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A Heuristic Inquiry into my use of Theraplay® with children experiencing the impact of relational and developmental trauma

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Abstract: In this paper, I share my process of conducting doctoral research using Heuristic Inquiry. As a practising Theraplay® counsellor/psychotherapist working with children who are experiencing relational and developmental trauma, I start by locating myself in the research and explain Theraplay as a model. Heuristic Inquiry is then used to examine my own practice, and what this process of research illuminated for me. Specifically, the use of *tacit maternal knowing* - a way to use maternal wisdom in the professional realm as a de-gendered, de-sexed skill - is theorised. I explain why, in my opinion, trying to understand how and why Theraplay works for children experiencing relational and developmental trauma via a perspective that seeks to find *the* answer that is generalisable and manualisable is inappropriate for this form of work. This paper will be of benefit to: those wishing to research their own therapeutic practice in a way that honours the uniqueness of the therapeutic relationship between client and therapist; those wishing to use Heuristic Inquiry as a research methodology; those wishing to research using arts-based methods; and practitioners interested in Theraplay as a model of work for this clinical population. It argues that employing creative methods of research is congruent with modes of therapeutic work.

Keywords: Theraplay; Heuristic Inquiry; Relational and Developmental Trauma; Tacit Knowledge; Tacit Maternal Knowing

Locating myself in my research and practice

In my working life, I am a psychotherapeutic practitioner. Alongside that, I am a therapist educator and researcher. I am, of course, many more things, but here my focus is writing about the expression of myself in my professional realm.

My main client group is adopted children in the UK. I see them through funding from the government Adoption Support Fund (ASF). This fund was designed to make it easier for children who have been adopted to access therapeutic support once they are in their adopted families. I now do this in private practice but worked for many years in a National Health Service (NHS) Child and Adolescent Mental Health Service (CAMHS) as part of a specialist team for looked after or adopted children. I started out working with children using my original training: a psychodynamic approach that was quite traditional in terms of understanding the meaning of children's play and the inner dilemmas that might drive that play. I worked with the understanding that if these dilemmas were enabled to travel from the unconscious to the conscious, then distress would be alleviated and the child would be able to settle, accept the love of their adoptive parents, and thrive. I believed it was the process of making conscious the unconscious that would make the difference.

The problem was that, from my perspective, it didn't seem to be working. Children remained in therapy for lengthy periods of time with little or no change becoming apparent. Was I just a bad therapist? Or were these new parents just as bad as the

old and failing to meet the needs of the child? Or were the children so delinquent that they were beyond therapy? It all felt rather gloomy, hopeless, and judgemental.

I then heard about Theraplay®[1] and attended a Level 1 training delivered by US trainers in London. In my terribly English worldview I was thinking - *Really? Touching children! Singing! Putting lotion on them! How could that be therapy?!* But having paid for the training (good old English stinginess!), I was going to give it a go.

For some children it was like magic. Cases that appeared to carry the hallmarks of significant adversity seemed to turn around in a short period of time. One case that sticks in my mind was only 6 sessions. Now, some 20-odd years on from that first training, Theraplay is the organising model upon which I base my work, even if what I do in the room doesn't look, at first sight, much like Theraplay. Theraplay has become integrated into my identity as a psychotherapeutic practitioner and is fundamental to how I use relationship in the service of the other to promote healing.

As a model, Theraplay seems to work for me. There are also stories of it *not working*. Such stories, when I put my research hat on, would either be positioned as anecdotal or as practice-based evidence. Working in the context of this form of information gathering, would refer to the adults around the child feeling there was some positive outcome although I appreciate that is a broad definition of the notion of a successful therapeutic process. I keep a broad definition of working in my practice: that something shifts in a family system to make it more possible for the people in the family to keep going with less distress. With this definition of therapy working, focus naturally fell on continuity of expansion of relationship rather than a narrow focus on symptom removal. Depending on your perspective on what type of knowledge should inform clinical choice, these pieces of evidence could be heard as compelling or just stories. From either perspective, the gathering of the material didn't seem systematic or robust in research terms. Money *et al.* (2020) pick up on the lack of systematic quantitative data that supports Theraplay as model. In the literature review of my doctorate, I also identified a lack of qualitative data that systematically critiques Theraplay - in the light of a rigorous quality framework such as the model Tracy (2010) developed.

I therefore wanted to establish a robust research process to illuminate what was going on in my Theraplay practice.

What is Theraplay?

In case you are not familiar with Theraplay as a therapeutic model, I will give a brief outline of its history and theoretical foundation, as well as how it is learned and practised.

Theraplay is not a talking therapy. Based on attachment theory and, more recently, incorporating neurobiological understandings of human relational development, it situates itself as a child and family play therapy (*What Is Theraplay*, n.d.).

Philosophically, it grows from a desire for equality. In the US during the 1960s, Lyndon B. Johnson initiated the Head Start Programmes (Vinovskis, 2005) and Ann Jernberg became lead of the programme in Chicago. Faced with a lack of psychotherapeutic provision for children exhibiting emotional distress, she developed her own model of work that could be easily understood and provided by adults with limited mental health training. From these early roots in what we might now call addressing wellbeing or early intervention type work, Theraplay has developed to work with a wide range of presenting issues and levels of severity along the mental health/mental unwellness continuum.

