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Womb-life and Birth Stories:
How explorations of our pre- and perinatal experiences can contribute to narratives of our Self and relational ways-of-being

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Dedication

For all the mothers,
Everywhere, for bringing
Us here, together

In January 2022, a mere month after a diagnosis of pancreatic cancer, my mother Doreen died. This thesis is dedicated to her memory, with unequivocal love, for without her, none of it would have been possible. My own exploration of our shared journey through womb-life and birth fundamentally changed our relationship; it opened up avenues in our communications, loosened blockages in me and drew us closer together. I am profoundly grateful that the Universe guided me into pre- and perinatal therapies a decade before she left us so that this could happen.
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Hvala vam.
Abstract

This thesis explores the storying of pre- and perinatal learning experiences, including personal regression events of womb-life and birth. It does this using a narrative inquiry approach as its methodological foundation, leaning into the theory that “human beings make sense of their lives and their worlds through stories” (McAdams and Janis 2004, 160). I undertook dialogical, interactive, unstructured interviews, very much in the spirit of Chirban (1996)’s Interactive-Relational and Patti and Ellis’s (2017) Co-constructed Interview approaches, with eleven participants who had undertaken a variety of different courses and trainings in pre- and perinatal psychology, and all of whom had undertaken at least one womb-life and birth regression experience as part of those trainings.

The various experiences provided my participants with an aetiologcal explanatory power, a means by which to make better sense of their Self-in-relationship modalities through a ritualised, psychosomatically experienced enactment of returning to the womb. I explore each of the individual participant’s storying of womb-life and birth explorations through their words, supported by my interpretive reflections and considerations of the meanings I identified. The findings clearly demonstrate how these stories have shared claims, through the construction of narrative understandings, in meaning-making of Self, relationships and embodied ways-of-being as part of the participants’ self-developmental therapeutic journeys.

In my analysis I draw inspiration from the dialogical socio-narratology approach of Arthur Frank (2012a). His concept of stories as actors with capacities to do work for and on people as resources, and his idea of narrative wreckage requiring acts of reclamation, applies to the narrative creations of my participants. The narrative reconstructions of their histories offer them an opportunity to consider and initiate change based on the self-stories they have told and continue to tell. This allows emplotment of compelling, alternative futures that arise from such reflexivity (Frank 2012b; Greenberg and Angus
2004; McLeod 1997), albeit requiring effort, perseverance and sometimes only accomplished with difficulty.

I draw on conceptual resources offered by Bollas (2018) in the conceptualisation of the unthought knowns apparent in pre- and perinatal psychological explorations and interact with Stenner (2017) in terms of fabulation and the psychosocial liminal spaces that notions of womb-life and birth conjure. I examine narrative by utilizing the work of a variety of narrative therapy theorists such as McLeod (1997), Greenberg and Angus (2004) and Speedy (2008). I also explore an application of Barad’s (2007) onto-epistem-ology in relation to aspects of my findings that map onto the human and nonhuman, to subject and object, to mind and body, and to matter and discourse. Additionally, I offer a critique of the potential shadow elements of therapeutic pre- and perinatal approaches in terms of power dynamics, mother-blaming and gendered perspectives of bodies.

Critically, this thesis contributes knowledge by shining a light on how womb-life and birth stories can trouble cultural tropes and plotlines as they are not usually shared, being partially hidden in a cultural shadow. I show how individuals can story a sense of their own womb and birth experiences in their meaning-making identity projects. Therefore, the thesis offers up a wider perspective of counselling and psychotherapy psychodynamics, extending understanding of psycho-somatic-socio-therapeutic endeavours to the pre-birth influences on our ways-of-being, and underlines the potential for the important contribution that narrative inquiry reaching into the very beginning of life can make to this professional field.
Lay summary

We all tell stories. About our lives, about our relationships, about how we see, feel and experience the world around us. I am even telling a story now, about telling stories. This thesis is about the stories told to me by eleven women of their womb-life and births, and sometimes of the pregnancies and births that they had experienced with their own children.

These eleven women had participated in a variety of educative trainings, and psychotherapeutic experiences called regressions, to explore the nature of their womb-life and birth through the lens of pre- and perinatal psychology, a multi-disciplinary approach to experiences in prenatal life from pre-conception through to the initial 12 months of life post-birth. Pre and perinatal psychology considers, in different ways, the impact of our womb-life and birth experiences on our personality formations, ways-of-being in the world and our health as children and adults.

Through the various experiences my participants had undertaken, they developed a powerful way to understand themselves and to make better sense of the way they were in relationship to themselves and others in their lives. I explore each of the individual participant’s storying of womb-life and birth explorations through their words, considering the meanings I interpret from the conversations we had together. My findings clearly demonstrate how the stories they tell can help develop narrative understanding, a way of making meaning of Self, relationships and embodied ways-of-being as part of the participants’ self-developmental therapeutic journeys. It therefore demonstrates the importance of womb-life and birth experiences, and the ability to verbalise them in stories, within the psychotherapy and counselling field.
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Prologue

I’m lying on my side, in a semi-foetal position, and feel relaxed; my eyes are closed and I’m breathing regularly, neither too shallow nor too deep – a more natural in-out of breath as I allow a naturally-arising process to unfold. I descend inside myself, allowing my mind to hover on the edge of awareness of arising thoughts and feelings whilst being conscious of where I am and what I am doing in this moment. As I start to let the thoughts, feelings and images unfold and evolve, I feel more cocooned from the world, slightly distant from it. A woman’s voice, mellow, soft and kind, breaks the silence: “What’s happening just now?” she asks. It is not a demand, it is a gentle enquiry, laced with curiosity, seeking connection to me. I pause; the space has a dream-like quality, words are hard to find. An image starts to form in my mind, of me as a prenate1, still not fully formed, but lying in the womb. I speak in response to the voice: “I am looking down my body towards my umbilicus, connected to my mother in a pool of light. I cannot see my legs or feet because they are in darkness, so it is as if I am looking towards a disc of light that mainly comes through the connection of the umbilicus. It is quite strong and bright at that point but diffuse around the rest of the womb”. I pause, and the silence descends again. I continue to allow the image in my mind to play out; I have a sense this is a memory I am having, paradoxically dream-like yet at the same time, familiar. I feel cozy and joyful; there is a floating sensation as though I am suspended in liquid, and feeling of warmth, firstly in my stomach area, but eventually spreading all over my body. Time feels unhurried and leisurely.

The voice comes again, just as gentle and soft: “are you alone?” she asks. “Yes, very much so” I reply: “It feels warm, safe, quite dark, dark beyond the ‘shell’, although there is a translucent quality to the space I feel myself to be in. Dark in

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1 The term ‘prenate’ (Emerson 1996; Sills 2009) is a synonym for the medical term ‘foetus’ or ‘fetus’, “an unborn baby of a mammal” (Oxford Paperback Dictionary and Thesaurus 2009). Throughout this thesis, when not directly quoting authors who use other terms, I preference the use of ‘prenate’, as it feels more relational (which, I appreciate, already asserts an ontological and epistemological position).
the sense of absence of light, rather than ‘bad’ ” I qualify, “but inside there is a very soft light”. The voice comes again, after what could have been a minute or an hour, I am not sure. “Does it feel ok if I come a little closer?” she asks. “Yes” I say, and I feel an energetic push towards my umbilical area. A new image forms: I see it as a white plastic cover on a drawing pin head; it feels a little uncomfortable, and I get a painful sensation of a stitch in my side. I say, “I want to go to sleep but I have a pain here”, indicating an area just under my rib cage on my left side, although the stitch seems to extend under the ribs: “It’s the stitch again, it’s keeping me awake, it’s really uncomfortable” I say. The voice suggests staying with the discomfort, if that feels ok, to see if anything else arises; nothing of note does and after some time, again a minute or an hour in this liminal space, I am unsure, the voice says to me, “It’s time to bring the session to a close. Does that feel like an ok-enough place to end?”. “Yes” I say, and she responds, “I’m going to move my hand away slowly”. She continues to ‘check in’ with me as the energy I can feel around my stomach dissipates. In this moment, as we disengage, I get a very strong image of floating in outer space, seeing the sun and a spaceship in the foreground, and say, “I am flooded by a sense of the universe being ripe with possibilities ... The limitless possibilities that are in space”.

I sit up and face the therapist whose voice had been guiding me: we sit for a few minutes ‘debriefing’ how the experience was for each of us – the witness who had made notes of important statements, the therapist herself, and me as ‘explorer’ client. I feel like a locked door on my unconscious has just been opened, a door I did not know was there. It has only opened a small crack, there is much more work to do to open it wider and see what is behind it. I am left curious and a long journey to find out more, the first step in a thousand, has been taken.
Chapter 1 Introduction

1.1 Background to the Study

This thesis explores the narrative understandings of Self and being-in-relationship that eleven participants to my study have derived and developed from experiences of looking at their womb-lives and births through the lens of pre- and perinatal psychology. Pre- and perinatal psychology (PPN) is a multi-disciplinary field of research and therapeutic approaches of the primary period of human life and its influences on emotional and mental well-being throughout the lifespan. PPN theories predominantly cover the family field\(^2\) into which the baby arrives (including intergenerational influences and associated epigenetic effects), conception, the interval of womb-life, the experiences during and immediately after birth, and through the baby’s first postnatal year (Sills 2009; White and Martin 2014; Chamberlain 1994; McCarty and Glenn 2008; Weinstein 2016; Axness 2012; Brekhman 2018). The stories my participants told me, and the narrative analysis I conducted, show the therapeutic possibilities for change, as part of their self-development, that such explorations and explanations have offered them.

To provide an entry point into the thesis, the Prologue tells a story about one of my own “emotional epiphanies” (Bochner and Ellis 2016, 50), an experiential piece of psychotherapeutic work called ‘umbilical affect’ where a psychological correlate of being in the womb is generated via an energetic connection (with, perhaps obviously, the umbilical area of the client) between a therapist and client. It was a compellingly powerful experience for me, my first ever regression, undertaken when I was in training more than a decade ago for my master’s degree in Core Process psychotherapy, and opened my eyes, mind and body to pre- and perinatal psychology. Although I could not possibly have envisioned it at the time, it was in essence the genesis of my research into womb-life and birth which has culminated in

\(^2\) the “resonance with the society surrounding you at the time you are born as well as the society’s trends” (Kalef 2014, 19). This idea combines with epigenetics as a “composite set of influences acting on babies when they are conceived and gestating” (2014, 20).
this thesis. The regression I have storied in the Prologue was undertaken as a demonstration for the training cohort with the course director, an experienced therapist of more than 30 years, assisted by a ‘witness’ who made notes of what she considered to be important statements I made during the process. The Prologue draws on my recollections, aided by notes the witness made. In this umbilical affect\(^3\) exercise, after a period of ‘settling’ and ‘checking in’, an energetic connection is made, with permission, by the therapist holding up a hand in front of, but not touching, the umbilical area of the client, at first some distance away – perhaps 2 to 3 metres– but then slowly bringing the hand closer until the client acknowledges a sense of connection in the umbilical area. The client then starts to explore thoughts, emotions and feelings that arise and is free to lie down if this feels facilitative to the process. Whilst the intent going into the regression is to have womb-life in mind, it does not automatically follow that what unfolds for the client can directly be interpreted as related to prenatal life, though in my case, it seemed to be, given I felt I was ‘seeing’ my umbilical cord and felt myself to be inside my mother’s womb.

In the debriefing, the course director asked me what I knew of the pregnancy I shared with my mother; at that time, I knew very little, only some stories about my birth, not the pregnancy *per se*. The course director wondered if my mother had been ill during it, and again I had to admit I had no idea – unlike the snippets about being born, life during my mother’s four pregnancies with myself and my siblings had never entered the family tropes. From an initial position of deep scepticism when the plan for us to undertake womb-life regressions had been explained in the training seminars, this initial exercise opened what I can only describe as a maelstrom of curiosity. What were these thoughts, visions, feelings, images and, importantly, embodied physical sensations I had experienced, and witnessed others in the cohort experiencing, in the regressions? Could they have been some kind of implicit memory, activated by the energetic palpation of the therapist? Was it possible – as the course materials and literature I started to read around umbilical affect, such as

\(^3\) Umbilical affect describes the blood flow, its contents and the feeling states exchanged via the umbilical cord between the mother and prenate (Lake 2005).
Sills (2009), Maret (1997) and Verny and Kelly (2010) suggested – that my womb-life and birth experiences had started to form my character strategies, elements of my personality or how I was in relationships? If so, how? Further prenatal regressions happened on the course, and I felt inexorably drawn towards pre- and perinatal psychology; it seemed from a heavily defended and dismissive position, a locked door in my unconscious had been cracked open and I felt almost compelled to learn more. I decided to write an elective essay on umbilical affect as part of my course work, so, without explaining about this regression experience to her, I called my mother to say I was to write an essay for my course about my womb-life and birth history, and asked if she would be able to share any of her memories about that. In that first conversation, one of several we were to have over the intervening years before her death, I was amazed to learn that during what would have been the second trimester of the pregnancy, my mother was quite seriously ill with a kidney infection, and she/we had been bed-ridden for several weeks. She could not say exactly when or for how long this had been - when we first spoke about it, it had been nearly fifty years since the event - but she remembered it had been during the summertime, and very warm and bright as we both lay on the bed, with the sun streaming through the window.

The infection caused a lot of discomfort, being bed-ridden was difficult for her, especially as she was also caring for my toddler sibling whilst my self-employed father was busy building a business, and even at night, she had found it very hard to sleep due to the pain in her side. Hearing her (our) story about this, it made me start to wonder, might it be too fanciful a leap of imagination that the painful ‘stitch’ in my side during my regression, located as it was in the exact position of my left kidney, whilst I imagined myself in the womb in the early part of pregnancy, be a recapitulation of the umbilical affect I experienced at the time? Had I shared my mother’s pain and discomfort either physiologically and / or emotionally? Why, if so,

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4 Recapitulation is “… what happens when an event plays out with uncannily similar physical postures, behaviors, emotions, and even circumstances as the original, challenging, imprinting life experience” (Kalef 2014, 14).
had I been left with this imprint – if that is what it was – and effect had that experience had on me?

I learnt much more in that and subsequent conversations I had with my mother about her life with me in the womb, about pregnancy-long nausea and vomiting and a very protracted, difficult, painful and drug-infused birth. In essence, the initial umbilical affect experience started a significant process of pre- and perinatal exploration for me; I was to undertake several other experiential courses that used different regression techniques and education materials. What would have been, for both my mother and me, a ‘negative umbilical affect’ experience of the illnesses she suffered, followed by what was a relatively traumatic birthing experience for us both, helped provide an explanation to me of the early effects that shaped not only my relationship with my mother, which I often experienced as both tense and somewhat ‘distanced’, but also other elements of my character and relational ways-of-being. Before this, I had never considered how womb-life or birth might possibly have informed and fashioned my object relations and ways-of-being-in-relationship, my personality or how I saw myself in the world; through the experiential work and the accompanying educational research, I could start to look back on how I had been and attribute the early formations of those dynamics. It would not be too hyperbolic to say the spark of curiosity that initial regression instigated has been life changing for me, leading to a far deeper personal exploration of my womb-life and birth and an immersion into pre- and perinatal psychology research.

This fundamentally changed my psychotherapeutic journey, significantly starting a process of creating narrative-based sense-making understandings and meaning around some of my being-in-relationship modalities. Specifically, it was the ability to bring womb-life and birth stories into my frame of reference that helped me cultivate self-understanding, healing and change.

One of the pre- and perinatal courses I undertook took place over eighteen-months, in six, week-long seminars, and explored each of the different areas of prenatal life – conception, implantation, womb-life and umbilical affect followed by birth. This was
where I conceived the notion to undertake doctoral research in the field. I realised the transformative experiences I had also seemed to be shared by others, and I was interested to learn if this was so. This thesis therefore re-orient my personal self-research endeavours to consider how other people have undertaken similar journeys of self-development, to investigate how understanding more about womb-life and birth had led to deeper understanding of Self and changed how people could be in relationship to themselves and others through that greater awareness. What I had noticed – both of myself and others I met during my own explorations - is how the storied interpretations of experiential work and pedagogical trainings provided an ability to develop narrative explanations of Self and our relational ways-of-being. It is this approach that I develop in this thesis, which speaks to the intersection of the psychosocial intersubjective relationality of womb-life and birth, and the narrative constructions people create to better explain themselves and their worlds. All psychotherapeutic endeavours aim to mobilise greater awareness of the negative impacts people have experienced in their lives, which in this thesis includes elements of womb-life and birth, to facilitate change in the ways we think and behave, to find improved strategies for coping with feelings, to better communicate and tolerate difference, and thereby improve relationship to Self and to others.

1.2 Thesis structure
After the Prologue and Introduction chapter, this thesis has a further five main chapters.

In Chapter Two, I engage with three main bodies of literature that formed the groundwork for the development of my project, underpinning its theoretical and conceptual framework. Initially, I explore the history of pre- and perinatal psychology and health as a way of grounding the reader in the theoretical approaches, including the breadth of ontological perspectives that exist, from the early roots in Freudian and post-Freudian psychoanalytic concepts through to the present, where biomedical science is often integrated with psychodynamic psychotherapy and somatically oriented therapies. I provide detail of perspectives and theoretical developments which describe the potential impacts and imprints that can occur
during the pre- and perinatal period from (pre)conception, through life in the womb, to birth and, in the context of this thesis, immediately after being born. After this introductory section to the theoretical territory, I move on to explain and explore the therapeutic approaches that are enacted in pre- and perinatal therapies, and how they produce meaning-making for clients, patients, or participants (depending on the ontological perspectives of the practitioners). I focus first on the process of womb-life and birth regressions, as these experiential happenings are the most common method used to access the embodied and cellular (implicit) memories of the preverbal period, enabling the possibility of cognitive integration through fostering meaning-making of personal understandings of Self and Self-in-relationship to the world. I then provide examples from the literature of analytical interpretations, meaning-making and understanding for clients / patients based on PPN theories which map onto the main areas of (pre)conception, womb-life – including implantation and umbilical affect - and birth. Given making meaning from pre- and perinatal therapies is often constructed, through storying, into narratives of understanding, I complete the chapter by considering narrative therapeutic methodologies. Here I initially consider concepts about the formation of Self and intersubjectivity as I apply them in this thesis, including the tensions and similarities, that is the complementary and contradictory elements, that arise between them, and their relation to narrative, and how these all feature in womb-life and birth explorations. I follow this examination of constructions of Self, other and the relationship between them to reflect on the use of narrative in our lives, and its power to provide therapeutic properties through the telling of new stories about ourselves and our histories which give an opportunity for change and healing. The chapter concludes with the area my study focusses on, the aims I had and the overarching research question I planned to answer.

Chapter Three presents my methodological approach to this research. It starts with a discussion on research paradigms and explains the ontological and epistemological positions I adopted for my research, expanding on my theoretical perspective, that is “the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria” (Crotty 1998, 2). I then explore the
methodological approaches that link to my ontological and epistemological choices based on my intellectual puzzle (Mason 2018) in more detail, to show how the stories we tell not only inform our lives, but how they become narratives which make more sense of our lives (Speedy 2008; Frank 2012b). As my research endeavours progressed, I developed a deepening interest in narrative, and its value in our psychotherapeutic realms, through reflecting on the ‘narrative turn’ that emerged in social science during the 1980s (McLeod 1997; Speedy 2008; Liu 2019), and most especially this interest was cultivated through the detailed discussions with, and the critical challenges, reflections and focused encouragement of, my supervisors. The ability to construct and use narratives about our womb-life and birth as part of our meaning-making and understanding is the focus of my research, as these narratives can provide deeper insight and appreciation of how we have come to be who we are, and what that means for how we are in relation to our Selves, the others we meet in our lives and with the world in general. I then finalise the chapter by explaining the methods I used as a consequence of my methodology. This includes a consideration of how interviews as an “interactional exchange of dialogue” (Mason 2018, 11) would make an obvious choice as a specific method of capturing narratives of womb-life and birth, the methods of analysis I planned to enact after the interviews, and how my methods organically and strategically evolved over the course of my research.

In Chapter Four, I present my research’s analytical findings, eleven individual explorations of womb-life and birth, one for each of the participants who volunteered to be a part of my study. In the sub-chapters we hear, mainly in the words of my participants supported by my explanations and interpretations where appropriate, how their therapeutic investigations and evaluations were storied in our conversations, whilst I also reflect on how their storying creates the narrative meaning-making of Self and relational ways-of-being.

In Chapter Five, I step back and conduct a detailed discussion of the findings, critiquing and exploring the holistic commonalities that cross the data in relation to other theoretical constructs. I examine how my participants were able to reclaim and transform their understanding of Self and their relational-ways-of-being from the
narrative wreckage (Frank 2012a) they had previously found themselves amongst. The power of storying and narrative meaning-making is shown in relation to the research question that drove my research. I then also, reflexively and respectfully, look at considerations of the shadow side of pre- and perinatal psychology. I scrutinize how there is a potential, albeit not maliciously intended, for the pre- and perinatal field to enact the same unbalanced power differentials between practitioners and clients and patients of other therapeutic and healing modalities. I debate aspects of parent- and (especially) mother-blaming that could arise in the field, as well as discuss de-personalized presentations of women’s bodies. I conclude the chapter by indicating how my research achieves its aim to highlight the contribution of womb-life and birth storying to narrativize healing of Self, and to inform how we can better be in the world.

Chapter 6 concludes this thesis with how I see its theoretical contribution, some of the limitations of my study and some future areas for research. Deriving inspiration from Didion (2017), I suggest we tell stories in order to live, and we can live through the stories we tell.
Chapter 2 Literature review

“‘Every man is somewhat older than he bethinks, for we live, move, have being, and are subject to the actions of the elements and the malice of diseases, in that other world, the truest microcosm, the womb of our mother’.”
Thomas Browne, *Religio Medici*, 1642 (cited in Ridgway and House 2006, xxv)

2.1 Introduction

Human interest in how we, as individuals, experience womb-life and birth has a long history, as the quote from Browne above shows. In this chapter, as I lay the foundations on which my thesis is built, a synopsis of the theoretical development of pre- and perinatal psychology and health (PPN) will help frame the discussion of literature that follows, and the unfolding of the research gap I identified which my project aimed to fill. By way of introduction to what follows in the chapter, I conceive there are essentially two main strands to PPN theoretical development. The first strand I would call the ‘psychodynamic-psychoanalytic strand’, where theoretical development is rooted, essentially, in psychotherapeutic clinical practice, in the methods, thoughts, ideas and procedures that arose from, and informed, psychiatric and psychodynamic practices from Freud onwards. There is, however, what I consider a sub-strand to these approaches which posits the transpersonal, theologically oriented nature of our spiritual genesis. The second main area of theoretical development I would call the ‘bio-medical strand’; this partially emanates from the psychoanalytic tradition but extends it by incorporating bio-medical science such as obstetric practice (including feminist critiques of it), epigenetics, and embryology.

Firstly, I lay out my own historical overview of the theoretical development of PPN, concluding this necessary foundational section with a diagrammatical ‘family tree’ on which I plot the theoretical stands as I see them. I go on to review, in more detail, various PPN theories, starting with the bio-medically-informed perspectives on memory, epigenetics, and stress, followed by the different conceptualisations from pre-conception through to, and just after, birth. I then show how these theories inform meaning-making for clients in pre- and perinatally-oriented therapeutic
experiences. I consider the healing potentialities offered through deeper understanding of pre- and perinatal impacts on identities, personalities, or characters (which I summarize as Self), and our intersubjective, psychosocial, relational ways-of-being. How these understandings are a feature of therapeutic approaches to narrative identities is explored before the chapter concludes with the research gap I identified, and the potential significance of my area of interest that led to my research project.

2.1.1 Historical overview

“The formative experiences of prenatal life, birth and infancy lay down the templates which shape how the body ego adapts to the world and experiences itself in relationship to the environment” (Appleton 2020, 49, italics in original).

The history of pre- and perinatal psychology and health (PPN) effectively began a century ago with the publication in 1924 of The Trauma of Birth by Otto Rank (2010), a psychoanalyst who was both a student and contemporary of Sigmund Freud, and The Ambivalence of the Child by Gustav Hans Graber: both books “reflected for the first time the prenatal and perinatal origins of basal elements of our individuality” (Janus 2021, 3). Sigmund Freud’s development of the psychoanalytic method is acknowledged as providing the nascent roots of PPN, although he is recognised to also have had what Maret (1997, 44) called a “schizophrenic attitude towards birth”, considering it both the primary anxiety (Maret 1997) and the first experience of fear (Verny and Weintraub 2002) whilst also positing that a baby has no subjective experience of birth since “…being a completely narcissistic creature, is totally unaware of [the mother’s] existence as an object’ ” (Freud 1936, cited in Maret 1997, 44). Likewise, he considered intrauterine life to be like an unstimulated version of sleep, drawing on contemporaneous understandings of biology and neurology which considered babies and infants as immature until at least two or three years postnatally (Ridgway and House 2006; Verny and Kelly 2010).

Freud’s contemporaries Jung and Adler had briefly considered the prenatal aspects of psychodynamic interactions before Rank and Graber developed their more considered analysis of the beginnings of selfhood and individual subjective
experiences in the prenatal realm (Janus 2021). Melanie Klein (1928) had, controversially, started to challenge the chronology of Freud’s Oedipus complex through her practice-based analysis with children and her supposition that its roots in a child’s psyche were much earlier than had been previously supposed. At the same time, she offered a tempting glimpse of psychoanalytic approaches to the epistemophilic impulse towards womb-life to come, how a child wishes to “appropriate the contents of the womb”, by beginning “to be curious about what it contains, what it is like etc.” (Klein 1928, 170, *italics* in original). As PPN ontological perspectives consider the first nine months to year of postnatal life as part of the “womb of spirit… a spiritual, psycho-emotional, and physical environment that is more or less nurturing and sustaining” (Sills 2009, 119), the conclusion Klein (1928, 167) drew that “Oedipal tendencies are released in consequence of the frustration the child experiences at weaning” can be directly associated with her early intersubjective theoretical evaluations with pre- and perinatal psychology. Later, in self-analysing one of his own dreams, Fodor (1945, 567) was convinced it revealed “the unborn child is capable of experiencing traumatic shocks before birth” and speculated that the “chilly reception” in the psychoanalytic community at the time to Rank locating neurotic development due to birth trauma was “the fear that penetration to the level of birth would challenge the basic nature of [Freud’s theory of] the Oedipus complex” (1945, 552). Furthermore, setting the scene for how later PPN psychological theories have broadened out beyond pure science, Fodor (1945, 598) concluded “It is not to the embryologist that we should look for discoveries as to the essentially psychic nature of man. The spirit, soul, or organismic mind, cannot be revealed under any microscope. The evidence for its existence must be sought outside physiology, mainly in mental manifestations”.

Although Janus (2021, 4) posited there was a relative pause in PPN theoretical developments due to what he considers the “dominance of the scientific patriarchal zeitgeist” after Rank and Graber’s work, Winnicott (1958a), in a presentation to Scientific Meeting of the British Psycho-Analytical Society on 18 May 1949, reflected on Freud’s, and his own, position on intrauterine and birth memories. Of particular significance in his paper, as the negative aspects of womb-life and birth, especially
trauma, are often the focus in the literature, Winnicott (1958a) drew a clear
distinction between ‘birth trauma’ and ‘birth experience’. Birth experience can
possibly be “so smooth as to have relatively little significance” but also “Contrariwise,
birth experience that is abnormal over and above a certain limit becomes birth
trauma, and is then immensely significant” (1958a, 180). It could be considered that
Winnicott’s 1949 paper laid the modern foundations of the psychodynamic-
psychoanalytic strand of PPN theory, which was expanded through the Objects
Relations school including Melanie Klein (Hinshelwood and Robinson 2011) and
W.R.D. Fairbairn (1994), who took a Rankian view of birth trauma as the locus of
psychopathology. The field was extended in the 1950s and 1960s by Frank Lake,
Stanislav Grof and Athanassios Kafkalides with their initial (and separate)
investigations of intrauterine life using LSD. In the late 1960s and in the 1970s
Elizabeth Fehr⁵ (Feher 1980), R.D. Laing (1976), Arthur Janov (1970) and Lloyd
deMause (1982) also contributed to the field, along with the continued work of Lake
until his death in 1982. Modern psychotherapists such as William Emerson, David
Chamberlain and cranio-sacral therapists Franklyn Sills and Ray Castellino carried
on developing theories through the 1980s and into the 21st century. These
approaches often incorporated spiritually oriented perspectives advocated by Lake,
Sills, Emerson, Graham Farrant and others, and ultimately sought to understand the
wider effects and affects of social environments on our individual and collective
psychologies during womb-life and birth.

Meanwhile, the bio-medical strand developed in parallel from the 1970s, including
thinkers like Suzanne Arms (1994) and Robbie Davis-Floyd (2009), who offered
feminist critiques of birthing practices within a medical setting, and Thomas Verny
(Verny and Kelly 2010) and Bruce Lipton (2015) who contributed research on cellular
memory and environmental impacts on pregnancy and birth. This area includes
alternative and complementary medical approaches⁶ like craniosacral biodynamics,

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⁵ Leslie Feher uses her mother Elizabeth’s maiden name, Fehr, when referring to her, and I have followed this.
⁶ “Complementary and alternative medicine (CAM) is treatment that falls outside of mainstream healthcare.
These treatments range from acupuncture and homeopathy, to aromatherapy, medication and colonic irrigation”
(NHS 2022a)
“an approach to the teaching and practice of Craniosacral Therapy that acknowledges the deepest foundations of the human system” (Sills 2019, on-line). Such approaches also have an orientation to the spiritual, so are connected to the sub-thread I indicated in the psychodynamic-psychoanalytic strand. More recently, the two main strands have been integrated by postmodern practitioners, such as Karton Terry, Cherionna Menzam-Sills, Charisse Basquin, David Haas and Matthew Appleton, who have all incorporated biomedical perspectives into (psycho)therapeutic practice. These modalities offer broad assistance to people in coming to a holistic understanding of the potential pre- and perinatal roots of their relational ways-of-being by combining a pedagogical approach along with experiential therapeutic experiences to womb-life and birth, including body-oriented therapies and regression experiences.

