et. al. (2014: 4), London School of Economics (LSE) & Centre For Mental Health (CMH)

Appendix 6 - Case Study Notes - Removed

Appendix 7 – Abstract from Published Article

ABSTRACT – A Journey to the Heart of Contemporary Parent-Infant Psychotherapy Practice: An Interpretative Phenomenological Study

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EC GYNAECOLOGY
Research Thesis

A Journey to the Heart of Contemporary Parent-Infant Psychotherapy Practice: An Interpretative Phenomenological Study

Vivien Sabel*

Integrative Relational Psychotherapist, Clinical Supervisor, Leeds Beckett University, United Kingdom

*Corresponding Author: Vivien Sabel, Integrative Relational Psychotherapist, Clinical Supervisor, Leeds Beckett University, United Kingdom.

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Abstract

Whilst the nature of infant mental health has long been regarded as significant, it is only in more recent years the phenomenon of Parent-Infant Psychotherapy has developed, is receiving attention, and is in receipt of significant financial input and governmental support. This qualitative research sought through investigation to journey to the heart of contemporary Parent-Infant Psychotherapy (PIP) and in doing so uncover current practice in PIP from the perspective of those working in the field of PIP. Semi-structured interviews with four PIP Clinicians were conducted via online face-to-face interviews and the research was evaluated using Interpretative Phenomenological Analysis (IPA). Five superordinate themes were identified 1) Preventative work seen as key to PIP 2) The type of model of practice is variable, leaning toward an integrative model with relational, ethical practice is seen as paramount 3) Compassionate and non-judgmental practice is deemed essential 4) Observational skills from all involved in infant, maternal and paternal healthcare are seen as vital 5) Individual parental attunement seen as key to good practice. Twelve subordinate themes were identified they are further noted and briefly explored. Parent-Infant Psychotherapy has been defined as clinical work undertaken by qualified clinicians with women (and in more recent years men) during and post pregnancy: mothers and their infants, parents and their infants, and fathers and their infants in order to provide support to achieve an optimal relationship between primary caregiver(s) and infant to provide a solid emotional foundation for the future mental health of the infant. The clinicians involved in the study are highly qualified in the fields of psychotherapy, psychology, and infant mental health. Some of the participants involved have completed their own research in the field and others are involved in writing substantially about their findings. Some are involved in teaching and sharing their findings with both clinicians and families. The findings demonstrate the significance of the experience of working in PIP and all concerned recognise the importance of such early clinical work. The findings also identify potential discourse with regard to contemporary training, service provision and practice. These findings deliberate propositions for clinical practice and may support the field of PIP to find the courage to revisit all areas of PIP training and practice in support of all families PIP clinicians are honoured to serve. They further support existing research, but also may provide a framework for a contemporary and new paradigm of a 'right-brain to right-brain' embodied therapeutic model in the field of PIP. This foundational study will provide further opportunities for additional research.

Keywords: Infant; Parent; Mother; Father; Primary Caregiver; Parent-Infant Psychotherapy; Psychotherapist; Clinician; PIP; PIP Training; Training; Paradigm; Early Years; Infant Mental Health; Mental Health; Perinatal; Postnatal; Antenatal; Maternal; Paternal; Practice; Attunement; Mirroring; Non-Verbal Communication; Non-Judgmental; Compassion; Observation; Therapeutic; Clinical; Familial; Attachment; Self-Care; Equity; Embody; Embodied; Relational and Integrative

Citation: Vivien Sabel., *et al.* "A Journey to the Heart of Contemporary Parent-Infant Psychotherapy Practice: An Interpretative Phenomenological Study". *EC Gynaecology* 5.4 (2017): 125-159.

Appendix 8 - Participant Information Sheet

Research Title: The Blossom Method:

Researcher: Vivien Sabel UKCP, BACP and SCPTI registered Psychotherapist/Clinical Supervisor/Integrative & Relational Psychotherapy Lecturer.

Research: Towards completion of Doctorate in Psychotherapy by Public Works (DPsych) Metanoia Institute and Middlesex University

Academic Advisor:
Metanoia email:

Appendix 9 - Informed Consent Form - Removed