Jernberg (1979; 1984), through her writing and from hearing people who worked with her talk about her, comes across as a very pragmatic person. Taking a similar line of thought to Bowlby, she started by looking at what goes well between a child and caregiver when there is emotional wellbeing. She then used that as a foundation for thinking about what a mentally unwell child may have missed out on, and, therefore, what they may need to get back on track towards emotional wellbeing.

In developing Theraplay as a model of practice, Jernberg recruited Ernestine Thomas, a secretary on the ward of Michael Reece Hospital, because children that clinicians found hard to engage seemed to gravitate towards her and open up to her. Phyllis Booth, another key figure in the development of the model, studied in London and attended lectures with Bowlby and Winnicott before returning to the Headstart programme in Chicago, taking that theoretical base with her. Combining these women's contributions, Jernberg wrote that Booth provided the *why* Theraplay worked, while the "exuberant spirit and intuitive wisdom" that Thomas contributed provided the *how* of Theraplay (Jernberg, 1979 p. xiv). Bowlby (1999) developed his *theory* of attachment, Jernberg developed a *practice* of attachment that sat very well with Bowlby's theory.

[1] Theraplay® is a registered service mark of The Theraplay® Institute, Chicago, IL, USA

On the surface, Theraplay looks simple. The practitioner designs a series of interactive, playful, relationship-orientated activities that the child and the primary caregiver are led through by the practitioner. The aim is to embed the attachment-enhancing behaviours that we see in positive attachment: close proximity; eye contact; warm containment of the child by the adult; the adult leading the child through sequences of increased arousal and then supporting them to calm.

Activities are organised around four dimensions as a way to consider what this child/adult pair may need to promote even more positive attachment experiences. An assessment tool called the Marschak Interaction Method is used and the child/caregiver relationship is considered in terms of the capacity of both parties to give/receive Structure, Engagement, Nurture, and Challenge (Booth, 2010).

In the Theraplay model, the capacity to give/receive *Structure* underpins a person's internal process of feeling safe, being organised, and accepting regulation from the outside-in. *Engagement* underpins relational connection, getting into the right arousal state for the task in hand, and a sense of shared joy. *Nurture* underpins the development of empathy, being able to hold a positive self-regard, and learning how to regulate oneself. Finally, *Challenge* underpins a sense of mastery and capacity to tolerate the discomfort of challenge. Booth (2010) offers the most comprehensive outline of the model and gives vignettes of work, while more recent books (Norris & Lender, 2020; Lindaman & Hong, 2021) are aimed at the Theraplay practitioner.

Training in Theraplay consists of attending two intensive, taught blocks of study known as Level 1 and Level 2. Professional skills in the model are developed via a practicum process where cases are brought for exploration with a training supervisor. All of these elements must be completed before someone is qualified to provide Theraplay and can call themselves a Certified Theraplay practitioner. If you are not certified, you are not doing Theraplay, but can use the principles of Theraplay in your practice.

Within this training process, it is recommended that Theraplay is adapted for trauma. However, my experience was that for the children I was working with - many of whom had multiple adversities in childhood that had developed into trauma responses - it was the deep application of the core processes of Theraplay (i.e., the relational aspects of working with attachment processes) that seemed to enable shifts and changes in the family dynamic. The Heuristic Inquiry into my practice helped me understand why these two things are materially related: the experiences that can lead to trauma and the application of the core processes of Theraplay.

Central to developing that insight was to step back from assuming trauma was an "event." There are many forms of trauma, and it is easy to become entangled in questions of "what to do." However, it is important to first take time to fully understand the starting point of the therapeutic intervention, building on the reflections that emerge from the question of "*why* to do." In the next section, I will explain the definition of relational and developmental trauma that I use for the adopted children I work with through clarifying my research focus.

Clarifying my research focus

Trauma comes in many shapes and forms. In everyday language, the term has become a shortcut to acknowledging that something frightening, difficult, and impactful has happened to someone. This everyday use of the term does, however, diverge from the clinical use of the term and can obscure our understanding in professional dialogues if we don't take time to ensure that we are talking about the same thing and its enduring impact on the person experiencing trauma.

Being exposed to things that are frightening and overwhelming is an ordinary part of life. Human beings are designed to process those experiences. Attachment to a safe adult is one of the main processing and regulating mechanisms for infants and children who feel frightened and overwhelmed. Holmes (2001) sees a secure base as an inoculation against the negative impact of life challenges.

The core damage of trauma is caused by an event or series of events that I describe as "too much, for too long, and with nothing you can do about it." Central to the experience is a felt sense of "I'm going to die," an intimate experience of helpless knowledge of annihilation with its attendant experience of humiliation. If the experience is survived and becomes somehow unthinkable, unspeakable, and unprocessed, when there is trigger in the outside world the person who has been through that experience in the past is immediately back there, experiencing the event or events again. The event is in the past, but the experience of the intimate agony of annihilation is in the present.

I therefore use the present tense in talking about trauma clinically. The event that caused the psychological impact is in the past, but the impact is ongoing and feels very present to those close to the sufferer, as well as to the sufferer themselves.