PPN theory has therefore been derived from psychotherapeutic clinical practice, increasingly supported and informed by advances in medical science, and often includes theological, spiritual dimensions in therapeutic approaches. Theoretical development of both strands was further supported by the creation, in 1971, of the current International Society for Prenatal and Perinatal Psychology and Medicine (ISPPM) in Germany, with its North American counterpart, the Association for Prenatal and Perinatal Psychology and Health (APPPAH) founded in 1982 (Janus 2021): both organisations publish their own research journals which covers this broad range of theory. To give a visual perspective of PPN theories in relation to a timeline from Freud to date, I have developed Figure 1 below. This shows the approximate years in which theorists started operating or investigating pre- and perinatal themes, not necessarily when they started publishing literature in the area. Lake represents a good example of this, as he wrote about PPN theories in the 1980s, but his use of LSD and breathing techniques in regressive therapy commenced in the 1960s.
Figure 1: PPN Theory Timeline and Theorists

<table>
<thead>
<tr>
<th>Year</th>
<th>Theorists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>Freud, William James</td>
</tr>
<tr>
<td>~1940</td>
<td>Rank, Graber, Jung, Klein</td>
</tr>
<tr>
<td>1950</td>
<td>Nador, Winnicott</td>
</tr>
<tr>
<td>1960</td>
<td>Bowlby</td>
</tr>
<tr>
<td>1970</td>
<td>Janov, Fehr, Grof</td>
</tr>
<tr>
<td>1980</td>
<td>R.D. Laing deMause, English</td>
</tr>
<tr>
<td>1990</td>
<td>Hayton, Cheek, Chamberlain, Castellino</td>
</tr>
<tr>
<td>2000</td>
<td>Emerson, Sills</td>
</tr>
<tr>
<td>2010</td>
<td>Terry, Appleton, Menzam-Sills</td>
</tr>
<tr>
<td>2020</td>
<td></td>
</tr>
</tbody>
</table>
2.2 Theories of pre- and perinatal psychology and health

From the historical overview above, I now turn to a review of some of the key theories pre- and perinatal psychology proposes that are pertinent to this thesis. I explore, in sequential way, how PPN theories relate to the various means by which we, as humans, come to be, from preconception through to postnatal spaces, although there is not a clear linear path that can be easily collated into sections and subsections in the way the writing of a thesis necessitates, given the gestalt of humanity rests within a much wider space of universal existence.

As already noted, PPN theory embraces elements of biological sciences perspectives, including the intergenerational transmission of genes, alongside theological or spiritual philosophies into the existential nature of creation, and psychosocial, psychodynamic-oriented therapeutic approaches. As a researcher and practitioner in the field, I find myself resonating strongly with the words of McCarty (2012, 59):

“Worldviews, conceptualizations, research methodologies, clinical applications, and language expressed in the early development and PPN literature can vary so greatly that I feel like I could be talking about different planets or species. At other times, I find recent thought and research bringing the perspectives closer, bridging our understandings.”

Like McCarty, I have attempted to bring some integration to the different presentations of the theories.

2.2.1 Bio-medical underpinnings

“How can one cell generate the billions of billions of cells I now am? We are impossible, but for the fact that we are” (Laing 1976, 36).

The aphoristic ponderings of psychiatrist R.D. Laing (1976) on life before birth in his exploration of *The Facts of Life* predate the technological advances that have allowed increasing understanding in bio-medical science, including in the field of embryology. As he also mused, “It seems credible, at least, that all our experience in our life cycle from cell one is absorbed and stored from the beginning, perhaps
especially the beginning” (1976, 36). Laing therefore offers an excellent introductory position in which to review some of the current understandings of bio-medical science that inform pre- and perinatal psychological theories.

2.2.1.1 Concepts of memory: cells and consciousness

Fundamental to the principles of pre- and perinatal psychology is the ability to present a reasoned argument that we are able, through some mechanism or other, to remember our womb-life and birth. Interest in what sort of, if any, memories of birth and intrauterine life are created within the prenate, and the experiences that generate them and thereby influence later behaviour, character or personalities of infants and adults, extends back, as already noted, to Freud, Rank, Klein and the early psychoanalytic theorists. Winnicott (1958a, 191), in considering the Freudian and Rankian positions on intrauterine and birth memory, was relatively emphatic when he stated, “One can certainly assume that from conception onwards the body and the psyche develop together, at first fused and gradually becoming distinguishable the one from the other”. Here, Winnicott presupposes a form of consciousness from conception onwards, noting in his own analytical work with patients that personal birth experiences can be held as memory material if it manifests as significant for the prenate involved. Nearly three quarters of a century later, publishing over six years of scientific and medical research, Verny (2021a) believes we should abandon the idea that our mind is only encapsulated in the brain within our skull and be open to evidence that brain activity is distributed throughout the body through what he calls “the embodied mind”. He claims to challenge contemporary neuroscientific doctrines by suggesting:

“Memory is truly a body-wide web. Whether or not we can consciously access a memory is not as important as the realization that we had the experience, the lived event, which has left some kind of impact, influence, mark, trace, record, or imprint on our cells and tissues.” Verny (2021a, xiii-xiv)

In this “Embodied Mind Hypothesis”, Verny combines elements of epigenetics, recent research on brain structure (synapses and neurons), immunology system functionality, cellular biology and single-cell organism intelligence, along with his deliberations on organ transplants, consciousness and body memories, to show “the
existence in our bodies of an intricate, unified, multilevel, homeostatic, cellular memory system" (Verny 2021a, 113). This holistic approach echoes the words of Rodolfo Llinás (2002, ix), a professor in neuroscience and philosophy, who urged that, just as a change of direction away from dualistic thinking in Western society is needed so essential non-dualistic philosophical theories can be followed, “so there must be a fundamental reorientation of perspective in order to approach the neurobiological nature of mind”.

Verny’s hypothesis builds on memory research conducted over the intervening seventy plus years since Winnicott’s nascent considerations. Within the PPN field, the discussion encompasses the differences between explicit (or declarative) and implicit (or procedural) memories (Kalef 2014; Karr-Morse and Wiley 2012; Weinstein 2016), cellular consciousness and memory (Ridgway and House 2006; Lake 2005; Verny and Weintraub 2002; Emerson 2021; Sills 2009; Wade 1998; Terry 2013b) and, as a subset of these, body (somatic) memories (Rothschild 2000; Ogden, Minton and Pain 2006; Terry 2013b). Explicit or declarative memory, in the context of this thesis, is the conscious ability to recall things and “to tell reasonably factual stories about them” (Levine 2015, 16). Moreover, explicit memory also involves another narrative-based operation, episodic or autobiographical memory, which spontaneously emerge as “representative vignettes of our lives. These memories generally convey a vague feeling tone”, possessing “an oblique capacity for ambiguity” (Levine 2015, 17) that enlivens and enhances our storytelling. However, Weinstein (2016) notes that autobiographical memory is unable to fully capture the psychophysiological conditions brought about by traumatic experiences, which tend to be incorporated into implicit memory. This is created from “particular circuits of the brain that are responsible for generating emotions, behavioral responses, perception and probably the encoding of bodily sensations” (Siegel and Hartzell 2014, 11). Implicit memory is in operation at least from birth, although Levine (2015, 94) asserts that “‘hidden’ memory traces do exist (in the form of procedural memories) as early as the second trimester in utero and clearly around the period of birth”.

Single-celled organisms such as amoebae, slime mould and bacteria display forms of intelligence, communication and learning that do not require a developed nervous system or the sort of functional brain typically considered to store memories, and it is the scientific research into such animals as well as immunology that forms the starting point for concepts of cellular consciousness and memory (Lipton 2015; Weinstein 2016; Verny 2021c; Menzam-Sills 2020; Terry 2013a). An oft-cited example of human cellular memory is the immune system, the cells of which help fight infectious diseases: “These cells recognize and remember infectious invaders and attack them if they return in the future” (Weinstein 2016, 42) which is the basis of vaccines that introduce a form of the disease to be defended against should the host organism (that is, the person immunised) encounter it in the future. This is thought to affect the development of neurons, a key component of memory storage in the brain (Verny and Weintraub 2002; Verny 2021c), and this sort of memory can also be seen in the information carried by the cells responsible for the early stages of foetal development (Ridgway and House 2006; Menzam-Sills 2021).

The experiences of the environment in which cells develop and exist are thought to be biochemically stored from conception in the psycho-neuro-immuno-endocrine network, a holistic linking of the nervous, immune, hormonal control and brain systems (Weinstein 2016; Verny and Weintraub 2002). Lipton (2015, 210) also believes single cells can learn from environmental experiences and thereby build cellular memories, though he is more circumspect about the idea that cells store these memories: his “immense respect for the intelligence of single cells” is tempered by his not believing “cells are physically endowed with perception mechanisms that can distinguish and remember a taste for chicken nuggets!”.

The principal and fundamental aspect of these various evaluations, from a pre- and perinatal psychological perspective, is that complete memories of all experiences are carried in our bodies from “conception and the separate experiences of being a sperm and an egg”; the resultant cellular consciousness is why “we are constantly (unconsciously) and profoundly affected by these experiences in every aspect of our lives” (Larimore and Farrant 1995, 22). As Emerson (2002, 68) puts it “… mind pre-exists the nervous system” leading to “a level at which the conceptus is aware of
Differentiating between explicit memory and the more emotional content and learning that comes from lived experience, Appleton (2020, 66-70) describes the “templates of embodiment”, where the potential for imprinting exists at each stage of our development, from pre-conception, the journey of the sperm and the egg, the post-conception movement to the uterus\(^7\) and at implantation. Imprinting is also then experienced in the womb, most notably through umbilical affect (Moss 1987; Sills 2009; Appleton 2017, 2020; Menzam-Sills 2021) and subsequently in birthing experiences. As Kalef (2014) and Appleton (2020) have noted, and as hinted at in my own presentation of my regressive experience in the Prologue, these experiences can be positive. Indeed, Moss (1987, 203) noted how the umbilical cord could be experienced as providing a “life-giving flow, bringing … renewal and restoration” and Glyn Seaborne-Jones, in reflecting on his own regressive experiences of womb-life, described it as “completely blissful – absolute perfect peace” (Posey 1977, 203), whereas he had experienced his birth as traumatic. There is something Rankian in this perspective, the womb conceived as always protective and nourishing, a space that we would ideally return to in contrast to the primal trauma of birth (Rank 2010), and conceptualisations of the womb as home / not home proliferate in PPN, as will become apparent in later parts of this thesis (Somé 1999; Linn, Emerson, Linn and Linn 1999; Appleton 2021; Terry 2013a).

2.2.1.2 Imprinting and imprints
The principle of cellular memory, cellular consciousness or cellular sentience within PPN correlates to the use of terms ‘imprint’ and ‘imprinting’, which are the experienced impacts resulting in ‘life patterns’ or ‘patterning’ behaviours, although

\(^7\) “the part of the female reproductive tract that is specialized to allow the embryo to become implanted in its inner wall and to nourish the growing fetus from the maternal blood” (A Dictionary of Nursing, 8th edition). Also called the womb.
sometimes the terms are used interchangeably. In PPN theory, the term ‘imprint’ is used in a different way to ideas of mammalian and avian imprinting, a releasing mechanism in the environment of the young of a species which initiates innate, inherited behaviours, as explored in the work of Josef Konrad, and which is more connected with Bowlby’s attachment theory (Harré and Erneling 2012; Llinás, 2002). However, there is an associated overlap with this concept and other constructions of the term when used in PPN, albeit in subtly different, multivarious ways across the different disciplines. Prior to what I might call the ‘epigenetic revolution’ within PPN theoretical development, where the basic or pure scientific findings on epigenetics which emerged in the 1990s (Hurley 2015) could start to be aligned with and threaded into those early speculative wonderings of Freud, Rank, Winnicott and their contemporaries, pre- and perinatal therapists were already considering how we can be imprinted or shaped by experiences during our development. This echoes the starting point for a common perspective of ‘imprint’ in PPN theory being “something that makes a stamp or an impression on a body or a surface” (APPPAH 2016, 6), “the lasting effect a positive or challenging event or circumstance has on any living being, human or otherwise” (Kalef 2014, 11). Essentially, in connecting the term to cellular memory, imprints are considered “memory traces that are held in our cells and tissues” (Appleton 2020, 68); the cells that first form the prenate have their own inner life even as, and because, they interact with their environments (Stulz-Koller 2021; Sills 2009).

Imprinting can happen due to the pre-conceptual experiences and pre- and perinatal living conditions of either or both parents (Hoover and Metz 2021; Tahir and Khalily 2016), from when individuals were germ cells, when a future mother was a prenate in her own mother’s womb. It can also happen during either future parents’ adolescence (on the sperm and eggs) (Hurley 2015; Weinstein and Shea 2017; BBC 2014; Seng and Taylor 2015) or through to the prenate’s conception and life in the womb. All these stages carry potential risk factors that may contribute life-long tendencies or changes to the (future) child’s physiology, body structure, psychologies, and metabolism (Assman 2021; Odent 2012; Yehuda and Bowers, 2015; Yehuda, Engel, Brand, Seckl, Marcus, and Berkowitz 2005; Axness 2016).
Moreover, although Kalef (2014) had noted imprinting can have both positive and negative effects, generally the PPN literature highlights the more negative aspects as these are the elements worked on in therapeutic interventions.

2.2.1.3 Epigenetics
Pre and perinatal imprinting has direct links to epigenetics, the study of how genes get expressed or suppressed by a variety of cellular materials or small chemical tags that attach themselves to deoxyribonucleic acid (DNA), the molecule that carries genetic information for the development and functioning of an organism (Guerrero-Bosagna 2016; Assman 2021; von Lüpke 2021). According to Weinstein (2016, 151), “epigenetics research explores how the activity of genes is altered by interactions between genes and the environment”, and is rooted in the understanding of how the genes that are held within our DNA are ‘expressed’; a beautifully simplified explanation of epigenetics is given by Dr. Jean-Pierre Issa:

“… skin and eyes and teeth and hair and organs all have exactly the same DNA. You cannot genetically tell my skin from my eyes or my teeth. Yet these are very different cells. They behave differently. And that behavior remains the same for as long as I live. That difference, not being genetic, has been termed epigenetic. It is a difference that is not due strictly to genetic changes but to the way we utilize these genes.” (NOVA 2007)

Although the detailed science of epigenetics is beyond the scope of this thesis, it is important to note how the scientific principles of epigenetics are merged with, and support, some of the other affective-based principles of pre- and perinatal psychology, including the impact and influence of intergenerational and transgenerational environmental effects (Palakodety, Gardner and Fry 2020).

Cellular material – the ‘marker’s, ‘switches’ or ‘chemical tags’ that turn on, or keep turned off, optimal gene functionality during development – sits on top of the genome, such that the sum of all tags attached to the genome of a given cell is the epigenome (Brenner 2014; Guerrero-Bosagna 2016; Verny 2016; Weinstein and Shea 2017; Assman 2021). My basic understanding of epigenetics is as an evolutionary adaptation to prepare offspring for the expected environmental circumstances as experienced by earlier generations, before we were born. If, for
example, the world is a stressful and dangerous environment for the parents-to-be, then passing on adaptive survival strategies through genes to offspring increases survival chances to cope with these environments. This was demonstrated in the work of Marcus Pembrey, a Professor of Clinical Genetics at the Institute of Child Health in London, in collaboration with Swedish researcher Lars Olov Bygren, who, in the early 1990s, discovered the life expectancy of grandchildren could be affected if their grandparents had experienced famine at critical times of their development: in essence, this suggests that genes had a ‘memory’ which was passed on to future generations and triggered by environmental effects (BBC 2014).

A prenatal link to the term ‘imprinting’ as an effect of epigenetics has been made by Reik and Walter (2001, 21): “Genomic imprinting … is brought about by epigenetic instructions – imprints – that are laid down in the prenatal germ cells”. As an exceptionally influential genetic mechanism, imprinting is believed to affect the transfer of nutrients between prenates and newborn from the mother. “Consistent with this view is the fact that imprinted genes tend to affect growth in the womb and behaviour after birth” (2001, 21). Karr-Morse and Wiley (2012, 170) advise against seeking simple cause-and-effect answers in epigenetic research though, as “epigenetics is only part of the equation”, and they give some insight into a variety of research projects that have sought epigenetic connections to both physical illnesses – cancer, diabetes, heart disease, asthma – and emotional and behavioural health – addiction, depression, post-traumatic stress disorder, schizophrenia, dementia and autism. In relation to the epigenetic differences between identical twins, one of whom was schizophrenic whilst the other was not, Karr-Morse and Wiley (2012, 181-1) noted the combination of “Hormones, external environmental factors, and a series of random events will shape the degree of epigenetic dysregulation” and created “domino effect of negative events”. It stuck me that this might be a general principle that could be applied to the discussion of individual experiences of how imprinting occurs.

To summarise this section and my understanding of this complex territory, pre- and perinatal psychology conceives of memory being a combination of explicit memories
that are stored through ‘traditional’ concepts of a brain, constructed of neurons, dendrites and synapses connected to the central, peripheral and autonomic nervous systems (Verny 2021b), combined with memory held more holistically throughout the body, at both an implicit memory and a cellular level. Thus, our cells from the very beginning are conceived to have a form of consciousness, potentially starting one or two generations before us, through the science of epigenetic gene expression and in response to the environment in which they develop. In similar ways to unicellular and multicellular organisms, our cells respond to those conditions within and around the organism of which they are a part. These experiences can therefore be captured at a cellular level as memory traces called imprints and subsequently experienced as embodied, implicit memory, often at an unconscious level, in different ways, throughout life.

2.2.1.4 Stress and the maternal environment
From a medical and biological as well as psychological perspective, the environmental living conditions for and, from the perspective of the prenate, of the mother have been researched across disciplines. One of the most important areas of research in this field has been on stress, defined as “a ‘person-environmental interaction, in which there is a perceived discrepancy between environmental demands and the individual’s psychological, social or biological resources’.” (Wadhwa et al. 2011, cited in Weinstein and Shea 2017, 24). In particular, whilst the management of occasional stress is a necessary part of developing adaptive human functioning, “if stressors become too intense or chronic they become toxic” (Seng and Taylor 2015, 25), overwhelming our ability to adapt or cope (Verny 2018). Even though the experience of stress is very subjective (Verny 2018), within PPN it is generally the construct of toxic stress, defined as “strong, frequent and/or prolonged activation of the body’s stress-response systems in the absence of the buffering protection of adult support” (Weinstein 2016, 66) that is the focus. This is opposed to what might be called normative ‘positive’ stress, “an important aspect of healthy development [when] stable and supportive relationships … facilitate adaptive responses” (Weinstein 2016, 65) or adaptive ‘tolerable’ stress, like homelessness, the death of someone close or a natural disaster creating a potentially damaging
physiological state that is “buffered by supportive relationships that facilitate adaptive coping” (2016, 66). Lake, for example, developed his Maternal-Fetal Distress Syndrome (MFDS) focussed on imprinting via umbilical affect, and the patterning in the prenate that resulted, based on the stresses put upon the mother, and passed onto her child; the prenate has to develop survival strategies to cope, which are then imprinted and rekindled in later life (Lake 2005; Maret 1997; Ridgway and House 2006; Moss 1987; Whitfield 2007). The biological processes for the influences of stress are multivarious, though there are indications to hormonal factors that are influenced by a mother’s emotional environment, including how she thinks and feels about things (Weinstein 2016; Seng and Taylor 2015; Verny and Kelly 2010; Verny 2018, 2021; Sansone 2021). There is an increasing realisation in PPN that prenatal stress can affect both men, women and their future offspring. If either parents’ environment is highly stressful at some point in their life, their later children can also be affected as “stress imprinting (epigenetic imprinting) can occur at any time in the life span of an egg or sperm” (Weinstein and Shea 2017, 26), both intergenerationally and transgenerationally (Assman 2021; Hurley 2015; Palakodety, Gardner and Fry 2020).

At the same time, the trend to look more towards the maternal impact of stress on prenates has continued in the literature, I would speculate because many of our earliest experiences are inside the maternal space of mother, so “the stress of the mother’s world ‘programmes’ the fetus to survive” (Seng and Taylor 2105, 26). From an adaptation point of view, in essence, the mother’s experiences of safety or danger shape her psychophysiological states; these affect the quality of her internal environment, providing signals to the prenate of how the world they are coming into is likely to be (Weinstein 2016). Stress during pregnancy, often in combination with other factors such as smoking or poor diets, has been linked in offspring to later-life dementia (Wiegersma, Boots, Langendam, Limpens, Shenkin, Korosi, Roseboom, de Rooij 2023), autism and ADHD (Ronald, Pennell and Whitehouse 2011; Beversdorf, Stevens and Jones 2018), schizophrenia and bipolar disorder (Meli, Öttl, Paladini and Cataldi 2012; Pugliese, Bruni, Carbone, Calabrò, Cerminara, Sampogna, Luciano, Steardo Jr, Fiorillo, Garcia, Fazio 2019) and adolescent
depression (Maxwell, Fineberg, Drabick, Murphy and Ellman 2018). Yet, as Piontelli (1997, 19) observed, early psychoanalysts put much of their theoretical weight on the potential impacts of the maternal emotions, as well as their phantasies, on the prenate and she warned seeing the prenate as a “totally malleable ‘tabula rasa’ on which the mother leaves her imprint, and pregnancy is regarded as important only in so far as her state of mind is concerned” as being uni-directional if not narrow-minded. Lake’s MFDS can be seen as one example of that sort of thinking. In fairness, Whitfield (2007) points out that Lake himself had started to turn his attention beyond the individual mother in his theorising of prenatal impacts but had died before he was able to do more investigation on it. However, understanding the impacts of stress on mothers-to-be holistically will lead to improving outcomes for them and prenates, which is of primary importance to psychosocial healthcare initiatives (Seng 2015).

In the following sections, I will explore PPN and other relevant literature related to human development from preconception to birth and the psychological correlate imprints that have been associated with them. In this area too, PPN blends the two dimensions of science and the spirituality of the creation of a human life in its approach, accepting the premise of a form of cellular consciousness within an innate embryonic ‘blueprint’. PPN theorists have presented detailed embryological processes as part of the interweaving of biological and psychological sciences (Menzam-Sills 2021; Appleton 2020; Terry 2013a, 2013b, 2013c; Larimore and Farrant 1995; Weinstein 2016; Linhard 2017). It is not possible within the scope and intent of my thesis to replicate the sort of detail provided elsewhere, but I refer to some of the basic embryological processes in simplified form in the following sections, continuing to hold the bio-psycho-somatic framework of the literature.

2.2.2 Pre-conception and conception

Menzam-Sills (2021, 77) reminds us that “The preconception period is an essential aspect of our history”. Although biologically-speaking, the first physical manifestation of cellular consciousness is at conception, Larimore and Farrant (1995, 23) suggest “on a transpersonal plane, the soul leaving the spirit realm and incarnating is an
even earlier experience”, which Verdult (2021b) proposed is the organizing principle that creates embodiment out of nonlocal consciousness. Appleton (2020, 59) has developed a concept which connects the two principles of biology and divinity which he calls the ‘bionuminal realm’ or ‘bionuminosum’, the ‘bio’ referring to life, in biology as well as life storying, and ‘numinal’, a derivation of the theologian Rudolph Otto’s terminology for human experience of divine presence beyond any philosophical, ethical or theological doctrines. Preconception therefore happens when a “dynamic exchange occurs in the bionuminal realm between numinous non-local consciousness and the pull of embodied, biological life” (2020, 73).

Bridging these theories around preconception and the actual resulting union of a sperm and egg that becomes the potential of a human life through conception, pre-and perinatal theorists have aligned the potential psychological correlates identifiable through regression work of the separate journeys undertaken by sperm and egg with the biological processes involved (Appleton 2020; Menzam-Sills 2021, 2023; Conscious Embodiment Trainings 2015b; Larimore and Farrant 1995; Sills 2007).

Theorists maintain a position that sperm does not only have male genetic coding, but also carry the imprints of the male generational line and are responsible for masculine properties within us; equally the ovum has female genetic coding, carrying the imprints of the female line along with feminine properties.

For the sperm, in what might be called normative reproduction, where a woman and a man have intercourse that results in conception, Peschek (2021) explains the sperm journey as a set of sequenced events, starting with spermaogenesis (the continuous production of sperm in sexually mature males) and a ‘resting phase’ in the testes. Then, there is ejaculation into a woman’s vaginal cavity followed by the mass deaths of millions of sperm due to the natural infection-fighting processes, protective acidic environment and higher temperature in the vagina. The surviving sperm then ‘trek’ via the cervix8 to the uterus before choosing one of the two

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8 “the neck of the uterus, which at its lower end projects into the vagina and contains the cervical canal” (Dictionary of Nursing, 8th edition).
fallopian tubes to enter, a choice that may be assisted by chemical messengers released by the egg to indicate where she is. The survivors then meet the egg and the dance of conception begins. The journey of the egg is similarly explored in PPN theory, albeit in less detail, and has also been described in expeditionary narratives that parallel the sperm journey: the ‘slumber party’ designates the resting period in the ovaries, followed by ovulation allowing a mature egg to drift towards the fallopian tube and undertake an odyssey, a rolling, tumbling movement down the fallopian tube where the potential for meeting the sperm that lead to a conception usually happens (Conscious Embodiment Trainings 2015b). It is also appropriate to acknowledge, as Menzam-Sills (2021) does, that sperm and eggs that are used in assisted reproductive technologies will, of course, have very different experiences of conception, although reports of imprinting from these processes appears to be sparse.

In terms of conception itself, one metaphor in which it occurs has been expressed by Appleton (2020, 89) as a recipe, the ‘ingredients’ being “the embodying consciousness, with its inherent sensitivities and traits”, the father and mother’s individual consciousness with their intrinsic sensitivities, embodied experience and characteristics, and “the sperm and egg, each with its own biological imperative”. The relational field of the parents “adds a further ingredient; it may be love, it may be anger, it may be fear” or it may have been influenced by alcohol and drugs (2020, 89). Other theorists have challenged the ‘traditional’ perception that a sperm needs to win a competitive race in order to ‘penetrate’ an ovum. For example, van der Wal (2007, 147-8) conceptualised fertilization as a “mating dance”, something he named “The Pre-conception Attraction Complex” which involves “a kind of chemotaxis (a biochemically induced attraction)” between both egg and sperm. There seems, therefore, to be an element of “choice” or collaboration between the gametes in fertilization (Larimore and Farrant 1995; Menzam-Sills 2021). Whatever the cellular experience of the union of the two cells, when they join, they become the one-celled

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9 “a mature sex cell: the ovum of the female or the spermatozoon of the male” (A Dictionary of Nursing, 8th edition).
zygote\textsuperscript{10} that starts to move towards the uterus to implant (Menzam-Sills 2021; Larimore and Farrent 1995), with occasional ‘rests’ in the fallopian tube.

From a spiritual angle, Menzam-Sills (2021) cites Robert Lawlor’s perception of an Australian Aboriginal explanation of conception which rest on the spirit of a child appearing in their future father’s dreams. Other cultural perspectives of stories from children about their lives prenatally and at birth, including preconception memories come from the USA (Chamberlain 2013; Carman and Carman 2019), Japan (Ikegawa 2020) and Germany (Bauer, Hoffmeister and Georg 2005).

In summary, PPN theory thus combines a third component with preconception and conception in its theorising of the epigenetic, ancestral and intergenerational impacts or imprints overlapping with the biological processes involved in sperm meeting egg, by introducing the precursory spiritual orientation or dimension which extends through the being’s on-going life (Lake 2005; Verdult 2021b; Menzam-Sills 2021; Carman and Carman 2019; Appleton 2020). Many PPN theories are consequently identifying and recognizing pre-conception and conception experiences as fundamental biological and spiritual events in our lives that can leave strong imprints on our bodies and our psyches.

2.2.3 Implantation

The psychological implications of implantation were considered by a contemporary of Freud, Dr Isidor Sadger, who had accepted, albeit with some resistance and reluctance, that psychoanalytic accessing the embryonic period, including implantation, helped some of his patients with their neurotic symptoms (Ridgway and House 2006). Implantation experiences also formed the part of the pioneering work of Lake (2005), Grof (2000, 2017), Kafkalides (2005) and Dr W. Swarty, a Primal therapist, who differentiated between Birth Primal and Implantation Primal (Ridgway and House 2006). Contemporary theorists have been able to combine modern embryological research with the theories around cellular memory and clinical

\textsuperscript{10} “the fertilized ovum before cleavage begins” (A Dictionary of Nursing, 8th edition).
regression work to posit the potential psychological implications of implantation. In simplified terms, the next biological stage involves the zygote travelling down the fallopian tube to the uterus of the mother, starting to transform through cell division along the way and arriving as a blastocyst\textsuperscript{11} ready for implantation into the uterine wall. Implantation is not automatic, however, as losses can occur both before the uterus is reached (including ectopic pregnancies where implantation occurs in the fallopian tube) as well as from the uterus itself (Symonds and Symonds 2004; Appleton 2020; Menzam-Sills 2021; Terry 2013b; Hartman and Zimberoff 2004). The situation is effectively one of life or death for the blastocyst, as it needs to implant to gain nourishment and start to grow / develop. Successful implantation is thought to happen for only approximately 55% of blastocysts (Sills 2007; Larimore and Farrant 1995; Terry 2013a; White 2013). Terry (2013b) puts forward the hypothesis that as vulnerability in human development is inversely related to age (that is, adults are less vulnerable than children, children than babies, babies than prenates), it could be assumed that the blastocyst, which develops into the brain, nervous system, heart, muscles and so on of the prenate, is the most vulnerable cell of all, and significantly open to the imprints of its physical and emotional environmental experiences on its journey to implantation.

In intersubjective psychosocial terms, Sills (2007) speaks of implantation being about relationship, nurturing and intimacy, a transition from being an independent cell to becoming completely dependent on the physical connection to the womb/mother. Appleton (2020, 91, 92-3) likewise notes how “Implantation is also the precursor of the prenatal umbilical relationship” and “It is an important threshold, whereby the embodying consciousness commits even more to the intention to embody”: it deepens the biological as well as intersubjective psychosocial relationship to mother, and, through her, the wider familial and cultural field. Lake located the geneses of the principal personality disorders and psychosomatic stress as being in the first trimester (Maret 1997; Ridgway and House 2006) and Ridgway and House (2006,

\textsuperscript{11}“an early stage of embryonic development that consists of a hollow ball of cells with a localized thickening (the inner cell mass) that will develop into the actual embryo” (\textit{A Dictionary of Nursing}, 8\textsuperscript{th} edition).
contested the idea of implantation might be blissful: “it is doubtful if an implantation memory, assuming it can be retrieved, can be anything but traumatic”, basing this supposition on the biological science that the blastocyst is regarded by the mother’s immune system as an intruder (Ridgway and House 2006; Terry 2013c; Menzam-Sills 2021).

In summary, to quote Terry (2013c, no page), for PPN theorists “implantation is one of the most formative realms in which we human beings originate”, a process that has potential for a variety of psychological and somatic imprints. There is also a high risk of not surviving this formative process, and I will refer again to implantation when I examine the literature on womb-related losses as part of the next section. Implantation, however, is where a substantial physical – and for some, spiritual - transformation of the human-to-be begins, from a blastocyst to a fully formed baby ready to be born. Life in the womb, and the underpinnings of our relational life, is the focus of the following review of literature.

2.2.4 The relational field: life in the womb

“The womb. You know that place. You have been there – for sure – because it’s how all of us got here… In that stunning realm of orchestrated creativity you become embodied, furnished with all the basic equipment needed for life on planet Earth… your most fantastic journey”. Chamberlain 2013, 1 (italics in original)

As previously identified, concepts within PPN on womb-life have both biological as well as emotional elements, a holistic bio-psychological approach to it, covering medical, physiological, psychological, emotional, cognitive and spiritual dimensions. It can be deduced from the literature so far presented that for PPN development of Self-as-subject and intersubjective relationship starts before conception and proceeds through to implantation. Yet as Chamberlain (2013) observed, whilst conception can happen in minutes and birth usually takes place over several hours, life in the womb following implantation is the beginning of up to nine months of formative development. This is a period in which a deeper sense of the Self-as subject of the baby-to-be takes shape, fostered, expanded and progressed within the
psychosocial, intersubjective relational field(s) of mother, the “first human being with whom we have direct contact” (Terry 2013a, 281): as Chamberlain (2013, 49) pithily put it, “The womb is not an isolation tank”. Sills (2009) designates the womb of spirit as a bidirectional interactive field between prenate and mother, echoing the thoughts of Liley (1977, cited in Ridgway and House, 2006), who considered the prenate is actually the dominant partner in the mother-foetus relationship. The womb of spirit includes significant others such as the father, siblings, parents and friends, as well as the cultural and societal circumstances the mother is living in, because her interactions with these can all impact on the growing child within her through umbilical affect in positive and negative ways (Sills 2009). The importance of significant others is reiterated by Bowlby (2005) who suggested a mother knowing who to rely on and trust throughout pregnancy and motherhood were fundamental contributors to a healthy personality in the infant. Albeit written from a postnatal perspective, the words of Woodhead, Faulkner and Littleton (1998, 1) could equally be applied to a prenatal point of view: “The environment for child development is a social environment, peopled by others, mediated by cultural beliefs, values and practices and amplified by the cultural tools and artefacts into which children are initiated …”. Subsequently, the intersubjective reality of the prenate as an active social partner needs to be acknowledged (Sansone 2021).

2.2.4.1 Discovery
Discovery as a term in pre- and perinatal psychology is attributed to William Emerson (Sills 2007, 2009; Menzam-Sills 2020) and used for the time when a pregnancy is either suspected or determined, because either a menstrual period is missed and the mother-to-be has an intuition related to her recent sexual activity, or pregnancy is confirmed by a test or other method. This is, biologically speaking, around the fourth week post-conception (Menzam-Sills 2023) and both Menzam-Sills (2020, 2021, 2023) and Appleton (2020) locate the embodied affect of discovery in the heart region. The speculation as to why this might be is because the time of discovery is correlated with the time the heart starts to beat in the prenate, around four weeks post-fertilization, although in embryological science the exact nature of what contributes a human heart beating has been debated. Männer (2022, 2), for
example, using a definition of “heartbeat” describing “the regular movement that the heart makes as it sends blood around your body”, notes that heart as an organ, at the stage of the traditional textbook timing of 21 – 23 days after fertilization, is considerably different physiologically, being tubular, than the mature four-chambered heart that it develops into. As he also notes, the concept of hearts beating “has religious, philosophical, ethical, and medicolegal implications” (2022, 1). Menzam-Sills (2021) marks this event as not just physiological in nature but also emotionally relational, so maternal stress at this critical time of organ development would accentuate the potential for psychological and physiological imprints (Appleton 2020).

The affective quality of the discovery by the parents, such as delight, fear, shock or sadness (Appleton 2020; Verdult 2021a), and how this is experienced by the prenate in the relational field through the mechanism of cellular consciousness (Wade 1998), leads to the potential for positive or negative imprints. Moreover, “How the prenate is recognized and accepted by mother is ground for his developing sense of beingness and self-worth” (Sills 2009, 134). Lake (2005) ascribed one of the deepest woundings that we can experience to the denial of our existence and if a child is unwanted or denied in any way, it can lead to discovery trauma (Emerson 1996; Appleton 2020), the imprints of which manifest in later life.

2.2.4.2 Umbilical affect

The umbilical cord is the vital lifeline connection between the prenate and the mother and passes through the placenta, which primarily moderates both the flow of nutrients and oxygen-rich blood to the prenate through the cord through one vein, and the deoxygenated blood with waste products carried away from the prenate by two arteries (Scogna 2015; Heil and Bordoni 2023). Embryologically, the umbilical vein begins as a connecting stalk in around week three post-fertilization and is fully developed by week seven (Heil and Bordoni 2023), so at a similar time to the heart,

12 “an organ within the uterus by means of which the embryo is attached to the wall of the uterus” (A Dictionary of Nursing, 8th edition).
as I previously discussed, and happens as the heart descends and creates space for the future brain (Linhard 2017).

Umbilical affect was a term first used by Francis Mott and adopted by Frank Lake (2005) to describe the blood flow, its contents and the feeling states exchanged via the umbilical cord between the mother and prenate, the cord being seen to bring physical sustenance, hormonal exchanges and toxic substances as well as good and bad feelings generated through the emotional states of the mother. Umbilical affect is therefore conceived as variably positive, negative or strongly negative (Verdult 2021a; Emerson 1996; Sills 2009; Whitfield 2007; Maret, 1997; Sills, 2009; Terry 2021), the quality and quantity of ‘affect flow’ lying along a continuum from blissful acceptance, through conscious or unconscious lack of awareness or disregard, to conscious or unconscious rejection (Maret, 1997). Umbilical affect is an extension of the theories around conception and discovery, the starting point for which, according to Stern, Bruschweiler-Stern and Freeland (1998), is the attitude towards pregnancy that an expectant mother adopts, from (pre)conception to and after birth, through initial bonding to full development. They insinuate the adoption of a ‘motherhood mindset’ is critical, as the notion of being a mother is a psychological transition a woman must go through, paralleling the physical birth of the child. During pregnancy, mothers-to-be begin to imagine and fantasize about a range of outcomes for their child, from what kind of personality they will have to how their physical health will be – something akin to three pregnancies: the physical prenate, the motherhood mindset and the envisioned baby (Stern, Bruschweiler-Stern and Freeland 1998). The authors identified three main ‘attachment patterns’ to pregnancy: dismissing, enmeshed and autonomous. A ‘dismissing’ mother lies in a form of denial of the pregnancy, waiting a long time to admit it to herself and her outside relationships; an ‘enmeshed’ mother is extremely close to her own mother, engaging in deep primary relationships without reflection; and an ‘autonomous’ mother lies somewhere between these two extremes, able to reflect on the present in a balanced and witness-conscious way (Stern, Bruschweiler-Stern and Freeland 1998). In a study that produces some empirical evidence for the effect of affect during pregnancy, Kita, Umeshita, Tobe, Hayashi and Kamibeppu (2019) found that violence inflicted by an
intimate partner on a mother-to-be resulted in failures of bonding post-birth, mediated by negative attitudes towards the pregnancy in the third trimester.

Similar to Thomas Browne’s musings, another remarkable historical precursor to PPN concepts related to affect in pregnancy in the way described above was a book by a British physician called James Augustus Blondel, and Johannes Heinrich Mauclerc, published in Germany in 1756 under the title *Drey merkwürdige physikalische Abhandlungen von der Einbildungskraft der schwangern Weiber und derselben Wirkung auf ihre Leibesfrucht* (Blondel and Mauclerc 1756, available online through Google Books) which translates as *Three Remarkable Physical Treatises on the Imagination of Pregnant Women and its Effects on their Wombs*. Such ideas overlap with the umbilical affect indicators constructed by Lake, as positive, negative and strongly negative (Maret 1997) that the prenate responds to in one of four ‘graded’ ways, ideal, coping, opposition or transmarginal stress, forming a “transmarginal hierarchy” which “describes the self-organisational and defensive processes that emerge as positive or negative are experienced” (Sills, 2009, 116). ‘Ideal’ responses follow physical, emotional and spiritual support for the prenate from implantation in the womb onwards, with mother and her psychosocial relational field fulfilling an archetypal role, giving understanding, attunement and unconditional love (Maret, 1997; Sills, 2009). ‘Coping’ follows the more likely course for most prenates, in which the womb of spirit is experienced as a mixture of positive and negative affects, satisfactory though not ideal, but where trust between mother and child is maintained and any distress the prenate feels through umbilical affect is manageable and tolerable. Maret (1997) comments that as this condition is more reflective of life outside the womb, it acts as a sort of inoculation against future disappointments when needs are not fully met. This idea echoes other research areas into stress, where the ‘right amount’ of stress, and thereby the management of specific neurohormones like cortisol that control this response, is necessary for normal functioning – although this still requires a safe holding field where the stressed infant can be met and helped to recover when necessary (Gerhardt 2004; Weinstein 2016).

When the trust between mother and prenate breaks down due to intense or long-running negative affect, the connection is less than ‘good enough’, and the
boundaries of tolerability are reached, ‘opposition’ as a strategy occurs (Sills, 2009). Lake used particularly horrific language, to my mind, to describe the affect flow from the mother that creates oppositional strategies as “ ‘[a] great nail of affliction or skewer transfixing the foetus at the navel, with an overwhelming invasion of bitter, black maternal emotions’ ” (Lake 1982 cited by Maret 1997, 29). Equally strong and horrific reactions are thought to arise in the prenate in ‘opposition’ to these emotions including wishing death on the mother, a feeling which is split off and repressed as unacceptable and leads to “wounding at the level of being” of the prenate (Sills 2009, 173). Finally, if the umbilical affect is so strongly negative to be perceived as impossible to keep at bay, the prenate no longer wants to cling onto life, but instead turns to wishing death upon itself - the ‘transmarginal’ response (Maret 1997; Sills 2009). Shock responses are triggered, and an existential crisis arises as the prenate is “cast into non-being” (Sills 2009, 176), leading to detachment, dissociation and alienation strategies.

Maret (1997) does point out umbilical affect flow extends over the complete range of emotional possibilities; from one end of the spectrum, the prenate can experience their mother’s joy and approval as something that underpins a sense of acknowledgement, support and acceptance, whilst at the other polarity, maternal dismissal and suffering will (or can) be experienced as a “ ‘bitter black flood.. of incompatible and alien emotions’ ” (Lake 1981, cited in Maret 1997, 27). Elsewhere, Lake talked of the prenate being “marinated” in the mother’s miseries (House 1999, 451) whilst others, for example Verny and Kelly (2010), consider the wider relational field where pre-conceptual attitudes of both prospective mothers and prospective fathers, and their extended families, to such things as alcohol, smoking or other intoxicants are just as important. Deeply rooted predispositions such as positive self-esteem can derive from the attitude of a mother to her unborn child; if someone feels secure on the premise of feeling loved and wanted “from the very edge of consciousness onward” (Verny and Kelly 2010, 16), they will have what could be called a volitional impulse towards being deeply self-confident.
In summary, umbilical affect is the direct result of the transfer of physical and emotional states and although the flow is bidirectional in nature, much of the PPN literature focuses on the impacts in terms of imprinting on the prenate. These encounters with the mother’s affective state, good and bad, will inevitably arise through any pregnancy; what appears most important, according to the literature, is how both mother and the growing child within her are able to cope with them and whether there are consistent and continual patterns of behaviour or events at either end of the spectrum by the mother that affect the child in utero.

2.2.4.3 Womb-related loss

The PPN literature identifies losses in the womb as a major subjective experience and a significant contributor to imprinting for some people. The major focus of the literature is centred on the loss of a twin in the womb, be that at implantation or at a later stage. These instances are referred to as ‘vanishing twins’, which has a foundation in medical science (for example Bastry and Yinon 2022, or Landy and Keith 1998), whereas ‘twin loss’ or ‘loss of twin in the womb’ seems preferred in PPN literature (for example, Ward 2018, Appleton 2020 and Menzam-Sills 2021), and the person who has experiences of this is known as a ‘womb twin survivor’ (Hayton 2009, 2010, 2011). The vanishing twin phenomenon, or vanishing twin syndrome (VTS), the identification that the actual birth rate was lower than the conception rate due to spontaneous reductions from multiple gestations to singleton pregnancies, was first identified as a hypothesis in the 1940s. The ability to use ultrasound technology, and the improvements in it from the 1980s onwards, confirmed this sort of loss as a feature of pregnancy, with a reported prevalence of VTS between 15 and 35 percent, although the actual prevalence is likely to be higher due to non-detection (Land and Keith 1988; Bastry and Yinon 2022; Piontelli 1997). While an exact aetiology of the condition is still unclear, VTS can be defined more specifically as “first-trimester spontaneous loss of a twin, which is reabsorbed either partly or usually completely during pregnancy”, although most instances are asymptomatic and “first-trimester vaginal bleeding is the only clinical sign” (Bastry and Yinon 2022, 67).
As Hayton (2011, 79) underlines, the premise and hypothesis of her book “is that all the experiences you had in the womb are hard-wired into your brain as a vague but profound impression” and she covers in some detail how twin loss can be experienced at any time during a pregnancy, from implantation through the first, second and third trimesters. Reasons can include the following: developmental or congenital abnormalities, placenta problems, and ectopic pregnancies that need to be surgically removed (first trimester); premature delivery or miscarriage of one or both babies with only one surviving, poor implantation, and intrauterine growth restrictions (second trimester); and accidental death, stillbirth and infection (third trimester). Hayton (2011, 79-90) identifies “womb twin companions”, the various objects that could have been in the womb alongside any of us. Some of these objects are: fibroids (“benign tumours made of muscle fibres”, 85) which are relatively undetectable clinically, one study suggesting detection is as low as 40%; polyps, growths in the endometrium lining of the womb (86); and intra-uterine contraceptive devices, which have not succeeded in preventing pregnancy but will remain in the womb until birth (87). The implication is, as I understand it, that psychosocial and intersubjective womb-twin experiences may also occur with these other objects.

Womb-twin deliberations are related to another concept within PPN, that of the “haunted womb” syndrome, occurring “when a baby has died in the womb before the current pregnancy” and where any unprocessed grief becomes shadow material, denied or suppressed in the unconscious, and with which any new life comes into contact (Menzam-Sills 2020, 9). This idea is a derivation of the toxic womb, where the qualities of tissue and cells mirror in the residual emotional tones, and in regression clients may conceive themselves being in a graveyard, or feel the presence of the lost sibling (Appleton 2020). Albeit from a different perspective, Weinstein (2016) identified women who had experienced loss, unresolved grief and trauma before and during their childbearing years as vulnerable mothers, advocating for more awareness and support during pregnancy for those that might be more at risk.
To draw this section to a close, holding of grief and loss for many women more often relates to miscarriages that are known to be the loss of a child, rather than the possible loss of a twin which the mother may not know about. Weinstein (2016) cites some qualitative research with women who had suffered a miscarriage from Bansen and Stevens (1992), who established that there was a ‘code of silence’ around miscarriage, coupled with a sense of guilt, responsibility, and grief felt at the same level as for other family members and sometimes for what was perceived to be life-threatening pain and bleeding. Weinstein (2016, 217) also noted the intergenerational aspect of unresolved grief, how “unresolved preconception, prenatal and perinatal loss may be transmitted across generations and live in the shadow of the consciousness of families beneath awareness”, stating women that have suffered a miscarriage are likely to suffer higher levels of anxiety in later pregnancies. From another tradition, the philosophical holding of the Dagara tribe sees “miscarriage is a direct or indirect intervention of god or some dimensional beings known as the chièkuo (chi-è-ku-o)” (Somé 1999, 72); these are “beings who travel the galaxy and have been called the “travelers” or the “passing through” spirits”. These spirits find it difficult to leave their worlds and come into embodiment in the human realm; if one of them enters a woman’s womb, this is likely to end in a loss through miscarriage, or even sudden infant death syndrome or stillbirth.

2.2.5 Birth
As already established, the early psychoanalytic community, and in particular Rank, had an interest in the effects of birth on our psyches, and over time PPN has extended research and theorising to blend scientific, medical perspectives with more psychosocial, psychodynamic influences to seek understanding of the physiological, emotional and psychological effects of birth. Again, as a therapeutically oriented paradigm, PPN is especially interested in the negative impacts that may be associated with birth. My conjecture is that as part of its dialectical approach in conceptualising the potential impacts of birth, PPN makes use of the feminist critiques of modern birthing practices from the 1970s and 1980s that focussed on the experiences of birthing women, especially in the United States, such as Arms (1979, 1994) and Davis-Floyd (1992), although later on Davis-Floyd, Barclay, Daviss and
Tritten (2009) also reviewed alternative obstetrical and midwifery practices in other countries including Japan, England, Brazil, the Philippines and the Netherlands. However, my review would suggest that there is a weighting - rather than an exclusivity - towards the subjective experience and imprinting of the baby, who may now be an infant, child or adult in a therapeutic setting, rather than the birthing mother. The differentials between ‘natural’, ‘normal’, what I would call ‘medically assisted births’, and the potential for ‘traumatic’ birthing / ‘birth trauma’ are considered from different perspectives as well. Wilks (2017, 205) provides helpful definitions of ‘natural’ childbirth, “one where there is little or no human intervention”, and ‘normal’ birth which “may also include interventions to help the progress of labour” such (non)pharmacological pain relief, labour augmentation using artificial hormones. What I have term ‘medically assisted births’ is based on Wilks (2017, 205-206), who noted that many national guidelines do not include in their definitions of normal birth things like “forceps\textsuperscript{13}, ventouse\textsuperscript{14}, caesareans\textsuperscript{15}, routine episiotomy\textsuperscript{16} or continuous electronic foetal monitoring\textsuperscript{17} for low-risk births”. Castellino (2000, 34) cites the Dorland Illustrated Medical Dictionary (25\textsuperscript{th} edition) when defining birth trauma as “an injury to the infant received in or due to the process of being born. In some psychiatric theories, the psychic shock produced in an infant by the experience of being born”.

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\textsuperscript{13} “a pincer-like instrument designed to grasp an object so that it can be held firm or pulled. Specially designed forceps are used by surgeons and dentists in operations” (\textit{A Dictionary of Nursing}, 8th edition)

\textsuperscript{14} “a device to assist delivery consisting of a suction cup that is attached to the head of the fetus: traction is then applied slowly. It has now virtually replaced rotational obstetric forceps” (\textit{A Dictionary of Nursing}, 8th edition).

\textsuperscript{15} “a surgical operation for delivering a baby through the abdominal wall, usually by a transverse incision in the lower portion of the uterus (lower uterine segment C. s.). It is carried out when there are risks to the baby or to the mother from normal childbirth and may be performed, if necessary, as soon as the child is viable” (\textit{A Dictionary of Nursing}, 8th edition).

\textsuperscript{16} “an incision into the perineum during a difficult birth. The aim is to make delivery easier and to avoid extensive tearing of adjacent tissues” (\textit{A Dictionary of Nursing}, 8th edition).

\textsuperscript{17} “cardiotocography, the electronic monitoring of the fetal heart rate (detected by means of an external transducer or a fetal scalp electrode) and the frequency of uterine contractions (using a second transducer)” (\textit{A Dictionary of Nursing}, 8th edition).
The viewpoints can be dichotomous and contrary, both subjective and intersubjective. For example, even though birth is recognised as the primary relational milieu and as a relational process (Sills 2007; Appleton 2020), Appleton (2020, 133) also posits the historical perspectives that led to an assumption that babies could not feel pain or remember birth, whilst now systematically refuted by many studies, led to “a cultural blind spot” around birth as experienced by the baby. The origins of this dismissal of subjective experiences may be found in the strong case Arms (1979, 25) put forward when she wrote “the history of childbirth can be viewed as a gradual attempt by man to extricate the process of birth from woman and call it his own”. Arms’s contention was the patriarchal attempts to take control of childbirth led inexorably to the medicalisation of birth and its being orchestrated and performed by men, who possessed the scientific knowledge in society, and a continued rejection by them of the phronesis of women and their midwifery-oriented birthing practices (Davis-Floyd 1992). I would draw a link between the demonisation of natural birthing practices in this technocratic approach that led to “the modern deception… that birth is inherently dangerous, risky, painful, and terrifying” (Arms 1979, 14-15) with the paradoxical subjugation, applied by a paternal medical profession, that babies themselves were isolated from this experience due to their sensory tracts not being completely myelinated18 (Appleton 2020).

At the same time, even though for babies, wrote Karr-Morse and Wiley (2012, 85), “birth is a huge developmental transition … Even when they experience no complications of any sort, the unbuffered exposure to visual, tactile, olfactory and audial sensations… present an almost unimaginable adjustment, overwhelming in its impact”, the validity of the concept of “birth trauma” itself is debatable. As Turner and Turner (2018, 212) wryly note, not all births are traumatic, despite a trend that seeks to blame it “for just about every problem humanity must endure”. This also opens up the possibility for individuality of experience to be recognised – psychosocially and intersubjectively speaking, whilst for a mother birthing might have been easy, quick

18 “Myelination: the process in which myelin is laid down as an insulating layer around the axons of certain nerves)” (A Dictionary of Nursing, 8th edition).
or ‘normal’, the baby’s experience might have been different to hers, and vice-versa (Wilks 2017). Furthermore, as Davis-Floyd (1992) reasoned, the birth process creates four new social entities – the baby itself, the woman reborn into a new role as mother, the man reborn as father (as well as, I would add, any other partners who will parent where the biological father is not going to be a parent) and a family unit is also formed.

2.2.5.1 Birth from the baby’s perspective
These tensions within the debates notwithstanding, PPN has produced theoretical constructs around the impacts of birth on the baby. There is a connection between embodied experience and the psychological correlates that may derive from it. Grof (2017) defined a framework for four identifiable perinatal experiences from his clinical work which he called the Basic Perinatal Matrices (BPM), and birth within this matrix had three parts. In BPMII, representing the initial start of labour with uterine contractions, complications in delivery such as the baby’s position, pelvic obstructions or negative affective experiences (fear, confusion, stress) of the mother seemed to present constructs of universal engulfment, potential existential crises and a sense of ‘no way out’ where visions of hell realms occurred. In BPMIII, the journey through the birth canal, contained complex experiences with analogies of a death-rebirth struggle that were distinct from BPMII experiences. In BPMIV, he placed patients who often provided detailed biological descriptions of birthing experience itself and emerging out of the womb. These processes represented a polarised ending and resolution of the BPMIII struggle, firstly through an “ego death” experienced as “final biological destruction, emotional defeat, intellectual debacle, and the utmost moral humiliation… the very depth of total annihilation” which then was contrasted with “visions of blinding white or golden light… feelings of enormous decompression and expansion of space” (2017, 139), resulting in an ambience of love, forgiveness, freedom and salvation.

Sills (2007, 7) collaborated with William Emerson and Ray Castellino to further develop Grof’s three birth matrices into four stages: “inlet dynamics” (BPMII); a subdivision of BPMIII into “mid-pelvic dynamics” and “pelvic outlet dynamics”; and “birth
and the bonding/attachment period” (BPMIV). This work also redefined the more
typical three stages in obstetric medicine into four as it was felt that this more closely
related to the actual birth process movements and corresponding physical,
psychological, affective and existential spiritual experiences of the baby (Sills 2007;
Appleton 2020). To summarise the very detailed physical analysis of these stages
provided in the literature, in babies’ journeys down the canal they meet a number of
“conjunct sites … specific areas of the baby’s cranium or body that are in conjunction
with the bony aspects of the mother’s spine and body” (Appleton 2020, 143, italics in
original), creating a “conjunct pathway” that can result in significant postnatal, and
sometime lifelong, physical sensitivity and affective charge linked to them.

2.2.5.2 Obstetric interventions

Obstetric interventions include forceps, ventouse, caesarean and pharmacological
assistance delivered by medical teams during birth. The backdrop to the theoretical
development within PPN of the impacts and imprints seen to be left on babies,
children and adults who seek pre- and perinatal therapies draw on what I have
broadly designated the feminist critiques, such as Arms (1979) and Davis-Floyd
machine age is upon us” and these accounts claim birth became medicalised and
technocratic with the increased use of technology, reiterating the tensions between
‘natural’, ‘normal’ and ‘traumatic’ birth. This was further complicated by what Davis-
Floyd (1992, 5) discovered in her research, the “dissonance between feminist
critique of birth and the beliefs, desires, reactions, and behaviors of the women I was
interviewing”. She thereby recognized that most of her participants were “not raising
their voices in resistance… but in varying degrees of harmony and accord” (1992, 5)
with the perceptions of how birth ought to be conducted in a modern society.

I believe these critiques, however, do influence the PPN standpoint on obstetric
interventions as the arguments put forward by feminists are partially taken up in
various ways by PPN theorists, producing narrative structures which can be utilised
in various ways by those seeking better understanding of their Self and
intersubjective ways-of-being. In my reading of it, the basic premise within the
literature is that interventions can often be necessary to save the lives of babies and / or their mothers, but should be avoided unless there is a medical emergency because they with otherwise interrupt the natural rhythm, sequence and process of birth, and these processes can lead to attachment and bonding disruptions postnatally (Verny 1992; Karr-Morse and Wiley 2012; Menzam-Sills 2021; Emerson 1998, 2001; Flores 2018; Davis-Floyd 1992; Castellino 2000; Malloy 2015; Buckley 2003; Verny and Kelly 2010; Arms 1994; Wilks 2017; Verny and Weintraub 2003; Sansone 2021; Verdult 2021a; Conscious Embodiment Trainings 2015a).

Pharmacological interventions, for example, have been inculcated in effects on babies’ postnatal behaviours, such as the inability to settle, sleep and feed, as well as attachment and bonding difficulties with both mothers and babies (Wilks 2017; Menzam-Sills 2021; Emerson 1998; Conscious Embodiment Training 2015a). Moreover, because the placenta is not able to fully filter out chemicals in the mother's blood from the prenate, it is known that some of the effects of obstetric pharmacological drugs such as analgesics, synthetic oxytocin used in the stimulation of labour, and anaesthetics can be felt by the prenate. This can lead to a disconnection in the communication between mother and baby in their joint project of birthing, with potential bonding and attachment implications (Arms 1979; Verny and Kelly 2010; Wilks 2017).

2.2.5.3 Post-natal experience
Frank Lake’s womb of spirit included the first nine months of post-natal life, but it is not my intention here in this thesis, focussed as it is on womb-life and birth, to review other well-rehearsed literature on infant and child attachment theory (Bowlby 1997, 1998a, 1998b; Klaus, Kennell and Klaus 1995; Dallos 2007), more than it has already been mentioned. One specific concern associated with immediate post-natal life related to pre- and perinatal psychology that is important to highlight is the separation of child and mother immediately after birth, whether this is a cultural practice or from a medical need: “separating mother and baby has been shown to cause physiological distress in neonates… less synchronicity … and less likelihood of successful breastfeeding” (McCarty and Glenn 2008, 124). When babies need to
be placed in neonatal intensive care units (NICUs), sometimes colloquially called incubators, the separation often happens in emergency situations such as premature or caesarean section birth, and usually in combination with pharmacological interventions. There is a ‘double-bind’ element to these separations, which are fundamentally needed to save lives, but are shown to have psychological and emotional impacts for both mother and child (Chamberlain 1999; Kristoffersen, Steen, Rygh, Sognnaes, Follestad, Mohn, Nissen and Bergseng 2016; Fullmer 2005; Castellino, Takikawa and Wood 2001; Colton 2004; Emerson 1996). In addition, Karr-Morse and Wiley (2012, 80) noted that whilst babies are struggling for life in the NICU, they are also likely to be “enduring highly invasive procedures, including the insertion of needles, catheters and tubes in veins, arteries, lungs, bladder and stomach”, all needed to help nourish, monitor and otherwise keep them alive.