If one of the ways an infant processes and manages the experiences of expected annihilation in infancy is to rely on the co-regulation of a safe adult, then there is a particular kind of

survival response required when that adult is actually the source of the annihilatory experience. This is the source of relational trauma.

For many of the children I work with, those experiences of annihilation occur even before birth: conceived by violence; exposed to toxic substances in utero; left hungry, cold, and wet when born; under stimulated; no consistent offering of face or voice or touch. At its very worst, the infant does not exist in the world because they are not in relationship. They have no opportunity to develop a sense of the *we-ness*; of merging with a mother. They never have the chance to move to the experience of *I am me and you are you* (Winnicott, 1990). Their ego state or sense of self is annihilated because there is a relational famine of the experiences that would enable it to develop. Offer a relationship, as we do directly and often energetically in Theraplay, and there is potential for the relational trauma to be reactivated.

With no sense of an independent self, being asked to act is impossible. Development is stalled. At the extreme end of the spectrum of developmental trauma, children have such a lack of connection to their embodied selves that they can be cut off from an understanding of their sensations, as if these are other than themselves. Eating, temperature regulation, the sensation of pain, urination/defecation, speech, sensory processing, and internalising a sense of the passage of time are all impacted by this experience of developmental trauma. Therapeutically, or educationally, we can trigger this trauma by asking a child, however, nicely, and however well-intentioned, to do something. If the child before us has no embodied sense of themselves as an agent that can impact on others - only as something that can be impacted on in a way that is too much and likely to extinguish them - the trauma becomes alive again in the present, triggering survival responses and behaviours.

Here I am theoretically describing extreme cases of relational and developmental trauma. While such extreme cases do occur, many more children have aspects of these trauma states. As responsible adults - therapists, educators, social workers, carers, parents - we can all help to develop a framework of co-regulation by actively wondering where in the child's developmental and relational stories the traumas have occurred and targeting our responses based on that. Table 1 outlines some of the core authors and terms used in the field of trauma.

Author	Term	Key points
American Psychiatric Association, 2013	No specific term used but trauma and stress-related disorders, anxiety disorders, obsessive-compulsive disorder (OCD) and dissociative disorders are defined.	APA recognises that neglect in infancy impacts on the formation of diagnosable disorders later in life.
Brewin, 2019, for ICD-11	Complex post-traumatic stress disorder	Complex PTSD develops from exposure to prolonged and inescapable trauma that is likely to be interpersonal in nature.
van der Kolk, 2005	Developmental trauma disorder	This is a diagnosis that attempts to bring together the impact of chronic interpersonal trauma, leading to the development of a wide range of symptoms not adequately covered by *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnostic categories.
Struik, 2014	Chronic trauma	Chronic trauma arises from traumatising events that occur before the child is 8 years old, often within the family environment, such as abuse, exposure to war, domestic violence, medical procedures.
Schore, 2012	Relational trauma	Relational trauma develops from a significant mismatch between the responses of the caregiver and the needs of the infant.
Perry & Szalavitz, 2006	Childhood trauma	Perry develops a model of neuro-sequential intervention to address the neuropsychiatric problems experienced by children exposed to forms of adversity in childhood.
Porges, 2011	No specific term for the trauma that develops from early exposure to overwhelming stimulus	Porges suggests the body gets stuck in the trauma response even when the actual trauma has passed, impacting social engagement systems and thus social and developmental processes.
Treisman, 2017	The terms relational, developmental and complex trauma are all used	Chapter 1 of Treisman's book gives a good overview of how exposure to events that are threatening can become traumas depending on context, intergenerational aspects of trauma and personal attributes.

Table 1: Outline of terms and authors in the field of early childhood trauma

So, if I seemed to be able to work with these families without adapting Theraplay, what was I doing? Discovering this became the quest of my research. In the next section, I will explain how I explored my practice within a research framework.

Through the initial phases of the doctoral programme, I found my focus shifted from wanting to fight the corner for Theraplay (and other relational models of therapeutic work) by *proving it works*, to having the professional confidence to accept that what I do is helpful to the people I work with.

I moved away from a position of feeling defensive about what I do. From my growing sense-making of myself and my practice such defensiveness gave too much power to a positivist stance of understanding therapeutic practice. This positivist stance, in its most unnuanced form, dictates that the same method should work with all people, implying that the one correct way to do therapy was to adhere to a protocol, rather than apply a flexible, context specific, experience-based intervention. Trusting my own experience that what I do is helpful and works, I found a more useful question presented itself: *what is particular about the relational techniques I use in my Theraplay practice?* If I could *see* what I do, then I could theorise it. If I could put words to the theory, I could share it. Then I could ask - is it like that for you, too? We could engage in a collegiate and critical exploration of both our practices. We could generate practice-based evidence while still ethically adhering to the core purpose of therapeutic work, putting the needs of the client first.

Once I'd shifted my mindset from *there is a truth* to *I'm interested in my experience to see if it is a shared experience*, epistemologically I had a metaphorical continent to dwell in. On that diverse epistemological continent - a large, connected area where multiple truths are approached with curiosity and cherished - I could then find my methodological tribe. I wanted a tribe, a model of research used by others, that shared with me the standpoint that we are people of experiences, and that sharing those experiences matters. There could have been several methodological tribes that fit - case study, narrative inquiry - but the one that seemed to align most closely with the Theraplay model of practice - thus lending congruence to the project - was that of Heuristic Inquiry (see *Table 2*).

Heuristic concepts and process	Theraplay dimension	Feeling/ experience of Theraplay dimension	Theraplay core concepts	Action in my Heuristic Inquiry process
The overall Heuristic process to hold and guide the research	Structure	- Safety - Organisation - Regulation	Guided by the adult; Playful	- Not rigidly sticking to presumed externally governed expectation - Safe messiness, valuing not knowing - Circularity, regularity, and repetitive actions in research writing
- Initial engagement **- Identification with focus** **- Self-dialogue** **- Immersion**	Engagement	- Connection - Optimal arousal - Shared joy	Direct here and now experience; Relation-ship based	- Fiction writing - Journal writing - Working - Talking to others
Theraplay core concept of Responsive, empathic, and attuned to self, to the researched, to researchers and to the process. HI processes of wrestling. This concept spans all columns as the term wrestling is not part of Moustakas' Heuristic Inquiry model				
- Incubation **- Indwelling** **- Focussing** **- Intuition**	Nurture	- Regulation - Self worth - Empathy	Right brained, non-verbal, preverbal Multi-sensory Affect engaging	- Personal therapy, osteopathy, and yoga for self-care - Clinical and academic supervision - Daily practice of meditation - Daily practice of writing - Commitment to emotion and following the senses in writing
- Exploration **- Illumination** **- Creative synthesis** **- Validation** **- Internal frame of reference**	Challenge	- Competence - Mastery	Fruits of all the core concepts	- Engaging with others in discussion of the fiction - Stripping away to make the tacit, explicit in writing up

Table 2: Connecting Heuristic Inquiry concepts to Theraplay dimensions and concepts

Heuristic Inquiry

Heuristic Inquiry as a research methodology started with Douglass & Moustakas (1985) paper that sought to provide a framework for researchers that created a "disciplined pursuit of essential meanings connected with everyday human experiences" (1985, p. 1). Moustakas went on to develop the methodology further (Moustakas, 1990) by formalising the stages of the heuristic process (see Table 2) that access and illuminate the tacit knowledge that people bring to their passionate inquiry into a topic of personal puzzlement. Although individual and personal, Moustakas indicates that "with virtually every questions that matters personally there is also a social – perhaps universal- significance." (1990, p. 15).

Sela-Smith (2002) critiqued Moustakas' method by picking up on the potential for researchers to avoid the deep discomfort of engaging with the deeply felt internal experience of the phenomena being explored, a human resistance to engaging with unbearable pain. She identified a "final frontier" of self-exploration that "requires setting aside the skills of controlled, objective observation and surrendering to embracing subjective experience and leaping into the unknown" (2002, p. 54). Throne (2019) highlights to potential of Heuristic Inquiry to uncover innovative insights, practice and implications of new perspectives on the phenomenon being researched via self-search process. The holistic approach to research human experience (Sultan, 2019) opens the door, in my opinion, to engaging with agnotology (Proctor & Schiebinger, 2008), the way in which knowledge can be moved to the realm of ignorance in a way that is more than information that is not yet known but knowledge that is side-lined and forgotten as it does not fit with the dominant narrative within the area of knowledge that one seeks to influence. Heuristic Inquiry, therefore - as uncomfortable as it can be for both researcher and, maybe for the reader - holds relationship to self and relationship or meaning to others as a central aspect of purpose and process in research.

Theraplay is a relational model. Attachment theory is based on people relating to each other. We have a vast range of research and meta-analyses of research (Wampold, 2015; Norcross, 2011) that consistently show that it is the quality of relationship that leads to positive outcomes in psychotherapeutic practice, often equalling the benefits of medication use. While the studies analysed are mainly explorations of therapy with adults - and I am considering children and families - it does fit with my lived experience - my personal practice-based evidence - that whatever I am *doing*, the actions I take in the therapeutic space are secondary to caring about and connecting with the people in front of me. If we know that relationship is the most significant agent of change in the therapeutic process, using my research to simply describe my approach would just end up adding another study to that body of literature.

So, although my intention in approaching my doctorate was to define what indicated that Theraplay was working, my exploration of the ontological foundations of research started a process of considering what was important to me and my practice in terms of knowledge. The literature tells us that relationship is the determining factor of the efficacy of psychotherapeutic practice, yet there is still a pressure for therapeutic provision to be founded on evidence-based practice generated from randomised control trials (RCT). To base therapeutic practice on such evidence places it under the umbrella of medicine, thus granting it high status. However, the more I contemplated this, the more it seemed that following a more positive or science-based ontology in my research would be a bit like banging a square peg into a round hole. I'd get something, but at the risk of damaging the very thing I was studying and producing something that was clearly aesthetically a poor production and, therefore, from a positivist ontological stance, very dismissible because of the ontological incongruence between the mode of study and what is studied. The seat of this incongruence is the form of knowledge that lies at the heart of that which is access through Heuristic Inquiry – tacit knowing.