2.2.6 Section Summary

In this section, I have reviewed some of the main theoretical perspectives developed in the service of what I call the psycho-somatic-socio-therapeutic endeavours that the field of pre- and perinatal psychology and health seeks to address. In summary, PPN theory covers the complete range of experiences that we have all progressed through, in one way or another, in our embodiment journey as a human, from pre-conception elements, including intergenerational aspects, to conception, implantation, womb-life and birth. Feher (1980, 61) put it thus: “The nature of the interaction between psychological attitudes, beliefs, expectations and lifestyle-in-the-world, and the physical processes of the body become apparent as the process of pregnancy and birth unfolds”. The literature I have reviewed has shown the combination of the latest bio-medical scientific knowledge related to embryology, epigenetics and other physical environmental influences with psychodynamic-psychoanalytic assessments of the impacts that womb-life and birth can have on the construction of Self, which in my thesis includes theories of identity, personality and character, and our intersubjective relational ways-of-being. I will now show examples from the literature of the therapeutic applications of these theories, focussing on the psychotherapeutic use of them in the service of meaning-making processes for the client-patient.
2.3 Meaning-making in PPN therapeutic approaches

“Each person must in some way answer the basic questions life puts to us all: “Who and what am I? What is this world in which I live?”. We answer these questions with our lives, with how we identify ourselves, how we use our powers, how we relate to others, how we face all the possibilities and limitations of being human” (Bugental 1992, 5).

At its core, pre- and perinatal psychology and health is a therapeutic approach to how people can learn, grow and change as a result of exposure to and immersion in PPN thinking and practices. In this section, I will review the underpinnings of pre- and perinatal therapy and provide pertinent examples from the literature of the meaning-making that is reported by the patients, clients and participants in research projects. The construction of new meanings within therapy requires human reflexivity as well as the ability to process emotions to facilitate second-order or identity change (Greenberg and Angus 2004) and therapy of all kinds offer clients a “reflexive decentering from and the reengagement with distressing life experiences, from different relational vantage points” (Angus, Lewin, Bouffard and Rotondi-Trevisan 2004, 90). As Bugental (1999, 1, *italics* in original) noted, “Psychotherapy is not what you think. It is about *how* you think... about how you live with your emotions... about the perspectives you bring to relating with the people that matter to you” and Verny (1994) observed that all insight-oriented therapies aim to resolve unconscious conflicts to assist in the amelioration of symptoms, thereby improving mental health.

PPN, therefore, like other therapies, offers a chance to re-evaluate ways of thinking, but its clinical practice is usually based on a blend of somatically oriented techniques integrated with more traditional psychotherapeutic and explanatory psychoanalytic approaches. Glenn and Cappon (2013, no page) outline a range of therapeutic protocols for pre- and perinatal therapy, which require integrating embodied, implicit memories with narrativing experiences with a therapeutically-attuned other: “Telling their story to an attuned other, reflecting on their experience, “getting” their experience in the body, including having any emotions that may arise, feeling “felt,” and understood all help the patient develop a reflective function more than just talking about an experience”. Appleton (2020, 15), for example, explains how his
approach incorporates pre- and perinatal psychology, somatic therapy based on a Reichian body psychotherapy, and craniosacral therapy as well as transpersonal psychologies that addresses “the impulse to encounter transpersonal states of consciousness, which we could think of as a spiritual impulse” as these states “seem to be innate in human nature”. The transpersonal, spiritual elements of PPN theory are, as I will demonstrate, an important element in the reported experiences of patients / clients. For example, Grof (2017) reported transpersonal experiences seemed to occur with increasing frequency in clinical sessions after a patient / client had already integrated psychodynamic and perinatal elements. In his definition of transpersonal as “experiences involving an expansion or extension of consciousness beyond the usual ego boundaries and beyond the limitations of time and/or space” (2017, 155), he included prenate experiences (he called them embryonal and foetal), transcendence of the ego in interpersonal relationships, and spiritual experiences. The psychic content of his BPM contained, he said, “two important facets or components: biological and spiritual” (2017, 101).

Therapists in the field, therefore, “are willing and eager to take their clients on a journey to the dark wonderland of womb life in an attempt to reach and resolve the original or primal traumas that, in conjunction with subsequent traumas, led to aberrant development of the client's personality” (Verny 1994, 162). The basis of the understandings that arise from these journeys rests in the conceptualisation of cellular consciousness, cellular memory and somatic experiencing which create imprints that inform, guide and develop our relational ways-of-being. Patterned ways-of-being are explored in the somatically-oriented, psychoanalytic and/or psychotherapeutic clinical sessions undertaken to work with them through repatterning (Appleton 2021), including deliberately accessing them through regressive techniques (Appleton 2020). Repatterning in pre- and perinatal therapies relates the therapeutic treatment of shock and trauma symptoms in such a way that the client / patient is able to integrate them and avoid repeating unhelpful relational patterns that stem from that trauma (Emerson 1998; Castellino 2000; McCarty 2002; Rand, with Caldwell 2004). As Hartman and Zimberoff (2004, 29, italics in original), citing early psychoanalysts Franz Alexander and Thomas Morton French, explain:
“Alexander and French (1946) claimed that “re-experiencing the old, unsettled conflict but with a new ending is the secret of every penetrating therapeutic result.” The actual experience of a new solution to an old problematic pattern convinces the person that a new solution is possible, inducing him to replace the old neurotic patterns”.

This sort of re-patterning can also happen at an embodied and somatic level (Terry 2002; Dymoke 2017). It is thought that implicit procedural memory forms the basis for creating mental models or patterned ways-of-being in early life (Siegel and Hartzell 2014; Kalef 2014), what Levine (2015, 26, italics in original) called “fundamental organismic response tendencies of approach or avoidance, of attraction and repulsion”. Repatterning approaches need to be holistic in nature, as Emerson (1996, 125) points out, because “the effects of prenatal traumatization cannot be predicted without knowledge of other factors”, advocating that a broader and deeper understanding of a client’s history is required to be able to interpret the contribution of pre- or perinatal experiences. He gives the example that being stuck in the process of being born is unlikely, in and of itself, to lead to claustrophobic symptoms in later life, but subsequent events of being entrapped may well recapitulate that experience, so that “life experiences are perceived in terms of prior and unresolved traumas” (1996, 125). This is also the basis of other trauma theories, such as post-traumatic stress disorder; PPN theorists extend these back into the womb, thereby offering a broader framework for deeper understanding and therapeutic change.

An example of coming to an understanding of the impacts of PPN imprinting is given by Troya Turner (Turner and Turner 2018, 217-8): in synopsis, as a young woman, Turner worked as a psychiatric and social nurse on programmes for women with the eating disorders bulimia and anorexia nervosa. Having herself had those “same secret behaviours around food” and, considering them a form of “passive suicide”, she felt compelled to meditate on her birth. In the meditation, she ‘heard’ the voice of a doctor warn her mother during the pregnancy that her tipped uterus might result in a stillbirth. Her mother later confirmed this is what had indeed happened, even though she had not told anyone else of that conversation. Turner equates the turning
of her mother’s joy at being pregnant to feelings of “fear, terror, panic and disaster” about the potential death of her unborn child that created the imprint which caused Turner to have “suicidal strategy with food” because “the non-conscious thought which had created my disease and mother’s reaction to those seemingly prophetic words had been locked into me before I was born”. In the context of my thesis, Turner’s evaluation that this was “the key to my lifelong silent suffering” is a prime example of the constructing a narrative sense-making understanding of womb-life and birth.

2.3.1 Regression in PPN therapy

Pre- and perinatal therapeutic approaches are associated with ‘regression’ and ‘regressive’ experiences. The term ‘regression’ within psychological methodologies has different definitions “according to psychodynamic, psychiatric and religious models. From a psychodynamic perspective regression is a reversion or retreat to a developmentally earlier form of functioning - mentally, emotionally, socially or behaviorally” (Berke 2009, 1). The American Psychological Society (2023) defines it as “a return to a prior, lower state of cognitive, emotional, or behavioral functioning”; the connotation is that these responses can occur spontaneously in relation to a trigger, “a stimulus that elicits a reaction” (APA 2023), a prompting event that elicits a memory, accompanied with emotional arousal, of a past experience. Winnicott (1958b) provides what he came to accept as a spontaneous prenatal example from his clinical work. Before working with Winnicott, in psychoanalysis with someone else, the patient had several times previously “thrown herself off the couch in an hysterical way” (1958b, 229). During the subsequent two-year period of analysis with Winnicott, the patient also “repeatedly regressed to an early stage which was certainly prenatal. The birth process had to be relived” (1958b, 229) and this “deeper regression” with Winnicott allowed him to recognize “how this patient’s unconscious need to relive the birth process underlay what had previously been an hysterical falling off the couch” (1958b, 229).

Regression and regressive experiences, within a PPN therapeutic framework, fulcrum on a prevalent view that pre-natal life and birth, and the inherent imprints of
both negative and positive experiences (Kalef 2014), can be accessed and understood as the drivers for behaviour, especially unresolved traumatic impacts which play out in attachment modalities or life strategies and behaviours (Glenn and Cappon 2013). These views underpin a wide variety of experimental regression techniques developed from the 1960s onwards that have accessed pre- and perinatal themes, either organically such as the LSD-induced experiences of Grof (2017), Lake (2005) and Kafkalides (2005) or more deliberately, as the following illustrative studies in the field show: bio-energetics, deep breathing and other ‘holotropic’ techniques that replaced LSD use (Grof 2000; Chamberlain 1999; Raymond 1987; Lake 2005); primal therapy (Janov 1970); natal or (re)birthing therapy (Feher 1980; Laing 1976); primal integration therapy (House 2000); somatotropic therapy (Emerson 2002; Castellino 1996); cathartic regression therapy (Emerson 2021); polarity therapy (Castellino in White 2013); and hypnosis (Chamberlain 2013; Cheek 1986, 1992). All of these authors have written about their seminal studies of accessing pre- and perinatal experiences in these and other studies.

Verny (1994) suggests Nandor Fodor was the first psychoanalyst to advocate birth simulation techniques. Although vague about what his methodology was, Fodor “suggested that nurseries should provide tunnels through which children could crawl safely and abreact their birth traumas” (1994, 169). In more recent times, and particularly relevant to this thesis as its focus is on participant attendance of them, pre- and perinatal therapy practices often utilize “small-group settings with typically no more than seven participants, held over several days” (Haas 2017, 159), called various names such as prenatal and birth process workshops (Conscious Embodiment Training n.d.), womb-surround process workshops (Birthing Your Life n.d.; Castellino Trainings n.d.) or birth process workshops (Early Imprints n.d.). In the description that follows, I hope to give a sense of the format of regressions, which have a somewhat ritualised form, drawing on descriptions in Appleton (2021), Ridgway and House (2006), Pescek (2021) and Feher (1980), supplemented by my own experiential participation in them. It is important to note this is a general
description to give an idea of what an experiential regression may include, not a definitive process that is followed by all PPN therapists in all regression settings.

2.3.1.1 Experiential regression process

When a group of regression participants gather, there is often a period of pre- and perinatal psychology education aimed at the purpose of the event, or a settling and resourcing period, anchoring the process to create safety (Glenn and Cappon 2013). This pedagogic and orientation period allows both a settling into the space and, I might posit, provides a form of psychological priming of participants for the regressions to come. When it comes to the actual regressions, participants choose the order of participation, often by volunteering, but might also use a form of ritualized selection process such as drawing lots if several participants volunteer at the same time. The participant whose turn it is sits in the middle of a circle with the facilitator(s), usually a highly skilled and experienced prenatal therapist, surrounded by the other participants. In larger groups, the latter usually only ‘hold the space’ by silently observing but are sometimes actively involved in regressions, especially in smaller settings, such as triad process experiences, and use therapeutic skills whilst being overseen by experienced practitioners. Usually, the regression takes place on the floor on soft coverings such as futons and with access to cushions and other soft materials, allowing freedom of movement around the space, including laying down. The participants are, by various means, helped into their process, which remind me of psychotherapy sessions where what arises for the client in the space forms the basis for exploration.

During the actual regression, the facilitator ensures the participant stays ‘present’ enough and does not begin to dissociate or get lost in a trauma process, but stays ‘in the room’, resourced and able to report what is happening to them. Participants are therefore in frequent dialogue with the facilitator, describing what they are feeling, thinking or doing; – thoughts, sensations, images, memories, as I exampled in the Prologue. The ‘turn’ is completed either when the participant feels it is, or is encouraged to end by the facilitator. Often an initial ‘sharing’ is held, with the witnesses and therapist/facilitator, as well as the participant, reporting what they are
left with from the process. A more analytical exploration of what happened, where there is a more ‘cognitive’ engagement with both experience and theory, would only happen some time after the experience, for example the next day, to allow any emotional charge and resonances the participant is experiencing to dissipate. It is this integration work that begins to turn embodied experiences into storied or narrativized form.

2.3.2 Making meaning: examples from the literature

In this section, I provide examples from the literature of analytical interpretations, meaning-making and understanding for clients/patients based on PPN theories. What is evident in my review is the literature provides a variety of presentations of therapeutic work, from what Stake (2000, 437) might call “instrumental case studies”, where the aim of the authors is to give more generalised insight into the specific field of pre- and perinatal psychology, through to anecdotal reports, such as those gathered from parents via an on-line website survey, about the stories told by their infants and children of prenatal experiences (Carmen and Carmen 2019). Examples also include the somatic and embodied imprints identified by some therapists (for example, Larimore and Farrant 1995 and Appleton 2020) and numerous transpersonal, spiritual experiences. In order to give a structure to this collection, I will follow the breakdown in the theoretical literature review, gathering together in different sections, where possible, pre-conception and conception, implantation, womb-life (including umbilical affect and womb-loss) and birth experiences, and for brevity call these all ‘imprints’.

2.3.2.1 Pre-conception and conception imprints

Chamberlain (2013) provides a good starting point for pre-conception experiences, citing a story in Elizabeth Hallet’s Stories of the Unborn Soul (2002) about how a psychotherapist, who had not wanted to have children, was able to make sense of her subsequent pregnancy. The pregnancy occurred unexpectedly and despite having been told by her doctors conceiving would be impossible due to the severe endometriosis she had suffered from for years. The therapist had a recurring dream over the course of a year in which a toddler appeared, asking “ ‘Mommy, when are
you going to be ready for me?’ … ‘I am Timothy, your son’ ” (2013, 159). The dream recurred until the therapist conceived, without planning, a year later, convincing her that the son with whom she later gave birth had foretold his coming.

The implications of preconception imprinting from the spiritual dimension was hypothesised by William Emerson (Linn, Emerson, Linn and Linn 1999), based on his clinical work, who suggested three types of (pre)conception journey that provide explanation for some people’s different manifestations of character or personality. These rest on the idea of a (dis)connection from divinity - Emerson uses the word God from the Judeo-Christian tradition. Firstly, there are souls or spirits who are willing to be conceived and happy to be in the human realm, feeling no or very little severance from God. A second group, comprising the majority of his sample, reported an “understanding that it was in their best interests to be conceived and that there was a special purpose for their life on earth” (1999, 37); however, they expressed a reluctance to leave the divine realm and an on-going sense of separation from and yearning for God. Emerson called this “divine homesickness”, positing that depression, craving for materialist desires like power and money or for unsuccessfully searching for romantic love could be the result of an unresolved, unconscious divine homesickness and a longing to reconnect with God. In the final cluster, Emerson (1999, 38) saw “… a journey of exile, in which people feel exiled from or cast out of heaven… [these people] perceive the transition to earthly life as having been made with intense resistance and against their will”, and he links bonding and attachment disorders, as well as more serious forms of depression and craving, to this divine exile or divine betrayal which reveals itself as “outrage and anger towards God and all authority” (Sills 2007, 13). Appleton (2020, 74), using the term Source or the Ground of Spirit rather than God, states “Some people

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19 “Source”, as defined by Sills (2009, 5), “represents a field of interconnection and openness at the heart of the human condition” which he links to “the archetypal energies described by Carl Jung”, as “inherent emptiness or the radiance of pristine awareness” in some forms of Buddhism, and “as a personal or impersonal God, a Universal Principle, or Creative Intelligence that permeates the human condition and all of creation”.

20 A level of the psyche where Spirit and body meet, Spirit enabling the body to be living, and the body allowing a grounding of Spirit. This meeting together in the psyche creates the human soul (Appleton 2020).
experience leaving Source as painful”, whilst also noting this ‘leaving’ is actually a
differentiation rather than something we fully lose. He groups those who experience
divine homesickness and divine betrayal as “reluctant embodiers” (2020, 74, *italics* in
original), a term that helps people conceptualise how their felt sense of shock,
disorientation, resignation, confusion, grief and denial (Menzam-Sills 2021) as well
as existential issues, suicidal inclinations and neurotic processes (Sills 2007) may
have come from losing connection with divine oneness. When explained in PPN
therapy, clients often have a sense of resonance or knowingness with the concepts
of both divine homesickness and reluctant embodiment which provides a deeper
understanding of their relationship to the world.

According to Terry (2008, 137), the psychological and emotional states of the father
as well as the time, place and relational situation of the parents “all had impacts on
your soul’s embodiment process”, which in turn has an influence on our ways-of-
being. He suggests the sort of themes that arise as psychologically imprinted
material include issues around journeys, transitions, the use and regulation of energy
in both physical movement and psychologically dealing with challenges, as well as
trust and intimacy in relationships. The idea of conception being linked to spirituality
can also be seen in other traditions, providing transpersonal explanations for our
existence that may offer healing perspectives to reluctant embodiers. For example,
Somé (1999, 24) suggests, from the perspective her traditional West African
teachings, that every relationship has a spiritual dimension to it, including the
relationship formed with the incoming soul before conception, and that all of us come
into life with a purpose, whilst Chamberlain (2013) cites Tibetan Buddhist belief as
seeing conception as an agreement between the karmic cooperation of the future
parents with the consciousness of the soul to be born.

Providing explanations of unexplained grief, in regression work the inevitable
departure from the ovary of an ovum to begin the conception journey can be felt as a
loss of ‘sisterhood’ of the eggs left behind (Sills 2007; Menzam-Sills 2021), a feeling
made more poignant due to the length of time they have co-existed with those left
behind, due to the genetic processes creating them whilst their mother was in her
own mother’s womb (Mbiydzenyuy, Hemmings and Qulu 2022; Mensam-Sills 2021; Assman 2021). Larimore and Farrant (1995) report regressive clients experiencing a sense of danger when undertaking the egg journey, due to entering the ‘space’ of previous conceptions, pregnancies and various womb losses (unfertilized eggs and miscarried or aborted pregnancies), which suggests a form of historical energetic resonance of these experiences retained in the body of the mother, the “haunted womb”, and ‘felt’ through the cellular consciousness of the egg. Embodied displays in regression for egg journeys that demonstrate imprinting include counter-clockwise movements of clients lying on their left hips, bent knees with open-wide legs and open arms and hands. Appleton (2020, 86) also identifies a body movement called “… the ovulation arch. It often arises spontaneously as a desire to arch back and in doing so complete a circle”; he suggests this is an embodied emulation of the ovulation process, described above as the odyssey phase of the journey. Larimore and Farrant (1995) describe the typical embodied movements and felt senses expressed by clients in regressive sperm experiences as feelings tension and urgency prior to ejaculation as well as the emotional expressions on their father (including anger, guilt and shame), wrist- and hand-flicking followed by rhythmic, wave-like total body movements and fertilization as burrowing the top of the head, between the crown and the forehead. In terms of emotional imprints, in addition to carrying the father’s unwanted affective states like anger, guilt and shame, clients have expressed feelings of rejection and inadequacy when the(ir) sperm is considered the opposite biological sex to that which the egg ‘wanted’ (Sills 2007; Larimore and Farrent 1995).

In terms of fertilization, Nantel (2017, 4) reflecting on her psychotherapeutic work, concluded “conception was a much more meaningful, possibly spiritual, event than the result of the random meeting of an ovum with a spermatozoid, at a time of her month when a woman happened to be fertile”. Regressive clients have also expressed the potential for ecstatic joy around the coming together of egg and sperm, or alternatively anger, violence, fear, and confusion (Appleton 2020). Sills (2007) additionally reports feelings of shock, dissociation, being engulfed or smothered (in the ‘being surrounded’ sense) as well as not being welcome in these
regressions, the imprints of which are associated with trust and safety issues in intimate relationships later in life.

2.3.2.2 Implantation imprints

Michael Farrant, in his personal regression work, experienced resting in the fallopian tube as part of the movement towards implanting, sensing this movement “was a time of spiritual reappraisal … another kind of breathing space where the fertilized egg takes stock of its origins, its pre-gamete truth as a spirit or soul” (Raymond 1988, cited in McCarty 2012, 38). However, other theorists explain how the blastocyst arrives at the uterus effectively famishing, with the desperate need to implant in order to get nourishment and survive leaving psychological imprints; if these sorts of “starving” experiences happen in regression, it can provide understanding and meaning-making for how the implantation process may have led to life-long implications for someone’s relationship to food, and may be the basis, through recapitulation, for later eating disorders like anorexia, bulimia or overeating (Menzam-Sills 2021, 2023; Terry 2013b).

From a spiritual or transpersonal standpoint implantation, like conception, has been linked with later feelings of divine homesickness and divine exile (Sills 2007), a psychological state “in which the soul experiences loss, rejection, inadequacy and shame at leaving the spirit world, and longs to return” (Hartman and Zimberoff 2004, 58). Furthermore, experiences in later life such as forming relationships of all kinds, struggling to feel at home somewhere, or finding it difficult to settle in one place may be associated with this first encountering of connection (Axness 2016; Menzam-Sills 2023; Sills 2007; Hartman and Zimberoff 2004). Conversely, and paradoxically, Lake (2005, 63) wrote, from a Christian theological perspective, of workshop participants regressing to conception and implantation as a time of being “… perfectly self-subsistent… of ‘being’, of ‘awareness’ and ‘joy’ of having God and the universe within this perfect sphere which they feel themselves to be”. Here Lake echoes Seaborn-Jones’s blissful experience of intrauterine life (Posey 1977).
In regressions, the physical location of embodied implantation affect is sited at the glabella, an area slightly above the eyes and in the centre of the forehead (thought to be because cells from the original implantation site migrate to this area during development). Regressive participants adopt “the implantation posture… on the floor, with the legs tucked behind them, forehead pressed against the ground, arms either by the side or … in front of the head” (Appleton 2020, 91). Clients can also be seen to enact a “gentle “burrowing” action of the head … and “grasping” movements of the hands” (Larimore and Farrant 1995, 23). Another occurrence, associated with toxicity in the womb such as nicotine or alcohol effects, is clients having “the urge to spit or cough”, reporting “the sense of having swallowed something that doesn’t taste good”, accompanied with rocking motions and pushing the head onto the floor which “expresses the protoplasmic movements of the blastocyst, in its attempts to clear the toxicity” (Appleton 2020, 92).

2.3.2.3 Womb-life imprints
Starting with pregnancy discovery imprints, Emerson (1996, 136) reported that many of his clients realised, through regression, that their “lifelong episodes of depression, self-destructiveness, or aggression are a direct expression of prenatal rejection”. Appleton (2020, 105) has identified adults with discovery trauma “are usually very sensitive to being looked at, to speaking in public or showing up to new places” and sometimes have a pervasive, unconscious sense of not being good enough, a fear of being rejected or always being wrong, “to stay small or invisible to avoid rejection… having difficulty recognizing and receiving love, appreciation, or recognition” (Menzam-Sills 2023, 5). The shock of a later discovery, several months into the pregnancy, can be just as impactful, leading to similar themes of not wanting to be seen as well as feeling alone in life (Appleton 2020). Yet at the same time, as in other areas of our prenatal experiences, “we, also, have great resilience and the capacity for creative adaptation” (Appleton 2020, 107) to the less-than-ideal circumstances that may have been experienced.

Therapeutically, umbilical affect can be “a very emotionally charged area that needs to be engaged with very carefully” as “the history of the prenatal relationship is
One potential coping defence in the womb against negative umbilical affect, if prenates are psychologically stronger than the mother, may result in attempts to help by taking on and introjecting mother’s distress and pain, becoming a “fetal therapist” (Sills 2009, 142, *italics* in original). Understanding the imprint of this function might help clients explain a predisposition to take on caring and helping roles or careers, or defend social or political causes, as well as a shadow of denial and disregard of self-needs. Psychological rejection of a pregnancy can be felt as negative umbilical affect by the prenate and appear in postnatal behaviours: Verny and Kelly (2010) relate a case of a newborn refusing to bond with her mother and suckle, without having any such problems with a nurse. The mother’s gynaecologist established directly from the mother that her child was unwanted, and that the mother wanted to terminate the pregnancy; this rejection and lack of intrauterine bonding had stayed with the child once born and manifested itself in a volitional impulse to protect herself from the mother, even by refusing food. Kafkalides constructed a view of ‘rejecting’ or ‘accepting’ wombs from his clinical work (Kafkalides and Kafkalides 2017). In the paradoxical case of a man who had been “loved, over-accepted and wanted” (2017, 92) by his mother but still displayed the symptoms of a prenate from a rejecting womb, Kafkalides implicated the wider relational field of the mother, such as the father, mother-in-law or others, contributing to the “rejecting womb… the subjective feeling of the fetus during its embryonic life… [which] does not presuppose always the conscious rejection of the fetus by the mother” (2017, 92).

Womb-loss has also been experienced in pre- and perinatal therapy. Hayton (2011, xv), for example, having discovered herself that she was a womb twin survivor - in her words “I suddenly came to the conclusion that I had once had a twin but my twin died before I was born”– established a self-funded research project, a 59-item questionnaire which between 2007 and 2011 had responses from 877 verified cases of womb-twin survivors (wombtwin.com, n.d.). She and her collaborators identified a number of common psychological themes, including having a fragile sense of self and feeling something is missing in life, having two distinct personalities or characters and feeling oneself to be very unusual, such as being too empathic or
wanting to heal the world. Other themes she identified were having difficult feelings that include loneliness, anxious-ambivalence and abandonment fears in relationships, feeling a deep sense of inexplicable guilt and, for some, spending “their lives re-enacting the life and death of their womb twin... death feels as if it very near” (Hayton 2011, 202).

Several of these themes can also be identified in the brief case vignette by Piontelli (1997) of Jacob, an infant of eighteen months who had a confirmed experience of twin loss just prior to his birth. Piontelli identifies this case is what drew her into a detailed longitudinal study of twins and their intersubjective relational lives pre- and perinatally, using ultrasound viewings of pregnancies as well as post-natal visits to the children. Working psychoanalytically with Jacob, she had observed him moving about “restlessly almost if obsessed by a search for something in every possible corner” and shaking “several of the objects inside my room, as if trying to bring them back to life”, seeming to have a fear that “each step forward in his development... might have been accompanied by the death of a loved one for whom he felt himself responsible” (1997, 18). Similarly, Dilcher (2021) presents the case of Erik, a 4-year-old boy, who lost a twin in the 16th week of pregnancy (second trimester); he had separation anxieties as he grew up and needed a lot of tactile contact with important others, becoming sad, scared and even hysterical if this was not forthcoming. Although his mother believed that Erik did not remember the event of losing his brother, she provided 14 drawings he had done, randomly selected by her, thirteen of which showed age-appropriate depictions of two people, usually framed with edges on the paper, in different proximities to each other. Asked about them, “Erik answers, they show him and his preferred superhero” (2021, 335) and his mother subsequently accepted that many of these drawings depicted twins in the womb. Dilcher (2021, 335) concludes “Being able to draw the lost brother as a superhero was his method to convert his fear and the horror of his twin brother’s death into a healing illusion”.

Appleton (2020) has observed strong emotions and imagery, along with specific body postures and movements, on multiple occasions in his clinical work and
regression workshops that he associated with twin loss in the womb, including at implantation. In addition, he says, for the survivor, the guilt and grief they are left with from the loss of their twin is equivalent to the sorts of grieving associated with commonly accepted bereavements; therapeutic regression work helps explain and integrate these powerful emotions. From a spiritually-oriented perspective, Carmen and Carmen (2019) relate a number of stories of children remembering their past lives and making decisions to leave before being born. One example helped explain an adult woman’s life-long fear of showers: Elizabeth Mitchell remembered leaving her mother, who was showering at the time, through a miscarriage when she was an 11-week-old prenate. She had told her mother when she was a toddler “‘I was in your tummy twice. The first time, I washed away. The second time, I came out like a zipper’” – she had been born by caesarean section (2019, 256-7). Somé has come to realise she is a chièkuo, a passing-through spirit, and had been miscarried twice by her mother, then died in infancy after a third pregnancy, “returning home” to the spirit world (1999, 73); in her current (fourth) incarnation, she has often thought about leaving again, but the relationship she built with her mother, supported by the “determination of my people to keep me here” through a “long and emotionally intense process … led to my staying here” (1999, 74).

2.3.2.4 Birth imprints
The clinical illustration provided by Winnicott (1958b), cited above, provides a good example of a case history or study. Grof (2017, 101) witnessed in his patients’ LSD therapy “concrete and rather realistic experiences related to the individual stages of the biological delivery” in conjunction with corresponding spiritual counterpoints. Grof (2017, 57 - 60) provides the case of a 26-year-old patient called ‘Richard’, whose behaviours and symptoms include depression, anxiety and unsatisfying sexual practices. The numerous LSD-induced therapy sessions Grof conducted with ‘Richard’ revealed a history of abuse by the patient’s father along with other childhood traumas. These sessions progressively led ‘Richard’ to a connection between birth trauma and his ways-of-being; Grof (2017, 60) summarised the therapeutic change for the patient the experiences of rebirth brought about as bringing “far-reaching improvement of the clinical condition. His depressions,
anxieties, and psychosomatic symptoms completely disappeared, and he felt full of activity and optimism”.