Tacit knowing

Conceptually, central to the methodology of Heuristic Inquiry is the notion of tacit knowledge, a process of knowing more than we can tell. It is somewhat tricky to articulate because the knowledge, and the process of knowing, is not situated in the verbal or cognitive realm. Tacit knowledge is "that internal place where experience, feeling and meaning go together to form a picture of the world and a way to navigate the world" (Sela-Smith, 2002, p. 60).

Such tacit knowledge arises from the combination of bodily action, practised expertise, and a process of shifting attention away from the vagueness of process to a focus on the more defined *what is done* that arises out of that process. It is hard to capture in academic, logical terminology. Moustakas (1990) talked about how the overall knowledge of a tree is internalised from the apprehension of leafiness, branchiness, light/dark forms, context. A deep, rich picture is gained from opening oneself to multiple aspects of a phenomenon. Engaging with tacit knowing leads to that place where you can stand comfortably in what you know and gaze with delighted curiosity to see what may arise in the landscape that you don't yet know, welcoming and integrating any newnesses, adapting to make space for further developments that the newness brings. Pictorial language seems to capture the experience of Heuristic Inquiry more readily than cognitive or literal forms of language.

This was another shift in my appreciation of a methodology that that led to an arts-based method of generating findings; a shift from focusing on what is produced to the process of production.

The early literature of Heuristic Inquiry does not name reflexivity but given that the drive of the methodology is to illuminate phenomena via direct first-person experiential accounts (Douglass & Moustakas, 1985), reflexivity is a valuable tool within the kit I carry as a researcher. Sultan (2019), as a later writer about Heuristic Inquiry, does talk about reflexivity, defining it as a process "which occurs when researchers place under thoughtful scrutiny the research process, the intersubjective dynamics between researcher and research partners and the extent to which their assumptions influenced the process of inquiry". Through the reflexive process, the researcher finds a way to see themselves in the context of what they are doing.

Reflexive embodied empathy (Finlay, 2005) fits well with the research process I chose to undertake, giving me a way to feel into the potential inner worlds of the children and families I work with. To see the broad context of the process of Theraplay work, I had to let go of focusing on the knowledge produced and enable myself to become immersed in the process of knowing. Building on this, my research method became one of writing fiction. Making space to see what emerged in the fictional realm was a way to find the space between doing nothing but sitting there, while also doing something. It was about letting go of being goal-directed and enabling a focus on process.

Writing fiction as research process and findings: Method entwined with ethics

In Heuristic Inquiry, I had found a research methodology that was defined enough to rely on, without feeling that it was so prescriptive that it obscured the fact that the process of discovery, through fiction, *was* my research. Now I needed to find a method of research that gave me data that illuminated my tacit knowing and tacit knowledge.

Early in my research journey, I had considered case study. In exploring this, I came up against all kinds of ethical challenges, particularly as I found I was focusing on relational more than procedural ethics.

I work in a small geographical area, my case load is very specific, and the children themselves were not in a position to give informed consent about me using their data, their life stories. It felt neither respectful nor congruent with my practice ethics to continue with a case study process. I therefore considered fictionalised case stories.

I was given consent from a closed case to re-view the video material generated during Theraplay treatment. From this I wrote a short story which later became a chapter of a novella.

The process of writing was very specific. I did what I started to term *inhabit the body space* of each person I saw on the video and write down what I was seeing, hearing, feeling, tasting, touching, and smelling from that position. In Theraplay we use video to review our work and come up with wonderings about what may be contributing to what we are seeing. Inhabiting the body space took video review away from a dominant positive research paradigm of cognition and verbal language to something that felt more poetic and dream-state. This is the process of reflexive embodied empathy (Finlay, 2005).

The process of writing the first short story was revolutionary to me in terms of liberating myself. Gill (2019), in reflecting on Merleau-Ponty's notion of "slackening intentional threads" (1962) writes, "we can by slackening them [intentional threads] acquire a feel for how they connect with the world around us. We can come to know reality by *dancing* with it through symbiotic interaction" (Gill, 2019, p. 48). This encouragement to loosen intentional bonds between experience and knowledge was further driven when I read Barrett Feldman's (2018) critique of Ekman (Ekman 2004; Ekman & Rosenberg, 2005).

Initially, I was trying to develop a taxonomy of understanding body language in Theraplay practice. It was hard to let go of wanting to find something concrete that was generalisable, transferable, and stable, and also that fitted with the concepts of knowledge and research that I had been immersed in culturally. Ekman was an author I have often turned to in my attempts to deepen my understanding of what I see on video material of Theraplay sessions and assessments. From my pre-research ontological and epistemological stance, I felt his publications, both academic and popular, had a provenance and so were trustworthy. I saw his writing as the foundation for my taxonomy of understanding the body language observed on the video. Barrett Feldman's (2018) cogent argument for how white Western bias can infiltrate even the most carefully designed psychological experiment left me questioning long held beliefs.

Unsettling, yes. But such fundamental self-questioning (not self-doubt), made it possible to record what was in my realm of perception. What I could know and connect with were my senses, and I could faithfully record that without editing or judging. This then generated data that could expose the tacit knowledge that I bring to my work. By loosening the intentional bonds of wanting to find out something specific and so researching towards that goal, I was able to dance symbiotically with my experience and come to know my own

reality in a different way. The arts-based literature, in particular Leavy (2015; 2013) and Tracy's (2010) work on evaluating qualitative research helped me develop my trust in fiction as research.

Drawing from my clinical theoretical knowledge, I created a strong frame to make it safe to let go, akin to what Kalff (1980) calls the free and protected space of a sandtray, by developing a practice of writing a set number of words daily. It didn't matter what those words were, so long as 1500 words were produced each day and each episode of writing started with holding the title of the research in mind. This non-purposeful doing corresponded to the innumerable bodily acts that were my shifting from foreground to background focus to access tacit knowledge through exploring and recording the process of tacit knowing. I was supported in this process by the ideas Metcalf and Simon (2002) and Cameron (2016) put forward in their writing about writing; and also by Yoga, cranial osteopathy, and personal therapy. In this way I was *Engaging* with, *Structured, Challenged*, and *Nurtured* by, people who were broadly encouraging of the *process* of the research, without necessarily knowing the content of what I was researching. The relational aspects of Theraplay, as well as the Theraplay dimensions, were embedded into the process of research as much as they are embedded in the process of therapeutic work.

From this research method emerged the novella *A Necessary Life(Story)* (Peacock, 2020). Strands from the fiction writing seemed to draw together. I developed relationship with the characters in the novella. What they did or said, how they reacted, seemed to come from within the character, even though I - as writer - was the person creating them by drawing on the experience of many years of practice with many children and families.

As a practitioner researcher, I revisited the ethical imperative on me time and time again. How could I integrate the procedural ethics of the organisation overseeing my research with my professional British Association for Counselling and Psychotherapy (BACP) Framework for Ethical Practice which emphasises the personal and moral values of the counsellor? It exhorts me to be committed to equality and inclusivity. I believe I have an insight into a possible way of understanding the marginalised experience of a small group of suffering people. How could I share that, using those years of experience, while not exposing individuals?

I can't predict some of the risks now that the novella is out in the world and I am publishing the findings from my thesis in a monthly blog (https://youdoknow.substack.com/p/introduction). However, Hall (2014, p. 338) identified that it is still possible to discharge one's relational responsibility through sharing material with people so that we can be '"responsively attentive' to replace the violence of the past". Hall is writing about researching with indigenous people in Australia and so may seem a bit distant from exploring relational and developmental trauma in the UK, a point which will reoccur in the next section of this paper. Olmstead *et al.* (2010) suggested a way to explore management of children's physical pain using an approach with a more relationally-orientated approach, arguing that traditional professional distance could prevent appropriate pain relief for children if nurses could not use their empathetic understanding. They needed to imaginatively engage with that child's perspective to discharge their ethic of care. The process of writing the novella connected with this relationally ethical engagement.

To discharge the relational responsibility aspect of fiction writing as research, the draft of the novella was shared with other experienced Theraplay people worldwide, who gave feedback as well as confirming that the content of the novella echoed their own experiences of undertaking Theraplay.

I had set out to do Heuristic Inquiry: I got absorbed by writing fiction about my Theraplay practice. I read widely out of curiosity about how fiction could be research, I was curious about what my peers would think of what I'd written, and I was curious about what I had written. I had forgotten about the processes of Heuristic Inquiry as developed by Moustakas, but as the fiction reached completion, I was interested to see that I had followed the stages (see *Figure 1*). As I then stepped back and used the fiction as a mirror in which to see the reflection of my tacit knowledge, I added two further processes to Moustakas' heuristic process: wrestling with multiple threads of potential meaning, and stripping away of anything that felt driven by others' expectations or my desire to be "right", until what was left was a felt sense of *yes that's it!*. No matter which way I looked at it, it still felt *yes, that's it!.* A felt sense of solidity and completely, *for now*, a punctuation point in the process of knowing. A point where tacit knowledge could emerge through the illumination and illustration of tacit knowing into becoming explicit knowledge to share with others. However, the pinpointing and fixing of that knowledge in itself changes the tacit process and allows knowledge to continue to evolve.

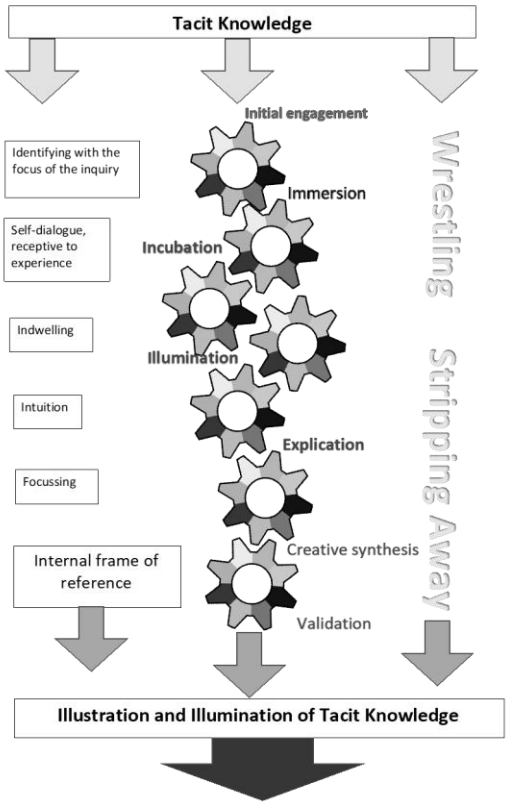

Figure 1: The Heuristic Inquiry process in graphic form with Research findings: What the fiction mirrored back to me

Research findings: What the fiction mirrored back to me

I self-published *A Necessary Life(Story).* The materiality of holding the paperback: the shiny cover, the smell of new pages - the turning of those pages and reading words in the same way that I would read words of other fiction by other writers - created a surprisingly different position from which to experience what I was reflecting back to myself. Other people may, of course, read the novella and see other things.