Sills (2007) and Appleton (2020) have provided many details about how regression work helps participants understand lifelong ways of being. During regressions, reluctant embodiers or those who experienced negative umbilical affect may feel resistant to the process of being ‘born’, feeling rage or alternatively a sense of collapse, depression and giving up, impacting self-esteem. These experiences can be mapped onto emotional and psychological correlations in life-long reactions to being under stress or pressure; for example, writing a PhD thesis may lead to behaviours like procrastination, or writing right up to the deadline alongside feelings of failure. Progress in birth regressions, especially as a form of repatterning, can also sometimes instil a sense of confidence, of moving forward in life, with endurance and energy. Conversely, regressions can help identify when people may have been stuck in the birth canal as part of the natural stop-start processes related to the contractions and gradual opening of the cervix, and how their senses of betrayal, resignation and mood swings in relationships may be explained by this, inculcating ‘life statement’ positions such as always getting things wrong, always taking the most difficult path or being to blame for others pain. Existential and spiritual connotations may also be evident, the exacerbation of divine homesickness or exile being extended to feelings of being rejected by God or cast out of Heaven. During the ‘arrival dynamics’, how the baby is met by the birthing ‘team’, such as how the umbilical cord is cut, how initial contact with mother is made or how various tests are conducted, can have implications for psychological health. Especially difficult is being separated from mother, more so if the baby needs to be housed in a neonatal intensive care unit (NICU), where separation anxiety along with a felt sense of being abandoned, not being welcome or being to blame can be imprinted.

Understanding the imprints of caesarean birth has also been investigated to explain imprints in adults. Ridgway and House (2006, 103) cite the work of Leslie Feher, who described how “The “Caesarean” personality needs a lot of help achieving goals”, with a tendency to blame their failures on the lack of support from others, whilst also
conversely having dispositions of enthusiasm, spontaneity and artistic talents (Shapira 2017). Verny refers to one of his adult patients having a caesarean birth imprint of having a powerful yearning for tactile contact of all kinds (Verny and Kelly 2010), whereas Emerson (1998), reiterating that traumas are typically multifactorial, also evidenced tactile defensiveness in his clinical work with caesarean babies and adults, even though the latter may have conscious attitudes of being affectionate to others. From a narrative perspective, English (1995) and Milliken (2007) have researched their own and other people’s experiences of caesarean section births. English (1995, 3-4) juxtaposes her wonder and amazement of how she had been born when witnessing a caesarean section later in life, how “the awesomeness of the experience” of “A human being entering the world through this different doorway, this extraordinary way to enter the world” at the same time reminded her of the fear imprint she had experienced as a child when dentists used suction on her mouth, as this is the first thing that happens to the baby on being lifted out of the womb. Likewise, when it came to pulling the baby out, witnessing it was “more than I could fully handle. I think the hardest part of my birth was when they pulled on my head. It is like being killed”, the baby being suddenly stretched rather than experiencing the gradual movements of labour. Finding out more about the imprints of her birth was critical to English being able to transition past and transcend the unconscious birth patterns she was stuck in and live more fully, with much more awareness of what being a human was about. Milliken (2007, 130) also realised that her caesarean birth had left life patterns of staying “in uncomfortable situations, waiting for someone to rescue me” and the recurring dream she had as a child of “falling next to the sharp edge of a very large razor blade”, abruptly waking up when she pulled away from the blade in her dream.

Similar imprints can happen for those born with forceps and ventouse interventions and there can also be residual shock effects at the sudden transition from womb to outside world, in combination with potential anaesthetic shock; these effects can be triggered in later-life during stressful situations, including embodied feelings around the head and neck area (Milliken 2007; Emerson 1998; Conscious Embodiment Training 2015a; Appleton 2017; Weinstein 2016).
Appleton (2020) and Terry (2021), in their clinical work with babies, children and adults, have identified a number of embodied and psychological imprints and strategies that arise out of umbilical affect. The resultant “Baby Body Language: Non-volitional/non-random body language that is expressed in movements the baby makes” (Terry 2021, 320) – also seen in infants, children and adults – are considered to be embodied reactions to toxicity experienced in the womb, including nicotine, bacterial or viral elements, high levels of stress hormones and / or narcotics. These embodied movements can also be seen in what they have called Metaphorical Umbilical Mouth Movements21 (MUMMs), as feeding postnatally transfers to the mouth; issues with toxicity in the womb may manifest in the pursing of lip and the sucking in of breath as little as possible through these closed lips, which also has the effect of tightening the diaphragm, sometimes accompanied by coughing, the “Umbilical Cough Reflex” (2020, 114). Alternatively, habitual sharp intakes of breath, licking lips or grimacing in response to stressful situations can be MUMMs. All these movements can often be seen in babies, children and adults outwith the consulting room, and might be demonstrated in psychological ways, such as difficult relationships with money and love (Appleton 2020).

Pharmacological imprints from drugs used during birth help explain disorientation and dissociation in stressful situations, as well as links to later addictive behaviours with alcohol, drugs and nicotine, or alternatively an avoidant recapitulation of aversion to things that would affect internal body environments, including rich foods, caffeine and fear around viruses (Wilks 2017; Menzam-Sills 2021; Emerson 1998; Conscious Embodiment Training 2015a). McCarty (2002) explained the defensive and disoriented behaviours, indicating unease, fear and wariness, in a case study of her clinical work with 3 ½-month-old baby Anna who was born with the help of a ventouse after a synthetic oxytocin-induced labour lasting 20 hours and spending five days recovering in a NICU. Anna’s sympathetic nervous system was activated in

21 A theory developed by Karlton Terry, who suggested that issues related to the umbilical cord in utero, physical and emotional, can often be seen in children and adults as mouth movements, like the pursing of lips, under stressful or difficult conditions, as they represent the postnatal equivalent of taking in food and air, and expelling carbon dioxide, of the umbilical cord (Appleton 2021)
therapy and as she appeared to reach overwhelm, she looked as if she was
dissociating, loosing eye contact and staring at the patterned dress of her mother.
McCarty (2002, 351) concluded Anna’s behaviours in the initial therapy session
demonstrated “a great deal about the beliefs and expectations that were already
embedded in her perceptions from her previous experiences of multiple interventions
at birth and in the NICU”, with subsequent therapy assisting her to regulate more.

2.3.3 Section summary
The range of imprints that can occur pre- and perinatally is evidently wide-ranging
and mirror other therapeutic explanatory frameworks for issues related to the
psychodynamics of development, and the potential resultant relational character
strategies that translate as individual identity and personality. Within this thesis, as
with other literature in the field, these different impacts have been drawn together to
highlight the areas of prenatal life and birth that potentially affect people.

The self-awareness of the adversities we have faced in life, including pre- and
perinatally, brought about by therapies can offer a “galvanizing power”, allowing a
recognition of “the transformational gifts that are inherent in every experience”
(Appleton 2020, 87). However, several authors, including Appleton (2020) as well as
Verny (1994), Emerson (1996), and Menzam-Sills (2021), caution against becoming
reductionist in considering the impacts and imprints of pre- and perinatal life,
because, as Appleton (2020, 12) observes, such reductionism is a “shadow side of
this self-awareness” and can create an attitude “whereby all life’s struggles are
accounted for by specific pre and perinatal ‘issues’.” There can be “a tendency in pre
and perinatal psychology, as in most approaches, to reduce human experience to
this or that causative factor” Appleton (2020, 87) remarks, with the danger that “we,
then, become the victims of our experience, with very literal stories that keep us
stuck within our victimhood”. What was evident to me as I reviewed the literature was
how differentiated in style the presentations of the imprints and impacts of pre- and
perinatal life are, as noted in the introduction to the section and demonstrated in the
examples I have provided. Appleton’s (2020) call for the potential transformative
nature of experiences rather than getting stuck in victim stories made me consider
the narrative therapeutic potential that womb-life and birth storying offers. What I started to identify in my PPN literature review was a lack of translating the regression experiences, other therapeutic interventions and the educative elements in terms that were recognisably a narrative therapeutic approach, even though it was clear that the case studies, stories and autobiographical accounts had a narrativizing flavour to them.

It seemed to me during my review that the combination of narrative therapeutic approaches to the understanding of our worlds combined with the pre- and perinatal perspectives was most pertinent, especially in bringing understanding to the intersubjective, phenomenological and existential experience of being human. Moreover, there seemed to be an interplay and a tension between the self-awareness that brought an understanding to character strategies, personality formations and identity constructions, and the psychosocial relationalities that womb-life and birth infers. I therefore turn in the next section to my review of narrative therapeutic approaches to investigate the overlap with pre- and perinatal psychology’s methodologies.

2.4 Stories, narratives and therapy

“Man is in his actions and practice, as well as in his fictions, essentially a story-telling animal. He is not essentially, but becomes through his history, a teller of stories that aspire to truth” (MacIntyre 2007, 216)

“The very history of humankind is a story full of stories” Botella, Herrero, Pacheco and Corbella (2004, 119) declare: it is through stories that we live, work, rest, fall in love, tell our family and cultural anecdotes, myths and traditions, understand our spirituality and transpersonal experiences. “Stories are the fabric of our private lives, our relational networks, our social traditions, and our cultural and historical institutions” (2004, 119). Psychology as a function has a long-held interest in storying, from Freud, Adler and Jung onwards, and its contribution to research in case studies, (auto)biographies, personality, life-span development, life scripts and meta-stories, symbols and myth in culture (Hiles and Čermák 2010). Paul Ricoeur (1984, 1985, 1988), a philosopher of narrative, explored the interrelationship
between narrative and time and emphasized that narrative understanding was a fundamental component in the comprehension of essential and specific elements of the human realm. At the heart of it, storytelling is not just a fundamental human activity, it is about symbolizing and communicating something to someone else (McLeod 1997; Gonçalves, Henriques and Machado 2004). The kind of truth to which MacIntyre (2007) refers, in his declaration of man(kind) as an animal that essentially tells stories, is about the personal making of meaning from understanding the experiences of our lives (Anderson 2004; Botella, Herrero, Pacheco and Corbella 2004; Speedy 2008). McLeod (1997, 31) defines a story as “an account of a specific event” and Hiles and Čermák (2010, 149) tell us “Events do not present themselves as stories, but it is the experience of an event that becomes a story”, citing Ricoeur who stressed that “story is ‘always preceded by a narrative intelligence that issues from [a human] creative intelligence’.”

A distinction between ‘story’ and ‘narrative’ can therefore be made; narrative is the linking together of individual events and actions in a storied form which can be reflected and commented upon by the teller and the listener(s) as an amalgamated, contextualized whole (Polkinghorne 1988, 2004; McLeod 1997); it is the language form through which people understand their lives (Gonçalves, Henriques and Machado 2004; Freeman 2015). Polkinghorne (1988, 1, my emphasis) believed that narrative was “the primary form by which human experience is made meaningful”. Whilst I think that “the” can be challenged, and has been – for example, most effectively by Liu (2019) - many in the social sciences see narrative, or at least the telling of stories, as a principal means of human knowing, a creative and interpretive ‘portal’ to human capabilities and reasoning (Riessman 1993; Greenberg and Angus 2004; Hiles, Čermák and Chrz 2017), used by us to influence the lives we live (Speedy, 2008). Siegel (2012, 12) explains “…the mind encodes elements of experience into various forms of representation…[whereby] mental models of the self and the self with others are created… The narrative process is one way that the mind attempts to integrate these varied representations and mental models”. Hiles and Čermák (2010) also consider narrative as an essential element of the human mind, being more than just a form of discourse or a literary genre, and Siegel (2012)
highlights how the constructing of autobiographical narratives provides an essential integrative function between someone’s own internal sense of themselves, as well as of their interpersonal relationships with others.

Within a therapeutic approach, people are viewed as “unique histories” (Polkinghorne 2004, 53), giving meaning to what has happened to them and, importantly, how constructing stories about their lives enables them to act. Woodward (2015, 46-47) makes a significant observation that I consider applicable to pre- and perinatal psychology, and the investigations of womb-life and birth: “The extension of understanding of social phenomena through personal stories and through analysis and therapy also requires crossing the boundaries of normality and abnormality and pathology” which necessitates a psycho-social, intersubjective approach. I will now turn to considering the construction of Self and intersubjectivity that permeates psychosocial approaches to the nature of being, as these constructs are an important element of the narrative therapeutic approaches being explored in my thesis.

2.4.1 Self and intersubjectivity
Understanding concepts about Self and intersubjectivity and their relation to narrative as I apply them to my thesis on pre- and perinatal life is important. As a starting point, in this thesis I use Self (with a capital ‘S’) rather than self (with a small ‘s’), based on the Jungian constructs of ego and Self as defined by Stevens (2001, 8): the ego, equivalent to Jung’s No.1, was “the son of his parents, went to school and coped with life as well as he could”; the Self, No.2, was “much older, remote from the world of human society, but close to nature and animals, to dreams and to God”. Sometimes subtle, sometimes obvious “the play and counterplay between them constitutes the central dynamic of personality development” (2001, 8). Yet there are also often overlaps in the literature between self or selfhood (small s), identity, personality and character which are worth briefly reviewing: my argument for this thesis is, because it is an investigation based on various aspects of human psychology that arise from the intersubjective ground of womb-life in birth, all
aspects can be seen in the PPN and narrative-focused literature, and so I will use Self as my preferred term to cover them.

The first three – selfhood, identity and personality and their respective associations and deviations as “interweaving themes” - have been effectively reviewed by Arciero and Bondolfi (2009, 1). What they call “selfhood” or “ipseity” (after “the continental hermeneutic–phenomenological tradition”), emphasizes how individuals can be consciously aware of themselves in and through the happenings and dealings with others in their daily lives. This, they note, “emerges from the ontological need to grasp individuals from their ways of being rather than by conceptualizing them according to the same categories that are applied to objects” (2009, 1). Identity is related to ‘who’ a person is or feels themselves to be from a relatively temporal dimension, the aspect of selfhood that is stable over time. Importantly for the arguments I am making, Arciero and Bondolfi (2009, 1) align identity with the narrative, drawing on Ricoeur, “as the act by means of which personal identity takes shape while events interweave to form a plot”; historical identity thus is derived through various forms of narrative. Finally, personality comes about from the various emotional inclinations that take shape over the course of someone’s life, and are reproduced in the composition of personal stories, where variances in narratives “reflect different ways of experiencing one’s own life”.

Meanwhile, and although much debated, the term ‘character’ is often used interchangeably in psychology with personality (Kupperman 1995; Fleeson, Furr, Jayawickreme, Meindl and Helzer 2014). One example is Winnicott (2005, 3), in a perinatal context, saying “A great deal happens in the first year of life of the human infant … in a study of the evolution of personality and character it is not possible to ignore the events of the first days and hours (even the last part of prenatal life when the infant is post-mature); and even birth experience may be significant”. Character also has a subtle undertone of morality associated with it, which interact to influence how someone acts, and form the long-standing individual psychological differences of traits, values and ideologies (Fleeson et al. 2014). Bollas (2018, 19) argues that character is “a subjective recollection of the person’s past” as well as “an aesthetic of
being” because we internalize the “phenomenological reality of the maternal aesthetic”, an internalization of the process of an idiom of care that forms and transforms the Self, something that resonates with PPN theory. In general terms within this thesis, Self will be used to designate these different aspects of personhood.

Self, however, is a sticky concept to define precisely, eluding a range of psychological disciplines, “a surprisingly quirky idea - intuitively obvious to common sense yet notoriously evasive to definition by the fastidious philosopher” (Bruner 2004, 3). Personality and a sense of personal identity are implicated in the descriptions ego and Self as described by Stevens (2001) and Bruner (2004, 5) brought a transpersonal element to the dynamic aspect to Self when he wrote “Self and soul have forever been yin and yang in the Judeo-Christian tradition”. I hold that ego and Self are inter-active (in the sense of acting between subjects) and intra-active (in the sense of acting internally within our Selves), elements of personality. Conceived this way, they fit well with descriptions within PPN theories, where the prenatal Self has autonomy of affect, agency, subjectivity and a sense of independence whilst being interlinked with, and inseparable from, intersubjective relationalities, most obviously to mother but also to the intergenerational familial-socio-cultural field, and to the Divine. This aligns with views held by William James, the nineteenth century psychologist, who “believed that development of a personal identity or self is an ongoing effort that involves the synthesis of many different ideas about oneself and its multiple facets into a single idea of self” (Polkinghorne 1988, 149); the facets include the “material self” (body), the “social self” and the “spiritual self”.

At some level then, we humans can identify a sense of an individuated, subjective Self, that is, a sense of Me being distinct and different from Not-me (Abram 2007); we associate this Me with the self-as-known rather than an “I”, the self-as-knower, another distinction conceptualised by William James (Hermans 2004). May (1996, 8, italics in the original) called this “the human dilemma” which arises out of the capacity to experience ourselves “as both subject and object at the same time. Both
are necessary - for the science of psychology, for therapy and for gratifying living". The Me can be considered a “constellation of psycho-emotional-physiological processes”, according to Sills (2009, 6), a sense of Self that becomes available to us in relation to something else – an Other – be that the environment in which we feel ourselves to exist, in relation to another being (human or non-human) or our transpersonal connection to the Divine. It is less a discrete object in Sills’s conception, therefore, and more a “dynamic matrix of energy-exchange processes that organize internally” (2009, 6), a perspective echoed by Mitchell (1988), whose position is Self cannot be perceived separately from relations with others in any consequentially psychological sense. Hence, from a position of narrative construction, separating out narratives of Self from narratives that include Other is a somewhat arbitrary task, fraught with overlaps and potential contradictions given the dialectic interplay between the self-as-an-object and the self-in-relation-to-other. At the same time, it is also clear that the idiographic nature of narrative shows our “relation to self as an object is clearly an important feature of our lived life” (Bollas 2018, xv), often focussed on “the living, loving, suffering, dying human being” (Freeman 1997, 171), even when the loving, suffering and dying are done in a world of others.

Narrative and identity are closely connected (Heavey 2015), the creation of inner stories that have themes, plots, characters and settings (McAdams and Janis 2004), making narrative “the prime vehicle for expressing identity” (Da Fina 2015, 351). Some narrative analysts going beyond the idea that narratives make meaning, positing they also are constitutive in creating who we are and our self-identities (Hiles and Čermák 2010). Identity can be understood as the integrated personal narratives in which our core beliefs about ourselves and others are represented (Angus et al. 2004) including the unanticipated life events that have produced discontinuity (Botella, Herrero, Pacheco and Corbella 2004), which womb-life and birth experiences have been shown to do. When identifying narratives oriented around Self, I would argue it is self-as-an-object that is the main ‘thrust’ of narratives within therapeutic settings. Whilst Matthews, Dreary and Whiteman (2003) note the importance of scientific conceptions of traits in relation to the multivarious theories of
personality, in the context of my research I propose a more colloquial usage, drawing on more conventional lay ideas of personality, that aspects of someone’s character remains stable over time and that these traits are influential in their behaviour (Matthews, Dreary and Whiteman 2003). Subjective recollections of the past are expressed through the sense of a participant’s way-of-being with herself and others (Bollas 2018), presentations that appear as a dichotomous yet dynamically interplaying polarisation between the positive and negative aspects of experience.

Human identity is also “a social achievement, contingent on audience, culture, history, memory and agency” (Speedy 2008, 45), “inner worlds, feelings and emotions are never outside the society and its social and cultural meanings” (Woodward 2015, 55), and therefore identities “emerge through semiotic processes in which people construct images of themselves and others” (Da Fina 2015, 351). The review of PPN literature showed how the cultural and psychosocial setting of womb-life and birth strongly feature in the narratives of therapeutic approaches; there is a power within culture that feeds into how life stories are constructed (McAdams and Janis 2004). Studies within PPN thus are not just about Self but also about intersubjectivity and the dis/connection and intra/interrelation to its social situation: “Questions about identity, the self and subjectivity… and to the interrelationship between self, psyche, and the society” (Woodward 2015, 58) are central to psychosocial studies. At the same time, whilst I agree with McAdams and Janis (2004, 169) that “life stories are always psychosocial constructions”, a co-authored production of person and person’s world, my argument would also be that the standpoints adopted within PPN are counter-cultural, troubling “dominant cultural narratives” of womb-life and birth which “are hegemonic and repressive”, offering “subjugated discourses that ring truer to the individual’s lived experience” (2004, 169). Moreover, as the bio-medical aspects of PPN have shown, bodies and embodiment are a fundamental part of womb-life and birth narratives in significant and multiple ways; I see alignment with the opposition of the phenomenological tradition to Cartesian duality between body and conscious selfhood (Heavey 2015; Stenner 2017). In what can be directly related to PPN theory, Woodward (2015, 63) says, “In the making of the self, the interrelationships between psychic and social
always include some of these elements of genetic inheritance and the enfleshed capacities and limitations of the body”. Here I also see the connection to the therapeutic nature of narrative, and how telling life stories and re-creating narratives offer the possibility of change and transformation of Self and relational ways-of-being.

2.4.2 Narrative therapy and change
In the context of psychotherapy and counselling, McLeod (1997) makes a distinction between story and narrative which I find particularly helpful for, and applicable to, the nature of my inquiry within the field of pre- and perinatal psychology; story, as noted above, is essentially an account of specific incidents, especially emotionally salient ones, whilst narrative refers to a complete discourse within a therapeutic setting: “The therapeutic narrative, then, can be viewed as an attempt by the client to ‘narrativise’ a problematic experience through the production of a series of stories connected by linking passages and therapist interventions” (1997, 51). New realities come about from the creative process of fabulation, the telling of stories through a symbolic means of imaginatively perceiving the world (Stenner 2017), a way to reach a personal truth that is less concerned with historical truth but allows for a narrative truth, “constructing meaning out of the chaos of lived experience” (Hiles and Čermák 2010, 148).

Da Fina (2015) noted that storytelling is a fundamental self-development device and as such, autobiographical stories have significant psychological and cognitive connotations within the theoretical frame of life-storytelling. Bruner (2004), referring to Phillippe Lejeune, a specialist in autobiographies, associates autobiographies with self-narratives, a form of public self-telling which people follow even if they are talking to themselves. This subtle interplay between self-telling and public telling suggests to me the idea that allstorying about our Self histories can be thought of as autobiographical and part of a therapeutic process, what Angus et al. (2004, 89) call “the autobiographical external”, the verbalisation of specific detail and descriptions of prominent life events. The therapeutic use of autobiography is the focus of Emilia Halton-Hernadez (2023) in her detailed exploration of the Marion Milner method.
Milner used a variety of creative self-expression modalities, including autobiographical writings, alongside her ‘pliable medium’ (Halton-Hernadez 2022) of painting, collage and clay sculpture, as “autobiographical acts for the purpose of gaining self-insight and promoting self-development”, believing “aesthetic, self-expressive techniques are a means to therapeutic ends” (Halton-Hernadez 2023, 2). Self-expression, especially how “autobiography might help constitute a sense of self and identity in the same way the psychoanalytic relationship does is at the heart of Milner’s autobiographical project” (2023, 10). ‘Autobiographical reasoning’ is another term for the meaning-making activity in narrative-focused therapies, linking different episodes in our lives to our sense of Self so that the past and present can be related to better by the building of ‘meaning bridges’ between them (Anderson 2004).

Milner’s use of alternative therapeutic techniques beyond traditional psychotherapy in the search for deeper understanding of Self and other seems to resonate with the alternative forms of therapeutic activity that pre- and perinatal psychology offers, which, I would argue, are also very creative, offering “one of the means by which an individual may engage in the pursuit of self-knowledge, self-development, and self-cure” (Halton-Hernadez 2023, 15). Certainly, regressive explorations are an aesthetic technique that relies on non-traditional forms of self-expression and show how, as Milner thought, “creative acts, whilst expressions of personal, often unconscious conflicts, are also themselves capable of bringing therapeutic assistance to these same problems” (2023, 15). At the same time, there is a need to translate the embodied experiential into a form of self-narrative, both in the course of a pre- and perinatal regression through communicating with the therapist and afterwards through the creation of a narrative explanation for what happened. A strong perinatal theme can be traced in Milner’s autobiographical work, Milner believing in the importance of early object relations between mother and infant as critical in the formation of intersubjective relationships. “The reflexive construction of new personal meanings involves the self-organization and articulation of felt emotional experiences” (Greenberg and Angus 2004, 333) and through her self-analysis using narrative in autobiographical form, Milner came to a deeper understanding of her Self “as understood and expressed in the wake of object
relations understandings of the development of the self in preverbal, pre-oedipal life” (Halton-Hernandez 2021, 244) and the intersubjective relationship with her parents through the lens of post-Kleinian object relations. For example, learning about her mother’s difficulties with breastfeeding due to a painful abscess in combination with her adult understanding the emotional conflicts in her parents’ marriage, Milner was able to wonder what effect this aesthetic of care had on her own sense of Self and ways-of-being-in-relationship, especially in terms of “Winnicott’s term “continuity of being”… the understanding that the infant’s sense of self is dependent on the quality of care from its caregivers, namely its mother” (Halton-Hernandez 2023, 13) and “the importance of the mother-infant relationship in shaping and unconsciously determining one’s later relationships to other people and external reality” (2023, 60).

Narrative is therefore a powerful tool in the creation of new personal meanings (Greenberg and Angus 2004; Chiari and Nuzzo 2010) through the processing of emotions, and “a reflexive decentering from and then reengagement with distressing life experiences from different vantage points” (Angus et al. 2004, 90), thereby having a positive effect on self-identity (Lightfoot 2004; Da Fina 2015; Gonçalves, Henriques and Machado, 2004). It requires looking backward into our histories so that experiences and events can be related to each other and emplotted into a narrative understanding of Self, “seeing in retrospection not an impediment to knowing but an inroad, a pathway into dimensions of meaning that cannot be had any other way” (Freeman 2015, 28, italics in original). There has however, it seems to me, been relatively little focus around the use of narrative as a therapeutic tool in pre- and perinatal psychology, even though the field is rich with narrative conceptualisations and metaphor, starting with the central character in PPN, Otto Rank, who not only published The Trauma of Birth (2010) but also conducted a psychological analysis of mythology, The Myth of the Birth of the Hero (2004). In this work, Rank mapped “an insistent tendency in the myths to make all heroic figures fit the framework of a specific birth legend” (2004, 4), pre-dating Campbell’s The Hero with a Thousand Faces (2008) by some forty years. It is this gap in the literature, as I see it, that led me to consider how the reconstruction of narratives is used therapeutically to initiate change within the pre- and perinatal field of inquiry. In the
concluding section of this literature review, I will explain my area of study, its potential significance, and my research project.

2.5 My area of study
As noted already, many studies of pre- and perinatal experiences have been based on various forms of case studies, based on psychoanalytical theories informed by clinical sessions or biomedically-informed perspectives, such as Winnicott (1958a), Grof (2017), Emerson (1998, 2001), Kafkalides (2005), Verny and Kelly (2010), Lake (2005) and Janov (1970). I recognise and appreciate the importance of the case study tradition in psychotherapy and psychiatry and when done well they can be evocative and moving as well as educational and enlightening, especially in informing theoretical development. I also appreciate that much of the human social sciences have historically followed a positivist paradigm in the literature, as Flyvbjerg (2001) comprehensively evaluates, and thus in order to get published, papers were usually written in the scientific academic form. For me, this tradition now seems at odds with objectives of practitioners in this field to highlight the importance of womb life and birth in our psychological as well as physical development, the “honouring of both the sentience and intelligence of the unborn child” (Sills 2009, 3). Accordingly, in the case presentations I have read in the pre- and perinatal area there is something is missing for me: many read like “‘experience-far’ ” (Bondi and Fewell 2016, 6) assumptive reports from an author’s clinical perspective (in the medical and dispassionate meaning of the word) rather than “‘experience-near’ … close to the feelings and subjective states of those involved in therapeutic practice as practitioners and clients” (2016, 6).

This is also true, as I see it, with the more recent literature that is aimed at education and application of PPN theories in clinical practice or parents, such as Appleton (2020), Menzam-Sills (2021), Weinstein (2016), Axness (2012) and Verny and Weintraub (2002). There are a few publications that are more ‘experience-near’, such as English’s (1985) autobiographical account of coming to an understanding of the impacts of her caesarean birth, or vignettes from a variety of sources, such as Hayton’s (2011) womb-twin explorations, or Carmen and Carmen (2019) and
Chamberlain (2013) who both focussed on personal reports of prenatal consciousness and intelligence. However, as I see them, these emerge as *prima facie* evidence that supports the authors’ PPN theories rather than any detailed reflection on how the individuals that are cited have used their knowledge as an ongoing part of their lives.

Thus, I will now turn to outline my approach that I believe will replace the ‘missing something’ for me and for others, trading the relatively ‘experience-far’ research outlined above with an area of study and a methodological approach that is more ‘experience-near’. This is closer to how everyone involved in a study feels in their subjective and intersubjective states (Hollway 2006; Bondi 2013), answering Flyvbjerg’s (2001) call to *phronesis* through applying practical wisdom in contributory dialogical human sciences that will support non-academics and other relevant audiences. At the same time, there is also a ‘vested interest’ in experience-near research for me, as researcher, and the academy, particularly the pre- and perinatal psychology academy.

It should be apparent from overview of the literature that there is the wide plethora of choice open to a researcher in the field of pre- and perinatal psychology in terms of ontological and epistemological positions. Although to a certain extent my training as a therapist carries with it a certain ontology and epistemology – that of the moment-to-moment perceptual process of our existence rather than a fixed, enduring entity of ‘Self’, and that the knowing of the Self is a cognitive, embodied and often spiritual endeavour (Sills 2009) – in my research I wished to draw on an ontological position that combines a sense of how we come to construct our social relational worlds through a deeper understanding of our womb-life and birth. My position is that it is the telling of stories that specifically supports and deepens our Self-understanding and meaning-making through the narrative reconstruction that this activity offers, especially in how that construction is formed when we come into relationship, connection and contact with others, that is our intersubjective relationalities. I would define these relationalities as our experience of ourselves and other objects, including non-human ones, in any connection we have with them, the transformation
of which I believe to be a “dialectic-constructivist view of experiential therapeutic change” (Angus et al. 2004, 88). When applied to the experiential practices inherent in regressions and other pedagogic forms in the PPN literature, this describes an area of study that is:

**An exploration of how womb-life and birth storying contribute to and augment therapeutic processes of self-understanding and meaning-making of being-in-relationship to the world.**

I use the word “storying”\(^\text{22}\) to indicate the active and dynamic nature of “making stories” and, as I have already outlined, turning them into narrative understanding involves. This is an articulation of my intellectual puzzle (Mason 2018), therefore, about how womb-life and birth stories, once revealed to us through different methods, can inform, augment and be incorporated into the multiple realities we occupy throughout our everyday relational existences. This would be epistemologically viewed as inter-subjective relationalities because we can know and interpret our worlds through the creation of narrative-based principles that validate our experience of living (Mason 2018), and we do this in relationship to and with others.