There was a *eureka* moment of seeing that attachment theory is about mothering. Of course, it is about mothering! Attachment theory talks about how researchers see what mothers do and what it means in terms of the infant's development. The gaze that is turned onto the mother and infant is from the outside, and intent on making firm knowledge. Often that gaze has a strong male position, with Bowlby, Winnicott, and Stern taking the lead, and women like Ainsworth, Crittenden, Main situating their research in the paradigm of white, Western, masculinised research to make it acceptable. Even then, Ainsworth's contribution is largely overlooked in comparison to the work of Bowlby (Aldridge & Christensen, 2013).

Psychotherapy and counselling are very female professions. Table 3 gives the gender distribution of the therapeutic workforce for two of the major registering bodies in the UK. Many of us have inside experience of mothering whether it is from the reality of birthing children, or mothering through extended, blended, fostered, adopted experiences of families. Many have quietly and invisibly mothered children who have died in the womb, or who have never been conceived but have still been held in mind with love and hope and dreams. Many people without a uterus have mothered. Many have to engage with the impact of white western culture, should they have a uterus and choose not to be become a mother. We have all been mothered.

	Female %	Male %	Chose not to identify & other	
British Association for Counselling and Psychotherapy (BACP)	84	16	-	(BACP, 2014)
UK Council for Psychotherapy (UKCP)	74	24	2	(Brown, 2017)

Table 3: Gender distribution in the counselling and psychotherapy professions in the UK

And for many therapists I have spoken with, it is a guilty secret - maybe even a secret that is held in plain sight - that we use our mothering in the therapy room.

What do we really do? And *why* when the experience of being mothered is central to many schools of psychotherapeutic theory to understand the distress of our clients, is the lived experience of mothering not central to our theorisation of understanding our practice?

My research gave me a language to talk about how what I came to term *tacit maternal knowing* is a very particular form of tacit knowing: knowing how to make, sustain, develop, and productively use the relationships that research tells us is the main agent of change in therapeutic practice. In theorising the role of mothering in the development of healing relationships based on attachment enhancing sequences of place aka Theraplay, it becomes possible to remove the sex and gender elements from the relationship that is being created – anyone

can apply the professional skill of mothering in their practice where it is developmentally in the best interests of their client. First, we have to address the *why* question before some answers to the *what* question can be heard. In starting to present my research, I was often asked whether naming the idea as *tacit parental knowing* would make the concept more accessible. This, I believe, points to some of the reasons why tacit maternal knowing has not been integrated into psychotherapeutic theory in the way I found myself using it in my practice.

I am speaking broadly about a white, Global North worldview, although there may be echoes for women in other cultures. Women are the Other (Beauvoir et al., 2015). Their knowledge and expertise are seen via the lens of *man*kind. Women, in a fundamentalist Judeo-Christian influenced culture, are sinful, dangerous, and need to be subjugated (Fox, 2002). As women, we are raised in a culture of patriarchal misogyny. Even where individuals (male, female, nonbinary, genderfluid ….) do not consciously or actively pursue patriarchal and misogynistic beliefs, the structures of UK economic and social policy embed the negation and devaluing of the role of mothering. Being a member of the economically active workforce is seen as a marker of success, not investing labour in the care, and raising of infants and children (Hill, 2021; Mathewson, 2020). Caring roles, even when professionalised and highly skilled, attract lower wages/less status than managerial and technical roles (Bunting, 2021). Women still face more monetary poverty at the end of a working life because of the way their working life becomes structured by the expectations on them (Harkness, 2022). The world is constructed around "male" being the norm, to the detriment of women (Criado-Perez, 2019; Jackson, 2019).

Such issues feel entrenched, overwhelming, and unaddressable if looked at from the dominant worldview of there being an answer that would stop history impacting on present and future. If the issues are gazed on from a perspective of thinking that the answer will come via logical and systematic examination of situations, excluding emotional content, to find the answer that is replicable, transferrable, and timeless, the overwhelm can become like a state of trauma. Too much, too long, and with no sense of agency. We could fight or flee or flop. Ultimately, nothing fundamentally changes.

We can't examine the patriarchal and misogynistic side-lining of maternal knowing through the paternalistic and misogynistic gaze of traditional white, male ontology. To do so perpetuates the disempowerment of maternal knowing and, as Hall (2014) picked up, doesn't challenge a history of violence.

In my research I became indebted to indigenous researchers who opened my eyes to how oral, embodied, interdependent knowledge systems are a different worldview that underpin research, not as a counterbalance to white, Global North forms of research, not arguing that one is better than another, but because such knowledge systems just *are* in their own right (Kovach, 2009; Wilson, 2008, Davidson; 2018). I valued such researchers who didn't seek to justify their research practice via the lens of a white western research paradigm, but who owned their knowing and their knowledge. They own their place (Perry, 2018). This led me to change my ontological stance:

> *What if I accept that what I do is already magnificent. What if I accept my tacit maternal knowledge is valuable?*

How then do I tell others about it?

This internal shift from feeling like I had to always justify my worldview through the lens of a more masculinised, science-based, outcome-orientated approach to valuing knowledge, was profound. The process of mothering was not something that was an interruption to working lives, or an adjunct to therapeutic practice that needed to be theorised to understand the disfunction being presented in the therapy room, but what I do in therapy.

So, if I tell you what I do, maybe you will see it echoed in your own story of providing therapy too. Or not, which is equally fine.

Polanyi (2009) sees tacit knowledge as a way to avoid the dangers of perfectionism and the possibility that the pursuit of the answer could support totalitarian ways of restricting access to knowledge. By focussing on the tacit knowledge, and the tacit process of knowing I have been using in my Theraplay practice, I challenged within myself this perfectionist approach to therapeutic work and felt free to ask the question: *so what do I really do*?

Taking *tacit maternal knowing* seriously as a skill in therapeutic practice, and the caring professions more widely, means that vulnerability of both carer and cared about is made central to a tender narrative of connection. In that narrative of dependence/interdependence, as a more powerful person, the carer/therapist creates the space through having the courage to not know who the other is and let go of any thought of who they should be, while faithfully holding to a belief that care matters and care makes a difference in enabling the other to be who they can be. This is no different to Rogers' (1957) core conditions as necessary to therapeutic change but does not dance around the reality of reclaiming a specific form of relational skill that historically women have expressed by being mothers.

To centre this form of knowing in the theory and practice of psychotherapy means challenging the patriarchal and

misogynistic limitations that our culture places on our knowing. Through othering women and, by implication, seeing recipients of therapy as defective as they are expressing vulnerability and accepting interdependence, a vast and powerful body of knowledge to support the positive growth and, where needed, healing of others is discarded. As such, centring tacit maternal knowing in our theory and practice also holds the seeds of radical and political challenge of caring in our white western culture more generally.

The fiction mirrored back to me that I have limited my power as a Theraplay practitioner because I have feared being loud and proud of my maternal knowing for fear it would discredit my work and the work of the Theraplay model. The theoretical engagement with the meaning of the fiction has enabled me to find a framework within which my skills can be shared and debated, thus challenging some of the dominant discourses about how therapeutic endeavours should be researched and their quality assessed.

Conclusions: Implications for practice in Theraplay and beyond

My Heuristic Inquiry into my own practice, through the unique lens that writing fiction provided for me, affirmed the consistent research findings that it is the relationship that is the most significant agent of change in psychotherapeutic practice. This adds to a long history of such findings.

Beyond Theraplay practice, the Heuristic Inquiry highlighted how, in the research of relational practice, it is vital that we as practitioner researchers or academic researchers are challenging the ontological positioning of knowledge only being of value if it is generalisable, repeatable, and transferable (and if you are a white, western male). Such biases are the result of historical, political, cultural, and religious processes that in themselves become forms of tacit knowing. It therefore becomes vital that we research relational practice in an ontologically congruent way so that we can challenge the funding streams that prize a more science-based worldview over a relational worldview.

Focussing specifically on the model of Theraplay, and on the specific client group of children experiencing relational and developmental trauma, my Heuristic Inquiry enabled me to locate the tacit knowledge that I've been bringing into my work and name it *tacit maternal knowing*. Once seen, via fiction, I was able to theorise this as a practice issue, recognising that I work with maternal relationship. By theorising maternal processes in Theraplay practice, it becomes possible to intentionally and explicitly use the model to respond to the stage of development where the roots of the trauma are situated. The relationship is the primary source of healing because it is targeted at the developmental stage that is at the root of the experience that led to the development of trauma symptomology.

I set out to look at my Theraplay practice with children who were experiencing relational and developmental trauma. Along the way, I found myself opening a wider discourse in theorising and valuing concepts of *tacit maternal knowing* and *knowledge* as terms and practices that could be integrated into the development of Theraplay practice, and indeed all forms of therapeutic practice.

To summarise the learning from this research:

- Making *tacit maternal knowing* central to our theoretical understanding of how we work gives a theoretical framework to put relationship, care, and love at the centre of psychotherapeutic theory and practice.
- Making *tacit maternal knowing* central to Theraplay practice gives a theoretical language that can be used to explore why the model may work for children who are experiencing the impact of relational and developmental trauma. This could lead to developing further research and literature.
- We can use the experience of mothering to generate a less othering theoretical base of psychotherapeutic care for the people we work with. Where it is appropriate to use tacit maternal knowing for our clients, the theorisation of such knowledge can de-gender and de-sex the maternal aspects of the work.
- By courageously challenging the dominant discourse that good practice is about what we do, rather than who we are in relation to the people we work with, we can find languages and ways of sharing and affirming practice-based evidence with confidence. This then impacts on choice of research methodologies and methods in researching relational therapeutic practice.

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