An aim of my project is that in using narrative explorations, I bring to the fore the importance of this field to psychotherapists and counsellors, contributing to a wider understanding of the art of being human from our earliest experiences in life. As Polkinghorne (1988) noted, we construct narrative meaning through our cognitive processes and it is an *activity*, not something that is available as an object to be directly observed; however, the narratives we create from our individual stories and histories – and I would add the life experiences we engage in – when elucidated are available for study and examination. Posing my area of study and aim as a broad,

\(^{22}\) I came across the term “storywork” when researching indigenous origin stories, a term created by Jo-ann Archibald (2008, 3) to signify “that our stories and storytelling were to be taken seriously” which I think is a powerful term for narrative inquiry. However, as her research and the term itself relates directly to Indigenous culture and stories, out of respect and an ethics of avoiding cultural appropriation, I have avoided using it.
over-arching and main research question, which Mason (2018, 14) would call “the backbone of [any] research design”, I am looking to investigate:

*How does learning about pre- and perinatal experiences, including through regression explorations of womb-life and birth, contribute to narratives of Self-understanding and relational ways-of-being?*

My on-going reviews of the literature made me reflect on how I want my research to be less about ‘reporting’ or just making my interpretations of other people’s phenomena and more oriented towards how psychological lives are constructed and what is used to construct them by individuals: my thesis is that narratives are a fundamental instrument in our explanatory toolboxes for living our lives. This sense of something more to be offered than existing approaches within the pre- and perinatal literature, or at least something that adds to previous research and is sufficiently different to be appropriate for extending knowledge in the field of psychotherapy and counselling, led me to seek for an area of study that for me is more “experience-near” in that “however that experience is represented, it must retain its vivacity, which means its capacity to elicit another person’s ‘compassion’ ” (Hollway 2006, 472). More than that, rather than the experiential and academic studies of PPN participants in and of themselves being the endpoint, I aim to show how the narratives that are constructed offer the greater understanding of life histories and provide a bedrock from which psychotherapeutic change can be initiated. As I shall explain in more detail in the Methodology chapter, an approach that embraces narratives and narrativity, “the inclination to make spatiotemporal and events-based configurations of meaning” (Da Fina and Georgakopoulou 2015, 7), seems to offer that possibility.
Chapter 3 Methodology

3.1 Introduction

According to Denzin and Lincoln (2000, 19) “All qualitative researchers are philosophers”, working within interpretive paradigms, the combination of “beliefs about ontology (What kind of being is the human being? What is the nature of reality?), epistemology (What is the relationship between the inquirer and the known?) and methodology (How do we get to know the world, or gain knowledge of it?)”. In a post-structural and post-modern academy there is “no clear window into the inner life of an individual” Denzin and Lincoln (2000, 19) remind us, only socially-situated constructions between the worlds of the researcher and, where involved, participants. In this chapter, I will further explain my research focus and how I have come to develop the ontological, epistemological positions and the methodological choice that flowed from the literature review I used to frame my area of study, study aims and research question in the previous chapter. At the heart of the matter is the overarching qualitative research aim that seeks to interpret and make sense of the meanings people bring to the phenomena of the social world (Denzin and Lincoln 2000; Leavy 2014; Merriam 2009); within the counselling and psychotherapy profession, Bondi and Fewell (2016, 7) would agree with this sentiment, arguing research related to lived experience “needs itself to take a form that honours and fosters lived experiences of being and struggling to be in relationship to ourselves and others”. Based on these research principles, I will thereby develop my rationale of an inquiry focussed on narrativity as methodology and my critical engagement with narrative analysis of interview data as method.

My overall intellectual puzzle was driven by an intrinsic interest in my own experiences; drawing on Mason’s typology (2018, 12), it would relate to an “experiential” puzzle, searching for a way to investigate the interconnection between our experiences and the world. It could perhaps also be argued that there is also a strong “developmental” element to womb-life and birth research, beyond even the most obvious – that it is the foundation of our very existence and development as humans – as the experiences in that realm can be thought to shape who and how we
are. Whilst I am very cautious about declaring the puzzle as “causal or predictive”,
given such a positivist perspective, I feel it important to acknowledge, again, that in
some of the literature, like Rank (2010), who related all psychological issues to birth,
Lake (2005) who had similar views though located them in the first trimester of
pregnancy, and Chamberlain (1994) as previously explained, there is a causal
element linking pre- and perinatal theories and our personality formations, that
events whilst in the womb or through the birth process lead to ways-of-being
exclusively of anything else. For example, Verny and Kelly (2010, 106, my
emphasis) originally thought “The games we play as children, the entertainment we
enjoy as adults, even our sexual interests are, in one way or another, birth-related”,
though in fairness Verny (1994) subsequently changed his position, and cautioned
against reductionism in PPN theory. Reducing womb-life and birth experiences to
simplistic cause-and-effect goes too far for me, but it does indicate this element is
sometimes applied by theorists within the wider pre- and perinatal psychology field.

I wished to take an alternative perspective to such causality: my training, practice
and involvement in the psychotherapy profession has led me to the view that the
principal premise of psychotherapy and counselling is that we can bring an
understanding of our psychologies from the curiosity-led exploration of our life
histories. It is not only the understanding of but also the deconstruction of those
potential causalities, or at least our beliefs about them, that allows us to adjust self-
perceptions and behaviours and live life differently. Reflecting on my own experience
of PPN, this is also, perhaps, acknowledging what Jackson and Mazzei (2008, 303)
said about deconstruction through our expressions of narrative truth, to accept that
previous experience is questionable, problematic and incomplete, not a “foundation
of truth”. In conceiving my research project by reflecting on my own process of Self-
understanding through womb-life and birth work, I considered how nowadays, this
(my) Self that felt so locked into processes of rejecting and neediness can manifest
as a Self that very much fits in with the post-structuralist idea of being deconstructed
and unsettled to which Jackson and Mazzei (2008) allude. It is a Self that more often
becomes in the moment, rather than being the fixed and solid set of patterns I once
thought I was (Spry 2016). Yearning, like Pelias (2013, 388), “to be accepted or
rejected on the basis of who I understand myself to be”, narrativizing my womb-life and birth was necessarily important for developing my sense of who I am and how I have come to be, and was the ground from which my intellectual puzzle was formulated. My curiosity as to how others might experience this work and might see themselves as becoming through the lens of womb-life and birth experiences is the basis from which my ontological and epistemological choices spring, as I will explain further.

3.2 Ontological position
Ontology, as noted in the introduction to this chapter, is the study of the nature of reality and within a qualitative research setting, the debates about ontology fulcrum on convictions around whether a universal truth exists, and about objectivity. A spectrum of beliefs exists and competes, with at one end a conviction that reality is objective, and therefore it is possible to know universal truths about this reality; at the other end, theorists believe reality is only subjective and contextual and as such, it is not possible to come to one universal understanding of psychological experiences as they are all rooted in different contexts (Spencer, Price and Walsh 2020).

As already observed, pre- and perinatal psychology is also a very broad church with a wide spectrum of beliefs, opinions and philosophical perspectives, ontological and epistemological positions that are used to support the principal notions of PPN and its potential impact on all of us and because of that, has – ontologically speaking – different potential positions that could be taken by a researcher. I perceive there to be an ontological spectrum presented in PPN research which parallels Spencer, Prince and Walsh (2000), from positivist, realist ontologies through to theological, spiritual ontologies extending from the ground of psychodynamic therapeutic ontologies. However, there is also often overlap in these positions by PPN theorists: as PPN is a therapeutic approach, it seems to me, practitioners are open to applying knowledge in ontological and epistemological ways that seem inconsistent with research philosophies, such as speaking about divine homesickness (theological onto-epistemology) in connection with the embryological formation of the blastocyst or the effects of obstetric interventions during birth (biomedical onto-epistemology).
At one end of my spectrum, however, is the undoubtedly positivist-leaning paradigm with realist ontologies containing ‘pure’ science elements incorporated into PPN, drawing on, for instance: epigenetics (Weinstein 2016; von Lüpke 2021; Ott, Singer, Bliem and Schubert 2021; Janov 2018); neuroscience such as polyvagal theory (Porges 2011; Goh 2017, Dana 2018); and the defined medical models in midwifery and birth obstetrics (Arms 1979, 1994; Davis-Floyd, Barclay, Daviss and Tritten 2009; Oxorn 1986; Symonds and Symonds 2004). An example of this paradigm is Verny and Kelly (2010), whose book The Secret Life of the Unborn Child was considered revolutionary at the time of its publication in 1981 for its implications of the pre- and perinatal influences on our characters. They presented various scientific (that is, positivist experimental) evidence of potential influences on prenates in the womb, such as research that showed that a pregnant woman even thinking about having cigarette causes the prenate distress, as measured through increased heart rate, the physiological and psychological effects of which predisposes the prenate to “deep-seated, conditioned anxiety” (Lieberman, cited by Sontag (1970) in Verny and Kelly, 2010, 6-7). At the same time, they also introduce an element of subjectivity located in the prenate, as they state on the first page “...the unborn child is a feeling, remembering, aware being, and because he is ... what happens to him in the nine months between conception and birth moulds and shapes personality, drives and ambitions ...” (2010, 1). As another example, Yehuda and Bower (2015) found that extreme stress experienced by a pregnant mother in the third trimester has a statistically significant potential epigenetic effect on her prenate. Whilst this sort of research is of great interest and importance in pregnancy health management strategies, it does not tell the whole story of the person(s) affected and its generalised claims carry the danger of being interpreted as deterministically and simplistically causal.

At the other end of my spectrum, some advocates of PPN, especially in the psychotherapeutic field, incorporate transpersonal spiritual elements to womb-life and birth, including pre-conception experiences of coming-into-being and ‘reports’ of pre-conception stories as ‘fact’ and ‘evidence’ of consciousness from the very moment of conception, if not before. In one such case, Carman and Carman (2019,
xii) drew a distinction between ‘real-world babies’ and ‘textbook babies’ by presenting pre- and perinatal stories told by infants and children about their past-life memories and preconception, conception, womb-life and birth experiences. These stories had been submitted to a Facebook page by their parents, and the authors suggested “If every incoming baby is welcomed as an infinite spirit embarking upon a sacred journey, life here on earth will shift from mundane to spiritual” (2019, xii).

Between what I conceive as these two paradigmatic dimensions of PPN, realist positivism and theological subjectivism, lie other ontological approaches which attempt to integrate science and spirituality, presenting both biomedical science and transpersonal elements to our coming into being (Appleton 2020; Kalif 2014; Chamberlain 2013, McCarty 2012; Menzam-Sills 2021). It was in cogitating, pondering and at times wrestling with the dilemma of these potentially diametrically opposed paradigms that I started to perceive, in the words of Mason (2018, 5), “the enormous and exciting range of ways that social scientists might see the social world”. Returning to my own journey through the pre- and perinatal field, I considered which of the ontological properties in Mason’s non-exhaustive (in her view) but nonetheless comprehensive list applied to my personal learnings and investigations of PPN, and what sparked excitement in me, noting – amongst other things – was “understandings, interpretations, knowledge”, “identities… character, being”, “relationalities, connectedness, associations…” and “stories, narratives, biographies” (2018, 5). What emerged from this process was recognising the constructivist nature of pre- and perinatal psychology, particularly in a therapeutic sense, even when thinking with and through positivist biomedical perspectives or the feminist psychosocial critiques of birth management practices.

Within research philosophy, a constructivism paradigm assumes relativism as an ontology (Lincoln and Guba 2000); relativism essentially means that researchers consider there is no single reality or truth, and therefore reality is created, that is constructed by individuals, and often in relationship with others. Importantly, as Smith and Deemer (2000, 878) emphasize, relativism does not mean that “anything goes” but that it should be considered as showing that humans “are, and can be
nothing but, finite” and researchers need to shift using “imageries and metaphors from those of discovery and finding [reality] to those of constructing and making [it]”. Lincoln and Guba (2000) also point out how paradigms overlap or merge rather than being exclusively separate, especially in relation to axiological ethics, and the nature of spiritual inquiry is associated with constructivism. Such perspectives undoubtedly fit the plethora of ontologies that have been adopted within the PPN realm, especially as they are used quite interchangeably and alongside each other by theorists, who are more than content to talk about spirit coming into form through the biomedical processes of embryology, to develop and use regression therapeutic approaches and to create meaning and understanding that result from interpretations of these experiences in combination with bio-psycho education. Embracing a constructionist ontological position consequently brought me closer to defining an epistemology and methodology that fitted my research aims.

Another important ontological view that accords to the nature of my inquiry is laid out by Meretoja (2014), who states that there is relatively unanimous agreement amongst theorists that narratives help people create meaningful associations between experiences and events. However, there also exists a bifurcation between theorists who take an epistemological stance that narrative can be principally conceived as “a cognitive instrument for imposing meaningful order onto human reality or experience” and those for whom narrative is predominantly “an ontological category that characterizes the human way of being in the world, that is, something constitutive of human existence” (2014, 89). Importantly, Meretoja (2014, 89) is critical of such binary views, positing that the “complex interactions between ontological, epistemological, and ethical dimensions of the relation between narrative and human existence” is inherent in a phenomenological-hermeneutic approach. Embracing the idea that humans are self-explaining and self-interpreting beings, inexorably entangled in a web of historical and cultural milieus that inform, transform and are transformed by our meaning-making processes creates a narrative hermeneutic circle (Freeman 2023; Wiklund-Gustin 2010; Pettersson 2009). This develops Ricoeur’s (1988, 248) notion of narrative identity not being “a stable and seamless identity. Just as it is possible to compose several plots on the subject of
the same incidents (which, thus, should not be called the same events), so it is always possible to weave different, if opposed, plots about our lives”. In this view, our experiences are always more than the narratives we tell about them, and “new experiences constantly challenge our narrative interpretations” (Meretoja 2014, 97).

The ontological perspectives presented here are the ones adopted by me in this thesis, leading to my epistemological position, as I will now elucidate.

3.3 Epistemological position

Ontologically, a constructionist position posits that we are, all the time, in relationship to something, that we are not separate from, but are part of, the world(s) in which we exist. A coherent and consistent epistemological position in relation to a constructivist-relativist ontology, based on the principle that there are multiple realities rather than one single reality, is that reality itself needs to be interpreted. Interpretation can be, and often is of course, self-interpretation, but as outlined in the ontological position, even self-interpretation takes place within a social and cultural historical milieu. Moreover, and significantly importantly for my thesis on womb-life and birth, “self-understanding is not only achieved within our own narratives, but depends upon the regard, words and actions of others” (Wiklund-Gustin 2010, 32). This is my position in this thesis, an epistemological stance that holds we cannot view from no-where, that we are all intersubjectively situated and that it is through intra- and inter-subjective relational encounters that we have an opportunity to challenge, work with, re-develop and sometimes confirm our prejudices and biases. This reflects the philosophical hermeneutical concept on perception, in that in every act of ‘seeing’ we construct the world in a certain way, based on our own cultural and social histories (Zimmerman 2015): it is also reminiscent of Bakhtinian dialogism, in that for Bakhtin, the Self is dialogic, a relationship translated through multiple and interactive dialogue in the effort to grasp and understand human behaviour (Holquist 1990; Vice 1997).

This relational perspective, emphasising the conscious as well as unconscious internal representations of relations (Benjamin 1995), implies the two dimensions of
intrapsychic and intersubjectivity are complementary activities (Benjamin 1990). This complementarity avoids “the oversocialized conception of man” (Wrong 1961, cited by Woodward 2015, 16), allowing a separation of Self from the other, whilst acknowledging and retaining the relational between them. Yet it is important to acknowledge that the intrapsychic processes, active through anxiety and defences, fantasies and desires which allow the incorporation, ejection, identification and refutation of the other as a mental object, rather than a real being, “provide the background of the mind’s private space [so] that the real other stands out in relief” (Benjamin 1990, 21, italics in original). In my reading of him, this echoes Bollas (2018) where it is the encountering and experience of our mother’s idiom of care as a process of transformation which becomes the aesthetic of our own being, the internalized structure of our character, and is active in our identity formation. The conceptualization of personal epistemologies of how we can come to know ourselves through therapeutic experiential explorations of womb-life and birth connects to an intersubjective epistemological approach that embraces a narrative methodological approach. This is also, I believe, directly related to how Bollas (2018, xv) considered the processes of psychotherapeutic practices to be, at least partly, “preoccupied with the emergence into thought of early memories of being and relating … of the reliving through language of that which is known but not yet thought”, what he termed “the unthought known”. This symbolization of experience, how we come to know and narrativize the unthought knowns of our earliest experiences in life, is the focus of this thesis.

Before laying out my rationale for a narrative methodology that helps language these experiences, there is one more epistemological issue to acknowledge: there is an element of my research that is also intra-actively relational, not just inter-subjectively relational, in that I am an insider-researcher who has participated in the kinds of experiential explorations that my participants have (albeit separately from them); as such, there is a part of me that it is not possible to have full exteriority to the phenomena I am researching. As Willig (2018, 188) noted in relation to clinical practice, therapists seek out modalities of working that reflect their pre-existing perceptions of human nature and ways-of-being as it “offers a construction which
resonates with the questions and thoughts we may be grappling with in relation to the human condition”. I see such a resonance in my research and do not believe this to be inconsistent with my approach; indeed, I believe being reflexive about this lends weight to the arguments for an “onto-epistem-ology” (Barad 2007, 185), as “[p]ractices of knowing and being are not isolable; they are mutually implicated”. This position helps inform a dialectic methodology where capturing and describing lived experience is facilitated by the dynamic interchanges between participants and researchers (Ponterotto 2005). It also aligns with views on psychosocial research epistemologies, a paradigm that does not separate cognition from emotion and is based in intersubjective processes rather than (only) intrapsychic ones, recognising an intrinsically social view of Self that has permeable boundaries with others (Hollway 2008; Chodorow 1999). Such processes, in my reading of it, are also inherent in the practices of pre- and perinatal psychology.

3.4 Methodological approach

In a similar way to how McLeod (1997) describes narrative in therapeutic modalities as the ability to narrativize problematic experiences through producing connecting stories together, as noted in the literature review, Freeman (2015) quotes Peter Brooks as emphasizing narrative is not about assembling facts, but the intuitive sense of how stories fit together and make life more meaningful oversees which facts we choose to assemble: “‘Our daily lives, our daydreams, our sense of self are all constructed as stories’”, he said (Brooks 1985, cited by Freeman 2015, 22). As part of the process of developing this project, I frequently thought reflexively about what had drawn me into the field of pre- and perinatal psychology and, more importantly, what I felt like it had offered me. The experience I wrote about in the prologue was, as I said, the beginning of a longer exploration of the field, which this thesis is the current iteration. Thinking back, I came to realise how, before I started a concentrated investigation into pre- and perinatal psychology, my life has been literally and metaphorically shrouded in darkness, surrounded by a mental haargest23

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23 “Haar, or ‘sea fret’ as it is also known in North East England, is used to describe a cold fog that accumulates at sea, rather than on land” (Jack and McMahon 2021).
that creeps in at various times of my life and blocks out the light. I loved winter and its bleak, cold light-shortened days, a chance to withdraw and hibernate, especially around my birthday on Christmas Eve. From my early teenage years, I needed to, wanted to, and usually did, withdraw from human contact over the Christmas period. My house, especially the ‘living’ room, are a monument to this darkness; the home cinema I own has been the excuse for black-out backings on thick curtains, very dark grey walls and deep brown, almost black carpet, venetian blinds behind the lined curtains covered further with black-out blinds. These were almost permanently closed, even when I was not watching films on my cinema-sized screen. Someone once said I lived in a cave. In recent years, however, since I started this expedition into understanding my womb-life and birth, I have been opening up to the light: I have shifted from hating the idea of Spring to feeling joy at the shift of light, the movement to warmer, longer, more light-filled days. I have the curtains and blinds open, more often than not, even late into the evening; I have found myself reluctant to close them and have even slept with the full-length French-door-covering curtains in the bedroom open all night. It is not possible, nor important in the context of this thesis, to fully describe this internal shift: suffice to say, I believe the deepening research around my own process has contributed to an internal psychological change that has manifested in a visceral, physical way.

Such reflexivity, the axiology of my process, inevitably and necessarily, informs my ontological and epistemological position (Willig 2019; Ponterotto 2005) as it generated the curiosity that drove my research. I realised that I had started to tell rich stories around my PPN therapeutic experiences and relate them directly to my history, using narratives I created to explain and to transform how I was with myself and with others. I found my ability to maintain contact-in-relationship increased and the sort of conversations I was able to have with my mother before she died deepened our relationship and brought us closer than we had ever been. I wondered if I was alone in having these ‘therapeutic shifts’ in the nature of my being.

People are seeking healing from the therapies they undertake and at its core, therapy of all kinds offers clients the opportunity to develop a story-based
explanatory frameworks for what they feel has gone wrong, or been wrong, for them in their lives. I began to realise that it was the stories I had constructed from my explorations of PPN through education and experiential regressions that offered me an opportunity for narrative-based understandings of my ways-of-being-in-relationship – to myself, to others and to the world - and ultimately had offered the potential for transformative change. I was moved to find out about other people’s experiences and had noted the lack of formal narrative-based research within the PPN field, seeing it as an opportunity to extend knowledge and make a significant contribution through my research.

3.4.1 Stories to live by
In this section, I provide further detail as to how I see narrative as a methodological approach for investigating womb-life and birth. Simply put, my position is we are story-telling beings that make our Self and our realities, and make sense of these two things, through the use of narrative. Storytelling, John Yorke (2013, xviii) tells us, “is an indispensable human preoccupation, as important to us all – almost – as breathing”, reflecting the importance of narrative constructions of stories in our lives. Freeman (2015) suggests we construct narratives from a state of being that precedes the telling called ‘narrativity’. In a similar vein, Frank (2012b), whilst noting that a reliable differentiation between story and narrative is sometimes difficult to establish, states narratives can be understood as resources that are constructed from the stories we tell ourselves and others, and therefore also used to make sense of the stories we hear. I see this perspective as compatible with McLeod’s (1997) position on connecting stories together in narrativizing problematic experiences. It was by working through my thought processes in relation to the many possible areas of womb life and birth I wanted my project to be located in that I came to see how working with narrative as a methodological choice fits with the ontological and epistemological choices I made. The construction of narrative meaning therefore happens through our cognitive processes as an activity, not as something that is available as an object to be directly observed, but as the narratives we create from our individual stories and histories when elucidated are available for study and examination (Polkinghorne 1988; 2004). It is this ability to construct and use
narratives about our womb life and birth as part of our meaning-making and understanding that I believe provides a deeper insight and appreciation of how we have come to be who we are, and what that means for how we are.

What then do I mean by narrative, as this is the lens through which I developed my thesis? I want to acknowledge that the connections and the differences between *narrative* and *story* remains somewhat elusive in the literature; there are diverse, manifold descriptions, meanings and different ways of understanding “narrative” and narrative inquiry or analysis (Speedy 2008; Riessman 2008; Daiute and Lightfoot 2004). If people’s lives consist of moments that they story in order to make sense of them in different situations over time (Speedy 2008), I was interested in Frank’s (2012a, 27-8) argument that stories are *actors*, they have *capacities*, and these capacities are “stories’ narrative equipment … how stories work – what they consist of – [and] how stories do their work for people and on people”. Yet, like McLeod (1997), it seems to me the order is reversed: stories are used to construct narratives that are the resources that have wider application in our meaning-making. In the telling, retelling and re-enactment of stories, meaning is made (Combs and Freedman 2004). Narratives are therefore the *resources* from which new stories can be told, templates endowing storytellers and story listeners with culturally-established tropes and plotlines in order to express and understand the "living, local and specific" accounts being shared (Harraway cited in Frank 2012a, 14). I also believe stories of womb-life and birth trouble those cultural tropes and plotlines as they are not usually shared, being partially hidden in a cultural shadow, especially from an individual being able to story a sense of their own womb and birth experiences.

My position on narrative as methodology is consistent with a constructionist-interpretative paradigm, following interactionally-oriented procedures (Da Fina 2015). The narratives we live by are based on our relationalities - that is, our experience of ourselves and other objects, including non-human ones, in any connection we have with each other - and are dialogical; we form them in relation to other objects and our direct or indirect experience of them. In our human relations, this is especially
connected to our bonding and attachments in early life and our enactment of our personality strategies formed in response to that care (Sills, 2009). Our foregrounded relational lives are also set within a socio-cultural-political background which might usually be something we are not overtly conscious of, but in extremis, can be more foregrounded. This background is a part of our narrative histories and our narrative presents, “implicated in practically every aspect of human communication, social interaction and cultural practices” (Hiles, Čermák and Chrz 2017, 157). The methodology I am proposing is interpretative in a paradigmatic sense, as I think it inevitable that at some level understanding others, even when dialogically constructed, needs a translation, a metaphoric babel fish (Adams 1979), to convert what we hear others say into our own frames of reference, even when we shift our own frames as part of inter-subjective interactions. This also reflects philosophical hermeneutics where the “fusion of horizons” sees the integration of an other’s perspective as being two-way (Zimmerman 2015): in the terms of my project, hearing other’s narratives will change my outlook. This comes about through ‘discursive practices’, the active production of psychological and social realities (Davies and Harré 1990). Schwandt’s (2000) analysis of philosophical hermeneutics also resonates and accords with a constructionist relational narrative approach to understanding that is the foundation of my epistemological position, most notably in how he posits understanding is interpretation, is conversational and participative, and is produced in dialogue.

Methodologically speaking, then, my research aims towards an appreciation of how narratives, specifically formed from stories of womb life and birth, inform and influence our lives, how they can form the foundation of our world-understandings and are developed in relation to others. This is also important in terms of psychotherapy and counselling profession: what we do as therapists with our clients is to listen to, examine, be curious about and help re-form life narratives. Do I exist within a cycle of storying that is unhelpful and feels fixed and unchangeable? Or, in the words of Alasdair MacIntyre (2007, 216), can I see “‘I can only answer the question ‘What am I to do?’ if I can answer the prior question ‘Of what story or stories do I find myself a part?’.” How can we appreciate the influence of the patterns and
strategies for living that have been developed in response to our developmental histories in a way that gives us choice to change them, not to follow the old story every time, to live a better life (Frank 2012a)? What I am to do, how and why I do it, the kinds of decisions I make in terms of life, love, career, interests – indeed, the essence of how I come into contact with the world, and most especially other humans in it - forms a part of my everyday life. We make these kinds of decisions most often formed out of and formed into stories – real or imagined, sometimes known and sometimes unconscious – that underpin realities based on our experiential histories, including womb life and birth. In informing human life, Frank (2012, 2) says, “stories give form … to lives that inherently lack form”; in this, they can be transformational (Colton 2004). It is this ‘doing’ nature of narratives in relation to womb life and birth that I am most interested in, how they act on us, how we view the world through them (whether we realise it or not) and how deep reflection through interaction with others – be that a psychotherapist, in an experiential trainings or as a research participant engaging in interactive dialogue with a researcher - can bring hidden meanings to the surface; this reaffirms my constructivist position, advocating and promoting a methodological hermeneutical attitude (Ponterotto, 2005), where both me, as researcher, and the participants may arrive at more profound insights.

At the same time, I am resistant to, and troubled by, the idea of experiencing or interpreting life through narrative as only something that has to have a beginning, middle and end to make it viable and intelligible, however; nor do I see narrative as Clandinin and Connolly (2000) expressed it, as a kind of discourse that takes place over a period of time, within space, and in a certain context. I think my personal narratives can often be the kind of disorganized narratives that Dimaggio and Semerari (2004) discuss, drawn as they are from my imperfect memory and incomplete knowledge, often conflate, collapse, confuse and sometimes expand or break down time and space in my sense-making activities. In this view, I would suggest I align with some of Ying Liu’s (2019) innovative and impassioned critique against narrative coherence. In her thesis, Liu challenges the notion and insistence of temporally coherent narratives as being necessary or essential to leading what
she calls “a good life” (2019, v) by drawing on Butler’s (2004) concept of the violence this does to those expected to provide them. Much of what she says challenged me to think deeply about my project and what I was trying to do – much of her thesis resonated and accorded with my engagement of experiences in my life, both personal and in clinical work, and the incoherence and inarticulability of embodied experience. Yet it is not accuracy of memory that I am trying to test here: it is about how we can use the narratives we construct in a life-enhancing way to transform negative processes. Liu felt an enforced need to have temporal coherence when she was expected to explain her experiences, that she, as the client, “ought to tell” (Liu 2019, 46) or that “Mostly it is hoped that throughout the course of psychotherapy, the client achieves a higher level of narrative coherence” (2019, 47). In this sense, I have points of divergence with Liu’s approach: narrative as methodology, for me, is about deconstruction and reconstruction, dis-membering, and re-membering those parts of ourselves that we might be struggling to make sense of.

The positions from which Liu and I view narrative, and its uses, are fundamentally different, as my experience as a client and practitioner of psychotherapy has been quite different. In my training, personal therapy and practice, the unsaid, unexplainable, unknowable and unknown – and the unthought known - are always open possibilities in, and possibilities for opening into, our experience. There has also been no expectation of coherence on me or by me on my clients, other than that which the client wishes to establish; the mantra is ‘be curious to what arises’ – body, mind, spirit, emotion – and especially the embodied reactions that we have to situations. In this sense, my position seems to crossover between autobiographical and interactionist approaches (Da Fina 2015), as I am not so interested in coherent co-presentations, but more in how people construct their sense of Self through narrative and how they can better be with the inconsistencies and incoherence that arise in the liminal spaces between language and embodiment, where we are always in relationship to something else. We cannot be separate from our experiences, past and present, nor the embodied felt senses and their often-imperfect cognitive translations as memory and narrative that come from them. Much of this, as Liu notes, is preverbal though I disagree with her presentation of infants finding
dissonance in speech; this is not so for all infants, many if not most of whom need
contact and speech alongside touch to make relational connections (Stern 1985;
Klaus, Kennell and Klaus 1995; Gerhardt 2004). I do find agreement in her sense of
telling our stories to others through language has a relational dimension that bears
some sort of obligation for comprehension. I would argue, however, this can be
outwith a therapeutic setting rather than in one: I would suggest an intention of
psychotherapy, including the sphere of the pre- and perinatal experiences, is to bring
a deep reflection and therefore awareness to those parts of ourselves that are
getting in the way of who we would wish ourselves to be. With awareness, we have
the possibility to change; it is awareness that offers the potential for healing (Sills,
2009), but the spaces in which we undertake these explorations is the beginning of
the process, not the end. Perhaps, like Angus et al. (2004, 91) I share “a common
faith in humanity’s innate capacity for self-reflective awareness and for movement
toward positive growth and self-development”.

My reading of pre- and perinatal regression experiences is that the cognitive process
of narrativizing them begins with a debrief at the time but extends well beyond the
session work. In this sense, then, I am suggesting that narrative is a languaged form
of awareness, the “reliving through language of that which is known but not yet
thought”, the unthought known, to quote Bollas (2018, xv) again. It brings a storied
existence to that which is nebulous, ethereal, shifting and multi-faceted. In my terms,
narrative is not seeking or demanding temporal coherence beyond the explanatory
roles it provides our self-understanding, not least of which are our selves-in-relation-
to-others. I always held the intent for my research to be about investigating how (or
indeed if) other people, like me, use their explorations of womb-life and birth to re-
construct the (hi)stories of themselves, to understand themselves differently, to shift
something in their relationship to their worlds, perhaps even to the world in general.
To understand how, as Didion says, “We tell ourselves stories in order to live” (2017,
11). How to elicit these stories of how it is to live, through the paradigmatically
appropriate method of interviews, is explored in the following section.
3.5 To Methods, from Methodology

To borrow Kathleen Stewart’s (2016, 661) words about autoethnography, but apply them to my narrative inquiry, I believe hearing and collecting personal narratives of womb-life and birth “is one route into a broader-ranging, more supple exploration of what happens to people, how force hits bodies, how sensibilities circulate and become, perhaps delicately or ephemerally, collective.” Her words directly seem to talk to womb-life and birth stories. This approach echoes the core ideals of recognising that scientific knowledge, in the empirical, realist sense, has limits when it comes to human lives, relationships and identity; there is an opportunity to connect “personal (insider) experience, insights and knowledge to larger (relational, cultural, political) conversations” (Adams, Holman Jones and Ellis 2015, 25). Laurel Richardson’s (2000, 934) notion of “crystallization” through a mixture of genres speaks to my methods, moving away from “triangulation” around a “fixed point” and drawing on scientific, literary and artistic genres which combine “symmetry and substance with an infinite variety of shapes, substances, transmutations, multidimensionalities, and angles of approach” (2000, 934).

3.5.1 Interacting with the voices of others

As my methodology unfolded and grew from its initial conception, mimicking the cell-by-cell developments of the prenates it focuses on, from being a very inward looking process of self-reflection, I felt a growing need to be in relationship with others as part of the method, to make contact and honour people who are drawn into the field of psychotherapeutic understanding of early-life impacts on our meaning-making. I felt a need to make a more rounded presentation of how womb-life and birth storying informs people’s lives.

An obvious route to capture the narratives of others that is coherent with my ontological and epistemological position was through qualitative, discursive interviews, forming an “interactional exchange of dialogue” (Mason 2018, 11), ensuring that the appropriate topical perspectives are spotlighted to generate and construct the contextual, situated knowledge. By discursive here I mean specifically how both researcher and the interviewee are both engaged in an activity in which
meaning, identity and reality is negotiated (Georgaca and Avdi 2012). Narratives are, as Greenberg and Angus (2004, 345) tell us, founded in experience: “The stories that tell us who we are emerge in dialectical interaction between the experiencing and the narrative-making selves”. Following Mason (2018), my logic is that womb-life and birth stories and narratives are meaningful properties of the social realities that my research was conceived to investigate and interviewing is a “legitimate or meaningful way to generate data” from people who are “witnesses on the world” (Mason 2018, 111). Ellis, Adams and Bochner (2011, 278) also promote the idea of interactive interviews, recognising how “reflexive, dyadic interviews focus on the interactively produced meanings”. They explain how such interviews are collaborative endeavours between researchers and participants, where both participant and researcher “probe together about issues that transpire, in conversation, about particular topics” (2011, 279) – in my research, those of womb-life and birth. As Ponterotto (2005) declared, deeper meaning can only be uncovered through interaction, involving a mutual exchange of views, thoughts and positions and where narratives are co-produced (Hiles and Čermák 2010). Freeman (2015, 29) might call stories of womb-life and birth “big stories”, the sorts of narratives “often derived from interviews, clinical encounters, and other such interrogative venues, that entail a significant measure of reflection on either an event or experience, a significant portion of a life, or the whole of it”.

The interview plan was therefore for interactive, unstructured interviews very much in the spirit of Chirban’s (1996) Interactive-Relational approach. His words that “An interview, in the true sense of the word, gives an “inner view” of the interviewed person” (1996, xi) stuck a chord with me, reminding me of my epistemological position that we cannot view from nowhere. The metaphor of viewing seems pertinent to this position, given that views of a landscape – what we can actually perceive - are what is presented to us at a specific moment in time, affected by not only the weather conditions, but also how we are feeling, thinking, and behaving in the space. It also reminded me of how “the sun rises every morning, but not all sunrises are meaningful” (Combs and Freedman 2004, 137); it is the sunrises that are meaningful to us personally that get incorporated into our life narratives, but it is
in the telling and retelling of a story to others that our meaningful sunrise becomes socially and interpersonally meaningful. In Chirban’s method, both interview and interviewee are participants and are free to express their thoughts and feelings about the topic under discussion; the interview can still be professional whilst at the same time being relational. Importantly, as a skill set, it requires of the interviewer to have: self-awareness, enabling greater self-confidence; authenticity to encourage open and sincere exchanges of feelings and thoughts; attunement with the interviewee to help open up to their world; and engagement with a relational dynamic as this also fosters open conversations (Chirban 1986). The interviewer’s own beliefs, values and characteristics, as well as their style of being-in-conversation with someone, have a unique and substantial effect on the interviewee.

My method was also informed by a co-constructed interview approach (Patti and Ellis 2017, no page), “an intimate, relational, and flexible method of in-depth, conversational interviewing” using an “interactional methodology in which narrative-eliciting questions play a role” (Slembrouck 2015, 249). Other techniques were incorporated, such as free association (Hollway 2009), which uses open-ended questions, avoids “why” questions, and uses follow-up inquiries depending on respondents’ answers and furthermore a Mishler-esque narrative interview approach (Hiles and Čermák 2010), which as Josselson (2013, x) noted, “is a special kind of conversation where general guidelines of exploration can be offered, but once the interactional, intersubjective journey begins, few firm rules can be applied”. Patti and Ellis (2017) indicate there is great diversity in co-constructed approaches, where dialogical practices can be analytically critical whilst also holding a compassionate ethic with participants. This made me realise my professional skills as a psychotherapist, with more than a decade of clinical experience, was undoubtedly useful, and the more free-flowing nature of this kind of unstructured interviewing felt more appropriate to the nature of my inquiry, rather than a set of questions that “had” to be asked and answered. It helped that these approaches were something familiar to me. Moreover, I felt the ability to ‘hold space’ and be attuned to the participant if they were bringing difficult material to the conversation was an important ethical practice in this kind of interview.
I fully recognise that any experiences of womb-life and birth constructed or reconstructed within the interview context, with participants being asked to narrate specific instances in their lives, have a temporal and historical element to them. This presents another challenge to presenting prenatal and perinatal experiences, which echoes Liu (2019) and my own reflections above about how to work with embodied, felt senses through language; is it realistic to present areas of our life that are so obviously preverbal through the medium of language, especially that which is constructed through narratives? Yet I am not expecting, looking for or trying to develop “absolute truth” based in the facts of womb-life and birth but expecting veracity and authenticity in the sense of how participants produce and construct meaning through their narrative understanding of what happened to them in the womb and/or through birth. These experiences form correlates to their psychological-somatic processes, accessed through education in the possibilities of how early life can leave imprints on us, and in participating in the experiential explorations of womb-life and birth. Participants are then bringing their languaged explanations of how womb-life and birth are inculcated in their own present-day as well as historical behaviours. This returns us to Frank’s (2010, 3) recognition that “human life depends on the stories we tell: the sense of self that those stories impart, the relationships constructed around shared stories, and the sense of purpose that stories propose and foreclose.”

3.5.2 The ethics of listening

“Stories of people trying to sort out who they are figure prominently on the landscape of postmodern times. Those who have been objects of others’ reports are now telling their own stories. As they do, they define the ethic of our times: an ethic of voice, affording each a right to speak her own truth, in her own words” Frank (2013, XXI).

As per University of Edinburgh protocols, I undertook a full ethics application (presented in Appendix A). This asked the ethics panel to consider both the implications of autoethnography (as it was, at the time, a potential line of inquiry for me) along with the ethical requirements for interviewing. In the application, I indicated my intent to conduct narrative-based interviews with participants in the
form of loosely structured interviews over 1 to 2 hours, conversational in nature yet steered towards my main research question. I had expressed a wish that these would ideally be face-to-face but at the time of the approval process – and indeed at the time of the interviews – University of Edinburgh protocols did not permit in person research due to the on-going COVID-19 pandemic unless it was critical to the methodology (which in my case it was not). I was therefore required to confirm all my interviews would be on-line via a video-conferencing platform (either Microsoft Teams or Zoom). As it turned out, this was beneficial to my analytical method, as I was able to rewatch, many times, the videos, which aided my comprehension and analysis. As I explained in the application, I did not intend to conduct ‘semi-structured’ interviews as this gives the sense of a list of questions to be asked: I wanted to be open to respond to answers to my main question, but did intend to have a set of questions as ‘back up’, in case some participants needed more directed interaction. This proved unnecessary in the event. Josselson (2013) recommends ‘little q’ questions which should be framed in language that participants are more likely to recognise than formalised academic language often seen in research questions, and that was the method I employed in the actual conversations I had. I also produced the Participant Information Sheet (Appendix B) and Consent Form (Appendix C) for use once approval had been granted by the Ethics Committee, which it was in November 2020 after some minor correction requests.

It is worth highlighting the ethical and reflexive dimensions of my study: drawing again on Mason’s helpful framework (2018), ethics should not be something confined to an application to an Ethics Committee once in a research project, potentially separating the researcher from their own personal responsibilities and agency, but it should be a living part of the on-going task, an ethical practice that covers all aspects from research questions to writing up. This matches the kind of professional principles of counsellors and psychotherapists, including in the pre- and perinatal field (White and Bardsley 2014) and as such, is a position and a role that is easy for me to continue in research. As St Pierre (1997, 177) put it, “We are always on the hook, responsible, everywhere, all the time.” This could not be truer of womb-life and birth stories where there is a direct, umbilical connection between mother and
prenate, held within a much wider socio-relational field of father and/or partners, siblings, medical and birth-assistance staff, friends and other family members including past generations. There is only a limited number of words to tell a complex history, much of which is subconscious, unconscious, embodied, repressed or multifactorial. It is not simple. It is complicated. It is not science; it is about the art of being human. That comes with multiple interpretations: I do not take this responsibility to others lightly, and I embrace my “relational responsibilities… to the unnamed, unwitting participants who are implicated in our self-stories” (Hernandez, Ngunjiri and Chang 2015, 537).

In terms of narrative inquiry, it is the interviewer who influences the information that is exchanged during interviews, as it is they who select topics, themes and question wordings, as well as conduct the analysis afterwards (Slembrouck 2015). Speedy (2008) encourages and advocates a constant, cautious navigation between the competing elements of honouring participant voices and recognising the aesthetic principles that guide the researcher’s production of text. Quoting Spry (2016, 81), I empathically and compassionately recognise that “there is no “I” without others, as “I” is created through sociocultural interaction with others in context”. It seems to me that pre- and perinatal psychology, especially through the use of narratives around birth and womb-life, is a “risky poststructural practice of redescribing the world” (St. Pierre 1997, 177) given its associated multi-dimensional possibilities, tensions, confusions and conflicts, which when explored in a dialogical manner force an embracing of the delicious messiness of our onto-episto-methodological reflexivity (St. Pierre 1997; Mason 2018; Willig 2019). Reflexivity itself, as Finlay (2002) pointed out, is equally multi-dimensional, from examining the co-constructed, situationally social interactions, to deconstructing conventional meanings, to reflecting on personal biases and prejudices.

It was also important for my ethical practice in this study to ensure that all participants were presented in my analytical chapter, with an approximately equal amount of space. The interviews I conducted produced a huge amount of data for analysis, as will now be explained, so balancing the output was not difficult, despite
the agential, editorial cuts I had to make in order to meet thesis length criteria. However, whilst I could have chosen to present one or two exemplars of the interviews in greater depth, perhaps with some smaller vignettes of other participants experiences, I ruled this – and other – options out early on in my process. I could not talk of ‘honouring participant voices and recognising the aesthetic principles that guide the researcher’s production of text’ and then further reduce the contributions. Each participant had given not just their time to my project, they brought deeply personal, affective and sometimes emotionally-charged experiences to share with me about their lives, their families and partners, storying the impacts of their womb-life and birth on their ways-of-being-in-the-world, and how their understanding of Self had been transformed through the pre- and perinatal psychotherapeutic encounters they had undertaken. Therefore, each of them, at the very minimum in my opinion, deserved as much of their stories as possible to be shared with others through this thesis.

3.6 Methods in practice: analytical approach
In this section, I explain my methods in practice and the analytical approach I took to the data I collected. As an overview, having concluded that interviews were an appropriate method for the epistemological and methodological choices I had made, I recruited participants to the study, transcribed the interviews, then coded them using several analytical approaches (Bazeley 2021). I coded for themes, following a method very akin to that proposed by Braun and Clarke (2006, 2022) for thematic analysis. For each interviewee, after coding, I produced forms of ‘analytical memo’ (Saldaña 2021), although these were complete essay-like productions for examination in supervision, more akin to narrative portraitures (Rodríguez-Dorans and Jacobs 2020) by selecting and rearranging extracts from interviews, making observations about them, referring to literature and other thoughts that emerged. Approaching the research in this way, as a “reflexive process operating through every stage of a project” (Hammersley and Atkinson 2019, 22), rather than a strict, linear sequence of steps or stages, elements of my research changed as the process unfolded. As I will explain more fully, it was this process that altered the trajectory of my analysis from a micro-focussed seeking of themes to a broader,
wider and more inclusive analysis that aimed to “present a product in which the participant is visible and cognisable” (Rodríguez-Dorans and Jacobs 2020, 613). As Frost (2009) found in her narrative analysis, systematic explorations of a text slowly enrich the understanding of it.

My frame of reference for analysis, including the shift in approach, was also heavily influenced by Arthur Frank’s (2012a, 71) socio-narratological methodology using what he calls “dialogical narrative analysis” as a practice, “as close to being a method as I can justify” he wrote. This practice looks at both a story’s content – what has been told – and its effects – what happens or happened as a result of telling the story. As he notes, in such an approach neither researcher nor participant need to be an “expert” in anything, including narratives or story-telling: “My use of narratology dispenses with the baggage of seeking any formal underlying model of competence, while holding on to the recognition that being human, and especially being social, requires the competence to tell and understand stories” (2012a, 13). In leaning into this approach, as well as other forms of narrative inquiry and analysis (Speedy 2008; Avdi and Georgaca 2007; De Fina and Georgakopoulou 2015), I thought of how a Bahktnian approach to voice - “no voice is ever singular – every voice contains multiple other voices” (Frank 2012a, 16) – can also apply to research methods within a narrative inquiry. This reminded me of Ken Gale’s words, drawing on Deleuze and Guattari’s (1988) concept of “assemblage”:

“We know that as soon as we talk of our experience, our genealogies and our histories, as soon as we align our relational ontologies in particular ways, something shifts; our assemblage, a “body-without-organs” (Deleuze & Guattari, 1988), disassembles and in so doing, follows a new and different line of flight, is part of a new affect, striating space differently, and is always becoming.” (Wyatt and Gale 2016, 301)

Gale’s words resonated strongly for me as I see such an approach to “assemblage” as ontologically and epistemologically consistent with my narrative-based approach to womb-life and birth stories. Firstly, the idea of a co-construction of meaning through dialogue, how we are all assembled from a variety of inputs inculcating and incorporating social, cultural, environmental, and historical elements, speaks to the
gestalt of our experiences. Secondly, it resonated in how Gale’s description also
endorses the therapeutic nature of storytelling and narrative, how it allows new
directions and affects to be developed through the telling of our lives with others.
Further, pre- and perinatal psychology could be considered very post-modern and
post-structuralist: the ontologies – from the realist to the relativist – all challenge
some of the basic assumptions and understandings of what it means to be human.
They are Jungian shadow materials, personally and culturally (Menzam-Sills 2021;
Appleton 2020), made unconscious and repressed because to accept a reality that
womb experiences might form part of our relational modalities or personality
formations, to “take with us wherever we go as a dark companion that dogs our
steps” (Stevens 2001, 64), challenges much of the foundations of how we live as
humans and our beliefs around individual autonomy, agency and power. Yet these
experiences are present in everyone who has ever lived – we have all been born -
despite being often disregarded, suppressed and unacknowledged.

I now offer a more detailed explanation of my method for this study.

3.6.1 Interviews to generate data for (narrative) inquiry
To recruit participants for my study, I contacted several providers of womb-life and
birth experiential regressions known to me from having been a client in at least one
of their workshops, and whom I knew worked both pedagogically and therapeutic
with the material that arose in sessions. My first initiative was to explain the nature of
my enquiry and research and see if they would support it by sending a Participant
Information Sheet (PIS) to people that has also been clients of their work. I did not
seek direct access to their clients, preferring to allow prospective participants to
contact me, through the details provided on the PIS, if they wished to participate.

Three organisations said they would do this, so I sent them the PIS, leaving the
organization to choose how this was disseminated to their clients, and with their own
message by way of introduction. Ethically, I made an internal choice that my
selection would be a ‘first come, first selected’ one, with a quota cut off at 10
participants. Two organizations sent out the PIS in early December 2020, and within
hours of the second one sending it, my quota of participants was full. As I had two requests to participate come in more or less simultaneously, I settled the final list at 11 participants. I had to turn down several other interested people after this. At the time, I expected that there might be some participants drop out, either before or after the interview, but this did not turn out to be the case, so my thesis is based on the 11 participants who initially signed up.

All prospective participants contacted me via my university e-mail account and the interviews were set up this way. Once dates and times had been planned, I sent a Consent Form for participants to review. As we were in the middle of the global COVID-19 pandemic, the Ethics Committee had requested that all interviews were undertaken, as per University of Edinburgh regulations at the time, on-line via Teams or Zoom; meeting links were e-mailed to participants. I therefore decided to seek e-mail confirmation of consent where participants could not scan, sign and e-mail the form itself.

3.6.1.1 Participant Profile and Interviews

I will introduce each of the participants individually in the analytical Findings chapter. I have assigned a pseudonym to each of them. However, as an overview, the profile of the participants that I selected as described above formed a cohort of 11 women who had all undertaken at least one experiential workshop in womb-life and birth using regression techniques. Some had only had one experience, some had completed a full professional training in therapeutic techniques with babies and infants, which included detailed personal therapeutic work in regression along with an educational programme on pre- and perinatal psychology. All were working in different ways within the therapy profession. Professional trainings that had been undertaken by the cohort included cranio-sacral therapy, birth support (doula), osteopathy, psychotherapy, therapy for babies and children and nursing. Many combined a number of these skills and trainings in a pluralistic way.

The interviews themselves took place in late January and early February 2021. The interview schedule is shown in Appendix D. These were, as already described,
loosely structured conversations took place over 1 to 2 hours, including the initial preambles of getting technology to work and introductions, and the debrief / closing out discussion, when I explained next steps to participants. The core of the conversations were around 45 mins to 1 hour for most participants, though some were longer. They were conversational in nature yet steered towards my main research question where appropriate. The on-line nature of the meetings did cause some issues when the technology did not work well, yet we were still able to produce affective, embodied and engaging conversations. The recordings were video as well as sound; I confirmed consent again verbally at the start of each meeting with participants and said that they could turn off the camera at any time, should they wish to do so. None did, so in my transcription and later analysis, I was able to re-connect to the actual verbal and non-verbal process of the conversation, which aided my understanding.

3.6.1.2 Transcription method
I transcribed all the interviews myself as, following Frost (2009), this helped ground me deeply in the interactions and get a feel for the flow of the conversation. I returned to the videos often during the process of analysis and indeed whilst writing the analytical findings chapter, and this made the process, for me, much more relational than just working from scripts that may have been produced elsewhere. Over time, I found I had internalized the voices and faces of the participants when working with the scripts, really allowing a ‘bringing to mind’ of the individual participants. I followed these steps to transcription:

1. First, I watched the video of each conversation in its entirety, to remind myself of the flow of the conversation. I took brief notes on occasions but avoided too much interruption to hearing the content. This process, as I have found with previous research, always grounds me in the conversation: as a professional psychotherapist, I am well used to tuning into a client’s story and forming a good memory of what is told to me.

2. I then transcribed the interview completely using a three-column layout:
   a. The left most column was for the chronological time that started each piece of discourse.
b. The central column was the transcribed words we said. I also made a key for pauses and overlaps in conversation where non-verbal or confirmatory words like ‘yes’ or ‘no’ were uttered and occasional laughter or crying were noted in brackets.

c. The right column was my ‘coding’, described below, although I also wrote and highlighted anywhere on the script in response to either space restrictions or a more ‘free-flowing’ analysis.

3. After the first transcript was completed, I re-listened to the complete interview again, making any necessary corrections to my transcript.

4. By now, I had listened to the interview at least 3 times, and parts of it more than that, whilst actively transcribing the words so had started to notice where there were repeated phrases or words, or where certain things ‘piqued’ my interest and curiosity.

3.6.2 Coding and thematics
As I will go onto explain, the process of manual coding alongside testing a software tool whose rules I had to follow eventually led to my abandoning thematic analysis as an objective of my production, even though engaging in the process itself was fundamental to the eventual outcome. Hence, it feels important to explain the steps I took in some detail that led to the production of this thesis.

After transcription was complete for each participant, I coded each one in some detail and wrote analytical memos in various forms – from notes to full length ‘essays’ – to deepen my reflections on the conversations. My intent at the time was to get an overview of each of the conversations, but also to identify themes, if any, across the complete data set. Having attended an Analysing Qualitative Data course through the University focussed on coding for thematic analysis mainly using NVivo, a software application, the reflective work I undertook was very beneficial in helping explore academic constructions of coding within the methodological framework of qualitative research, and my initial analytical approach informed by coding strategies laid out in some detail by Saldaña (2021), Braun and Clarke (2022), Bazeley (2021) and Richards (2021). In essence, my work at this micro-level drew on Saldāna’s
definition of ‘eclectic coding’ as “a form of “open coding” … [as] [t]here are many occasions when qualitative data can be appropriately coded using a repertoire of methods simultaneously” (2021, 223).

I prepared and analysed my data manually; I had pilot-tested coding one script on NVivo, but I found it too depersonalised, unintuitive and somewhat clumsy, resonating with Saldaña (2021, 45) that for me personally, “There is something about manipulating qualitative data on paper and writing codes in pencil that gives you more control over and ownership of the work”. The idea of working ‘bottom up’ manually contrasting strongly with what I felt to be the ‘top down’ approach of software applications. The steps I actually followed were as follows:

1. I went systematically through the transcript and made ‘coding’ entries by hand. These consisted of:
   a. Words or phrases repeated by the interviewee in the conversation. As two examples, one participant (Helen) said derivatives of “death and loss” sixteen times and “incubator” on nine occasions.
   b. Ideas, thoughts or other possible threads I was reading or hearing in words; these were my researcher interventions, a form of analysis. As one example, I noted parts where Helen talked about learning or discovering things, in her exploratory work, subsequent research activities as well as in the interview; I marked these as ‘discoveries’ as a coded theme.
   c. I noted certain parts of the conversation in which I had reflected back to participants what I had heard or what ‘came up’ for me in the conversation at the time. The interview was intentionally dialectic and hence (for me) had similarities to a therapeutic session.
Figure 2 below shows my initial mark-up for Helen’s transcription.

2. I highlighted these different themes – again by hand – on the transcript, sometimes noting new themes (Figure 3). I started to use coloured highlighters to provide some form of ‘grouping’ across the scripts. It was at this point I started to notice other aspects of the conversation – for example, Helen appeared to make ‘life statements’, as I saw them, and I marked them up – these could be seen as my identifying threads that I saw in her storying rather than ones she described.
3. The ‘codes’ were then typed up in the right-hand column, yet again re-visiting the complete data set. During steps 5, 6 and 7, I sometimes went back to the actual video / audio to re-listen to how things had been said.

4. After this, I converted the file to a pdf and used the highlight tool to replicate the hand-drawn highlighting (Figure 4). Once again, this allowed me to take time to review all the ‘codes’ and highlights, making adjustments and thickening or deepening my appreciation of the conversation.
5. After step 4, I moved different themes that I had identified onto coloured post-it notes, using the groupings in the transcript, but sometimes moving them a different group if this seemed appropriate. Some threads appeared in more than one grouping. So, for example (Figure 5), in Helen’s case amongst other colours, I had red notes for an “Alone / Not Alone” theme, purple for “incubator”, and orange for where she seemed to describe her ‘character traits’. Doing this, I also started to see more links between themes.
6. I put the post-it notes on a large sheet of paper, grouped in their respective colours (Figure 6). Looking at this more complete picture of themes allowed a further deepening of how I saw them potentially connecting.
Figure 6: Constructing a 'carpet'

This carpet\textsuperscript{24} then, formed the basis of my write-up of the stories. However, so that I could move it around the house (as I like to work in different rooms), I turned ‘the carpet’ into a ‘tapestry’ by adding some hangers. As I worked with the material, I started to re-arrange the post-its, or remove them once I had worked on a theme. Figure 7 shows the ‘tapestry’ hanging in the hallway as it had been in my clinical practice room, but a client was coming, so I removed it to the hallway.

\textsuperscript{24} My supervisor Seamus Prior had gifted me this ‘carpet’ and ‘thread’ metaphor for how he saw I was presenting my participants storied themes. So, I adopted and developed the metaphor but as I subsequently abandoned this approach, I have avoided explaining it here in more detail.
In summary, with each participant, I developed broad categories in a thematically analytical way. For Helen, to continue the example, these were: “Discoveries”, how the supportive information her main training, cranio-sacral work and more specifically the womb-life and birth exploratory experiences informed her self-analysis; and “Ways-of-Being”, relating to the construction of her identity through character traits and personality formations she linked to her pre- and perinatal experiences. These two broad themes had ‘sub-themes’, such as “Death and Loss”, “The Incubator”, and
“Interview Constructions” (Discovery themes) and “True/False\(^{25}\) or Divided Self”; “Being Stuck”; “Being Alone” and “Boundaries” (Ways of Being theme).

3.6.3 Working through (and out the other side of) coding

This micro-level coding and thematic analysis was important for me to really intensify my ‘listening’ to what was being shared; it was, in fact, essential to my process. Yet increasingly, I felt an increasing discomfort with a “clinical” analysis using multiple coding rounds, and a growing wish to step back to regard the gestalt of what participants were telling me, drawing on a definition of gestalt that considers the experience and beliefs of people as a whole thing, seeing the various parts whilst constructing “qualities that are more than the total of all its parts” (https://dictionary.cambridge.org). I started to form an axiological resistance to the language of qualitative research around “coding” and “data” even whilst I recognise these are important terms that are universally used in research. However, as I immersed myself in coding my data, it increasingly felt to me that for my purposes, for the nature of my research related to deeply intersubjective relational contacts through womb-life and birth, these words are too clinical, that the multiple use of the terms in reports started to make this researcher feel further and further away from the individuals I was working with. I noticed this most strongly in my attempt, as part of the AQD course, to use NVivo. I wrote in my diary at the time about my abandonment of the software:

“There are important epistemological reasons – mine, not a generalized necessity [for this abandonment]: working through the software (not with – I have to follow its ways, not it following mine), I am disconnected from Eliza, my participant, from her words, the ‘feel’ of the conversation as I’ve just transcribed it, the picturing of her face as she speaks, as she smiles. I seem to be looking through the glass of the screen at a distance, not seeing things as clearly, as though she’s in a different room. The conversation has stopped. And I am now observer. A clinician, choosing and applying a “code” or “node” to “data”. Clicking on things, pushing buttons, filling in boxes like some sort of

\(^{25}\) Winnicott 1965
official form feels much removed from the process of engaging with a ‘script’, printed, held in the hand, picked up and read, re-read, moved around … scribbled on, an ACTIVE process of engagement, as though the participant is still here with me. I must exercise care with her in my hands, be more respectful. Treat her as a person.”

What were, for example, the messages – conscious and unconscious – those participants are asking me to see in their descriptions of life, of relationships, of self-understandings that have been illuminated by therapeutic explorations of womb-life and birth, complimented by other “work” they have undertaken?

Thus, I became more interested in understanding the gestalt of my participants, and what brought this home to me even more powerfully was working with another participant’s transcript – the conversation Claudine and I had. In that conversation, as I coded it, and then looked at the codes, I realised she had used the words ‘boundaries’ or ‘unboundaried’ in at least three or four different ways. I suddenly realised that I could not put these different uses into one theme, let alone group them with themes from other participants, like Helen, who had also used this term. I would have to have different codes for different types of ‘boundary’ themes in order to group them across participants – and in doing that, I would have been losing the essential elements of the personalised narratives the individuals were constructing of themselves and their worlds. Furthermore, as Greenberg and Angus (2004, 331) said, in an echo of the carpet metaphor, “It is often the rise and fall of emotional themes – and the conflicting desires, intentions, goals, and purposes they represent – that provide the connecting thread that weaves together disparate experiences to create a meaningful and coherent whole: a storied experience”. This approach to the narratives of my participants thus moved from the micro to the holistic, whilst still retaining the individual meanings, themes, perspectives and issues that each of them was dealing with.

In searching for a way to work with the detailed thematic analysis I had conducted, without dissecting and dissipating the power of the narrative gestalts, I came across Chodorow’s (1999, 126) use of the term ‘commonality’, an intersubjective reflection
that “One can be separate from and similar to someone at the same time”, when commonality between active subjects is realized through appreciating someone else’s subjectivity and humanity in reflection with our own, as well as in distinguishing the differences between subjectivities through the commonality of separateness. This seemed to me to better fit how I could work with the commonalities in my participants’ narrative constructions, without a need to group what appeared to be similar constructions under a more depersonalised ‘theme’.

3.7 Presenting the interactions

I wrote into and around these coded transcripts, creating the ‘analytical memos’ (Saldaña 2021), and ‘narrative portraiture’ (Rodríguez-Dorans and Jacobs 2020), using these to explore, through supervision, my detailed analytical approach. Some of these were very long and detailed, others were in the form of mind-maps or conceptual frameworks, some just notes for, and from, my monthly supervision sessions. It was this complete set of data that I drew on to complete the presentations in the Findings chapter, one for each participant. In examining these findings, in the words of Helps (2018, 61) “What’s important for me is not just the story, the bit of information shared; it’s about the impact that this story – or this way of telling this story at this and future imagined moments in time – has”.

My intent in these presentations to help show what I have been shown, to appreciate the richness of the participants’ descriptions of their storying of womb-life, birth and other elements of their lives has created – and is creating – their sense of Self and ways-of-being-in-relationship, how through this greater awareness they have transformed the stories of negative impact into narratives that are “good companions” (Frank 2012, 145). Echoing the post-structural concept of ‘lines of flight’, “the elusive moment[s] when change happens, as it was bound to, when a threshold between two paradigms is crossed” (Fournier 2014, 121), I see the explication of these narratives as crossing the historical and perhaps normalised view of human experience as starting after birth and the alternative paradigm that pre- and perinatal psychology suggests – that pre-birth (and even pre-conception) experiences are formative in our personality and character strategy formations.
In conclusion, I believe I have demonstrated my research design, methodology and methods offer a multidisciplinary perspective to narrative (Hiles, and Čermák 2010) as being coherent and consistent with the ontological and epistemological positions that my research in womb-life and birth adopts. I have presented my ideas of researching womb-life and birth stories through interactive interviews as method and narrative explorations as analysis in order to understand how they are used as meaning-making in psychotherapeutic journeys. In the next chapter, I will present the product of my research.
Chapter 4 Findings

“I think of us as explorers, pilgrims, or wanderers spending evenings sitting by the fire”.

(English 1985, 89)

4.1 Narrative Reconstructions of Womb-life and Birth

In this chapter, I present an analysis of the conversations I had with my participants. In the subsections, one each for Helen, Patty, Elizabeth, Isabella, Claudine, Eliza, Mary, Penelope, Catherine, Violet, Isabella and Martha, my pseudonymised participants, I start by mainly using their words to tell their stories, and how they believe the various forms of exploration they have undertaken in pre- and perinatal psychology produce an explanation of their historical ways-of-being, and how these new perspectives offer greater awareness of why and how they have been, and could be, as Self-in-relationship. The explorations they have collectively undertaken include specific training courses oriented towards aspects of pre- and perinatal psychology; other training courses (such as cranio-sacral therapy) that have, where undertaken, opened up curiosity about conception, pregnancy, womb-life and birth; and specific regression experiences such as womb process/surround workshops and womb-life and birth regression weekends. Interspersed throughout, I offer the occasional reflection, interpretation, or definition of what I think participants might mean by certain terms, where I think it might help the reader ground themselves in the conversation between the participants and me. I show, therefore, through a presentation of their words, how better understanding of their womb-life and birth (his)stories has contributed to deeper, broader and more attuned Self-understanding, and how they see this has positively shifted their being-in-relationship modalities in their relational worlds.

I end each of these conversational pieces with the participants in a separate section, thinking with and from each of the conversations, where I bring in my thoughts and reflections on what I think their stories mean, and how I think they are answering my research question. I have created the term ‘retro-reflection’ for those moments where...
participants are recollecting pieces of their past, through the lens of pre- and perinatal psychology, and using the knowledge to adjust their understanding of those events in present-time. This echoes Freeman (2015, 22), amongst others, suggesting how “the relationship between time and narrative” utilizes “the phenomenon of hindsight, the process of looking backward over the terrain of the personal past”.

Often the understanding of the experiences and investigations the participants have made in connection with relational ways-of-being, through pre- and perinatal psychology, manifests as embodied felt senses of ‘knowingness’, a resonance through non-verbal sensations, arising emotions and somatic symptoms to the ideas and theories of PPN in regressions and educative, training seminars. Such explanations are often hard to describe in words, but I maintain undertaking pre- and perinatal psychology education and associated regression explorations is, in essence, a psycho-somatic-socio-therapeutic endeavour. The insights generated offer participants the possibility of cognitive-based reconstructions, sometimes partially, sometimes more fully; the integration of the embodied knowingness with cognitive interpretations happens through the elucidations provided by facilitators and through personal self-reflexivity of what has happened and how it applies to their lives. It also happens in therapeutic settings and in conversation with others, including with me as part of this research project. I contend these reconstructions are the assemblage of stories that participants form into (an) explicatory narrative(s) of their ways-of-being in relationship, both historically and how they would like to be, given the additional awareness that this work brings. Inevitably, like all therapeutic encounters, I would suggest, these activities result in changes to awareness of Self, allowing alternative ways of relational Self-and-other interactions; they can also create tensions in the possibility of re-forming alternative views of Self, a resistance to the letting go of previously held self-constructs and paradigms.
Here then, in this chapter, we hear in conversation with Helen, Patty, Elizabeth, Isabella, Claudine, Eliza, Mary, Penelope, Catherine, Violet, Isabella and Martha what explorations in womb-life and birth have lent to their narratives of Self and relational ways-of-being.

A key for the quotes used is provided below.

### Key for quotes:

- (...) is a pause by the participant in a quotation, approximately a second per full stop;
- … is an ellipsis
- (word) is an explanatory or qualifying word or phrase
- [word] is an editorial replacement of a word or phrase to that used by the participant, or non-verbal communication such as laughter
- **Bold type** indicates an emphasis by the participant
4.2 Helen

Helen was a forty-something married mother of three children who originally worked as piano teacher, but re-trained as a counselling psychologist after she turned forty. She had always wanted to be a therapist since her early 20s “but knew it wasn’t the right time, and hadn’t had a lot of therapeutic work myself, so wasn’t particularly grounded, and there was quite a lot of stuff to work through”. Helen’s interest in pre- and perinatal experiences was first “piqued” in childhood “because my dad has often talked, throughout his life, of memories of his birth and womb experiences, so it was very much open as a possibility in my world which”, as she understated to me, “I think, now, is probably quite unusual”. She remembered her father “… specifically talking about coming out of the birth canal and how scared he was, that he could physically remember that sensation”. Her therapist training organisation covered the prenatal territory in one of their seminars and her curiosity was re-awoken; this was “like coming home or something, it was a real sense of familiarity”. Helen went on to do a CPD regression workshop, which formed the basis of her storying with me.

4.2.1 Discovery

An important aspect of Helen’s storying was around how her mother “didn’t find out she was pregnant [with Helen] until she’s six months’ pregnant”. According to Appleton (2020, 104) “most often, [pregnancy] is confirmed between two weeks and month after conception, as [the mother’s] next period fails to occur” so when explaining this later-than-usual discovery, Helen’s mother had told her “‘I kinda knew something wasn’t right cos my breasts felt differently and reminded me of being pregnant in the past’. ” Part of her mother’s history, however, was that “she’d also had a number of miscarriages, so it had been really tricky to conceive and things”. Her mother had said to Helen, “‘so I went to the doctor, saying, you know, ‘I can’t be pregnant, but I sort of feel like I am’ and they did a test, and she was six months gone”. Her mother’s confusion was also because “she was still having periods, what she thought was periods”; the medical team, however, “discovered that the bleeding

26 A ‘fact’ I have constructed: in our conversation Helen told me she started training as a counselling psychotherapist at 40, which was – by her own account – seven or eight years before we had our conversation.
was because she also had a fibroid”27. Helen had formed two alternative and contrary narratives to this prenatal event in its contribution to different aspects of her character and her associated life statements. I have separated these out into the two subsections below.

4.2.1.1 The companion enemy: “the strongest will survive”

Helen associated one of her character traits with the story of the fibroid; she told me “The fibroid was growing alongside, and what they said was ‘the strongest will survive’. You know, ‘there’s nothing we can do about this fibroid, but one or the other is gonna get displaced’”, that is, either the fibroid or the prenate Helen would be displace the other from the womb. “I often have that phrase ‘the strongest will survive’, and then I think, ‘Yes, and I did’”, Helen said, rhetorically wondering “So, what does that say about my strength? … and I’m really determined”, that her “character can be quite intense and I’m quite pacey … like, once I’ve got the bug, I don’t tend to let things go so [laughs]”. Helen is narratively re-constructing one of her traits as being associated with this piece of her prenatal history, linking her really determined strength as a part of her that emerged from her battle for survival with the fibroid. “Some people would just say it’s stubbornness”, she told me, but Helen can over-ride this pejorative, negative stereotyping to see the benefits: “I can give myself that element of, there’s that fire and passion, that you have to work hard to make it through, it doesn’t just come easy”. She believes this strongmindedness has “really managed for me to get through some tricky situations. Which I would not have been able to do it if I didn’t have that strength”. Although she did not elaborate on what the tricky situations were, Helen drew the conclusion that “I can see that there are real (..) benefits from it being such a, a complicated beginning”.

Helen observed another, paradoxically less beneficial aspect, that “when I think of the fibroid, I think of it as a companion, even though that companion could have

27 Fibroids are “non-cancerous growths that develop in or around the womb (uterus). The growths are made up of muscle and fibrous tissue, and vary in size…. Many women are unaware they have fibroids because they do not have any symptoms” (NHS 2022c).
killed me?”28, noting “If I think about my life, I am also noticing that sometimes I can be drawn (...) to people that I, kind of, inherently know aren't really good for me. Or I will stick in situations that I know aren't really healthy for me anymore, but I will stick there”. Considering this shadow side of her determined strength to cling on alongside a “companion-enemy” with a narrative sense of her Self-in-relationship, Helen reflected “It’s almost like I’m waiting for there to be a different outcome, or that this person, that I know now isn’t good for me, might become good again, or might, you know, like that waiting for something to shift, it invariably doesn’t”. Helen said, “I notice that other people are very good at kind of going ‘this isn’t good for me, I’m off, and I tend to stick it out, and stick it out, and stick it out, hoping it’s gonna be different, and then realising ‘no, it’s not’. ” In realising a relationship is not going to change for the better, “eventually I have to kind of bite the bullet and realise, this is toxic, or this isn’t good for me or, you know, this is literally gonna kill me, and then I leave. But I don’t do that easily, I don’t do that quickly, yo- you know?”. Helen is associating her relational way-of-being that determinedly sticks out in unhealthy relationships with her paradoxical in-womb, life-or-death relationship with the fibroid, that if she clings on, perhaps things will improve or get better.

4.2.1.2 “I’ve got something wrong”

Helen also contrasted her determinedly strong character with other familiar life-in-relationship statements, revealing she had been thinking “about mum not knowing she’s pregnant for so long. So, I’m there, but in a way, I’m not, I’m somehow hidden, it’s almost like a death, ‘she’s (i.e. Helen) not really existing yet’. And then when I exist, I exist for a short period of time before birth”, meaning after the pregnancy was formally confirmed and acknowledged, it was only a short time before Helen was born. Helen linked this ‘not acknowledged as existing’ narrative to “the statements that always come up are ‘I’m a nuisance’, and ‘I’ve got something wrong’.” Helen also implicated the parental-relational dynamic with her internalised sense of wrongness because Helen knew her mother “… had a very difficult relationship with my dad, who was having many, many affairs”. Contextualising this difficult

28 The NHS (2022c) notes, for example, “If fibroids are present during pregnancy, it can sometimes lead to problems with the development of the baby”.

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relationship with a supposition of how her discovery and birth as a third child was received, Helen deliberated “… that is what makes me wonder (…) was I welcome? Was I a real joy? Or was it ‘aw god, that’s another mouth to feed, with a philandering husband who isn’t helping, who I can’t see a long-term future with?’.” Helen recognised this was her own speculative reflection, as her mother “has never said this, in fact, she consistently, vehemently says the opposite”; yet Helen had her own uncertainty about this, retrospectively balancing the possible impact on the family circumstances: “I mean I think they genuinely were (…) glad to have a girl (…) but I think it would have also posed a lot of problems at the time” and that for her mother “I imagine in a way it could have been very anxiety-provoking for her, so to actually have to admit ‘no, I am pregnant, this is going to happen’ … It was great, but I have a sense it wasn’t quite that straight forward, you know?”.

Helen’s narrative-making around this difficult parental relationship dynamic inculcates her “feeling, if I’m in that darker place, the statements that always come up are ‘I’m a nuisance’, and ‘I’ve got something wrong’. It’s always ‘I’ve got something wrong’.” She associated these feelings directly with her other thoughts of how she might have been received into the family field, saying “So I wonder if that is a feeling of, yeah, they were probably pleased to have a girl, but it was ‘god this is tricky’.” Helen is, as I understand it, retro-reflecting on the connection between her in-womb experience of being discovered with her sense of being a nuisance and getting things wrong as an internalisation of the difficult family relational dynamics around the pregnancy and in the aftermath of her birth. In psychodynamic terms, she has taken up the badness between her parents as being because of her.

4.2.2 Birth and the fear of death
Helen had come, through the prenatal regressions, to an alternate perspective on her lifelong “great sense of death being around, like a fear of death”. She had previously put down to having grown up “… in old people’s homes” - the family business was running care homes - “So I saw a lot of people die, and I assumed it (this fear of death) was from that”. Yet, in the regression workshop, when re-enacting her birth by asking participants to lie on top of her to create the pressure of a metaphorical uterus, she found herself needing “…to be pushed out, basically. I
knew that I was about to be pushed out, so all of the participants were lying on top of me”. Helen developed the story, saying “…I have all these people lying on me, and I can really feel I’m working with all my might to get out, and then everything just stopped. Like a sense of (..), like the closest I can say, is like, when I’ve felt depressed, where I just haven’t got the wherewithal to (..) do anything. Like I’ve given up, basically, it was that feeling of giving up”. Here, Helen is explaining how she was energetically trying to ‘be born’ and exit the restricted space, but at a certain point, she just stopped, not having the “wherewithal”, as she put it, to continue.

Again, she had the opportunity to discuss this with her mother, “And I later discovered that’s exactly what happened. I was kinda coming down the canal, I got stuck, there was a panic situation of ‘how are we going to get her out?’.” It was, in Helen’s words, “a particularly traumatic birth” and she connected this, and the embodied experience in the regression, directly with her pervasive sense of death: “So, that sense of giving up, like ‘what’s the point anyway? it’s all hopeless’ (..) that, I carry that with me even when I’m content. Does that make sense? It’s like, always in the background, like a pervasive sense of (..) insecurity or death or hopelessness”. Indeed, she had shared this experience of feeling stuck in the uterus with her mother, telling me “I again remember saying to mum, ‘there was just this sense of being completely on my own, and it’s very hopeless’ and she said ‘well, you know [Helen] we were, like, really ill’, she said, ‘I know I’ve not really, probably, told you fully before, but we both almost died, it was an emergency situation’”. Helen was moved to tears when reflecting with me on this part of her regression exercise and the thoughts, emotions, and feelings that it brought up for her.

4.2.3 Thinking with and from Helen’s story
Helen’s narrative-making with me in the conversation was wide-ranging and rich; in my analysis, I was left with a strong sense of how the stories of her origins have been convincingly linked in her investigations of Self-understanding, solidified through the narrative constructions of the womb-life and birth explorations she has undertaken, as well as how important the contribution of discussing the regression experiences with her mother have been in not only filling in more of their shared history, but how that has deepened the understanding between them. The very
essence of her origin, as she told it to me, that started with the conception problems her mother had experienced before Helen herself was conceived left her carrying, even now, “an expectation that life is gonna be a bit like treacle”.

When I reflected back to Helen how embodied her sense of having ‘got something wrong’ was almost a cellular level of knowing, she had responded “It’s exactly that … It’s not a thought, and so when other people are saying ‘well, give me an example’ I’m like ‘I can’t give you an example, because it’s in here’ [indicating her chest area with both hands], ‘it’s not, it’s not this’ [indicating her head with both hands]”. I was intrigued by this response indicating the chest area, as it reminded me of something Menzam-Sills (2021, 275) had written about “discovery trauma” being “stored and sensed in the heart/chest area”, describing how Emerson had also postulated “pre-discovery as relating to the upper chest area just above the heart” and “post-discovery, the time after being discovered, relates to the area just below the heart” (2021, 275). There is also something very poignant for me in Helen’s reflections of how her strength of character, the determined element of her beingness that won a battle to displace an “enemy”, also holds a sense of sadness, grief and loss at having to kill the companion which could have killed her; she seemed almost incredulous, yet equally compassionately moved, that she felt so connected to this companion-enemy, and it seemed to me this story held significant importance in her foundational work of Self-understanding.

In terms of my research question, my conclusion is that Helen’s regressive work gave her a mechanism to construct a linking network between her womb-life discovery, her “complicated” birth, as she described it, to bring clarity to her strengths, such as her determined drive, passion and ability to work alone, and her vulnerabilities. Leaving the last words to Helen, she told me the whole pre- and perinatal work she has done has given her alternative standpoints, and opportunity through the awareness to give her the possibility to change: “So, j-just sort of realising that if I can look at it from a different perspective sometimes, that is helping (...) that I’m not at mercy to it, it always comes back to the same thing. That it can be different, and I do have a choice, it often comes back to that statement too”.

4.3 Patty
After a brief introduction of herself as “a somatic experiencing practitioner, also offering family constellations, colour-light therapy, Tantra meditations and pre- and perinatal therapy … just all the bits I’ve collected over 20 years of my own exploration”, Patty asked me if I had a specific question about pre- and perinatal psychology for her. Patty took my answer, asking how she came into the field, as an invitation to unfold an autobiographical life history that started in her early teens through to her fifties, covering approximately 35 years of exploration of different healing modalities and experiences, including those in the realm of pre- and perinatal psychology.

4.3.1 A life-long story
Patty opened the account by locating herself in the library as a teenager “reading Freud and trying to find answers and like what’s wrong with this? and what’s wrong with me?” She declared herself, at that time, to be in what she called her “core shame” which caused “a lot of trauma symptoms at that point, you know chronic depression and self-harming and just this incredible - these feelings of such despair and longing to die that I couldn’t understand in a way”. Yet she feels her ability to self-reflect was her “saviour”, causing her to question “why am I feeling like this? Why am I standing on a bridge wanting to throw myself off?”. Her connection to this “health in the system, mindful system”, I suspect, is a retrospective labelling of that reflexivity but reminds me of Sills’s (2009) concept of inherent health, a sense that there is a core part of us that recognises we can be well and drives us, consciously and unconsciously, to seek the reparation and resolution of our woundings. Putting these existential and suicidal feelings down to more than living within “this disconnected family I can’t connect to”, Patty left home when she was very young, at 16 years old, and moved to a much larger city when she was 17, starting to train in a hospital. Patty did not expand what she meant specifically by ‘disconnected family’ but I am left with a sense that she felt somehow out of touch and unconnected to her family powerfully enough to wish to leave home at a young age.

She began personal psychotherapy in her twenties, then started to train as a counsellor herself but feeling she was “going to get bored with my story pretty
quickly… I feel like I’m going round this story but I’m not quite getting anywhere”, she sought out the services of an energy healer who “brought me more into this body, into energy and into my feelings and sensations”. Patty’s description here reminds me of shock and trauma work, where clients are encouraged to start to feel sensations in their bodies, a way of re-connecting to present-time awareness rather than dissociation from embodied presence. Patty quit her training in talking therapies and joined a tantric community; although this gave her “glimpses of a reality I didn’t know because I’d been in so much dysregulation all my life”, she also could see that “... all these spiritual practices” were “really not good for my nervous system” as they also “highly dysregulated my system, I got very unstable, really quite off my head at that point”. My understanding of Patty’s use of ‘dysregulation’ here refers to opposite of emotional regulation, “part of a large repertoire of behaviors to control, manage and overcome emotional states” (Zurita Ona 2020, 5) and she is, rather poignantly, owning her inability to be able to do so at that point of her life. Recognising there was “no foundation in there to really help me integrate the experiences”, she “quit everything, gave everything up and I went to live in a community [overseas]”. Here she found the integration she was seeking, giving her “loads of co-regulation … this wonderful container, working there, living there with other people that were compassionate, kind and also seeking and looking for answers (and) many opportunities to explore many, many, many different healing modalities”. This experience countered the isolated, alienated feelings of disconnection from society she had had back in the UK.

However, around her mid-thirties, she had reached a point where “I felt strongly I didn’t want to live in their … goldfish bowl of a spiritual community. I wanted to live it in the world" and so she returned to the UK. She met her partner then, who she had been in relationship with for 15 years at the time of the interview. They have both undertaken a plethora of different personal and professional trainings, including one Patty undertook in pre- and perinatal psychology with a North American therapist. This led to other pre- and perinatal trainings and Patty, her partner and Patty’s sister holding weekly triads to do experiential work in womb-life and birth for two years
together. Patty also built a clinical practice that works with babies, infants, and adults, including using pre- and prenatal therapy.

4.3.2 The contribution of womb-life and birth

Patty listed the areas she felt she had connected to in the pre- and perinatal trainings for me – noting that two hours would not be enough time in which to put all the different pieces - saying “… the umbilical connection, repatterning; conception, repatterning; preconception, repatterning. Growing the body, moving from formlessness to form”. In other words, Patty was suggesting that in her pre- and perinatal experiences, she had connected to the complete life journey from having no form (‘formlessness’ before conception itself) to having a ‘form’, that is a body in which to live in, grown in the womb. She has, therefore, brought in several conceptual ideas from pre- and perinatal psychology, which, sequenced chronologically, covers the period before conception (preconception), conception itself, establishing an umbilical connection (umbilical affect) and growing the body in the womb (embodiment). At each stage, she mentions ‘repatterning’, the re-adjustment of these historical imprints, drawing on the ideas of neuroplasticity and a conscious, cognitive process of ‘re-wiring’ the brain from an unhealthy pattern to a healthier one (Gorman 1975; Samat 2021). In Patty’s much more poetic words, she told me “I really felt like I went through a few months of just feeling … like I was regrowing my body in love. Like, the whole journey (i.e. embodiment) but in love, in safety and in connection, really feeling connection, love around me”.

From this deliberation on the results of her pre- and perinatal trainings, Patty revealed the crux of perinatal events that, in our conversation, she linked to some of her relational ways-of-being: “… I was a premature baby, I was an incubator baby, so there was so much there, and I was a C-section baby, premature with a general anaesthetic”. Here, Patty catalogues her birth experience, taking her beyond the story of her embodiment. In her words, her birth experience created “all those layers of trauma right at the beginning. There was so much betrayal, there was so much abandonment that you know, like, woor”. She is saying, as I understand it, that her premature birth via caesarean section carried out under general anaesthetic (that is, her mother must have been anaesthetised), resulted in Patty being placed in an
incubator. She identifies this as a multi-factorial trauma experience which for her felt, affectively, like abandonment. She is leaning, I believe, into the theory posited in pre-and perinatal psychology that a caesarean birth under anaesthetic, followed by isolation in an incubator, leads to bonding difficulties between baby and mother, giving the sense to the neonate, despite the life-saving interventions of the medical staff, that they have somehow been abandoned (Emerson 1998, 2001; Milliken 2007; English 1985).

In Patty’s narrative construction, it was the ‘container’ of the pre-natal triad work with her sibling and partner, along with the years of self-developmental courses and practices, that allowed “the refinement in my dance. You know, with my dances with my partner, with my sister, those very close relationships, I see the refinement in the three of us, as we’ve all used our connection with each other to grow and to learn about ourselves and keep coming back together and working it through”. The storying Patty did, echoing Frank (2012), taught her who she is and how she has been self-educated by the story of her life narrative, her consideration of the earlier elements of her beinghood arising within a hierarchy of her self-development, or certainly at least the deepening of the inquiry. Moreover, Patty talks extensively about the greater understanding of the perinatal allows her increased capacity to manage attachment anxieties through an increased tolerance. I will close this section with her words on the value of how pre- and perinatal work has helped her change through a deeper understanding of Self:

“I'm down in the real core of myself. And it's amazing to be there. And it's exciting to be there, you know, and err, and it's exciting to feel the places where I can feel the disconnect and I can [blows out] feel the resource, I can feel this pain. I can find my way back more easily. You know? And um. Triggered less, my window of tolerance has increased massively. You know, I have a deep level of relaxation in my system now that is incredible, compared to where I started”.

4.3.3 Thinking with and from Patty’s story
The conversation with Patty was unique in that she framed so much of it with a fuller ‘autobiographical life history’, from her early teens up until we met in January 2021,
reminding me of how autobiographical work, in various forms, is therapeutic (Da Fina 2015; Siegal 2012; Halton-Hernandez 2023). Within the unity of this quest, therefore, it seemed impossible in my analysis to only focus on the elements of womb-life and birth, the pre- and perinatal realm. Yet in the context of this thesis, I draw attention to certain elements of how she expressed narrative-based self-interpretations of the importance of womb-life and birth and illuminate where understanding is separated and differentiated from explanation, adopting the hermeneutic-phenomenological argument offer by Giddens, cited by Flyvbjerg (2001). Particularly as Patty was often not direct in her explications, leaving – in the analysis – gaps and connections to be filled in, there is inevitable a double hermeneutic where my interpretations are drawn in.

I have realised what is noticeably in her explications, though, is a direct connection to the conditions of her womb-life. So, although she talks of ‘the whole journey’ from repatterning pre-conception onwards, the explicit trauma is located at birth. Dialogically, we can be curious about the details that are omitted in a story whilst remaining “committed to understanding how stories make life social” (Frank 2012a, 112), without a ‘finalisation’ of Patty as a research participant, or as a person herself, and all the characters that are presented in her narratives. My precis of the basis of her lifelong psychotherapeutic journey up to the moment of the conversation with me was one of an increasing intensity of self-inquiry, constructing a greater understanding of her attachment misattunements. Then, as she told me “I could go deeper into my birth work. And, erm, deeper into my early attachment working, birth working. I mean just deeper, deeper, deeper. Um, err, and it’s been [pause]. Yeah, a beautiful journey”. This more profound learning showed her how she could be held, physically and metaphorically, in what she considered and needed to be a safe way in order to be more of herself, and “so so much changed about being seen, deeper levels of being seen”. Patty also frequently referenced embodied experience, hers and with others, reminding me of Heavey (2015, 432) saying “the first relevant aspect of narrative embodiedness is the material body as the source and the topic of a narrator’s stories”, and of Frank’s (2012, 44) words: “In storytelling, the body embodies the story, which consummates the experience of the bodies participating
in the storytelling”. For Patty then, her narrative translations helped her inquiry of “what it is to be human in a world that requires adaptation” (Frank 2012a, 45), a furthering of, or another layer of, journeying that built on the previous explorations she had done from her early 20s on; “You know, so healings, you know, expanding my internal mother and my internal resources so that more of the trauma imagery could come through, y’know, more and more”.

How she understood her womb-life and birth stories as part of her social development is complex, covering everything from pre-conception through umbilical connections, after the formation of her physical body from a formless (preconception) state and touching on ideas related to bonding and attachment in relation to the traumatic birth experiences of being born early via a caesarean section with her mother under general anaesthetic. She readily juxtaposes positive outcomes (for example, her learning to ‘repattern’) with negative experiences (such as her birth story). She spoke of having often been “on the edge of connection-disconnect all the time, so enormous, the tidal waves are so enormous of the shock”, and how the prenatal triad work she did with her partner and sister provided “a container for that to move” and taught her that “to do it without support, I can’t begin to imagine how you would touch it without skilled support, you know?”. I suggest this shows her narrative reconstruction in action – the drawing together of what has happened (the stories) with how stories are strung together as narrative to motivate change actions and to bring understanding to her life (McLeod 1997; Frank 2012a).

In my analysis, I theorise that it is through the use of narrative that Patty relates the psychological and affective impacts that an emergency caesarean birth can be a shock and trauma experience for the baby as well as the mother, and can result in “deficient bonding that carries into childhood and adulthood” (Emerson 2021, 571), to her early relational disconnects: “this disconnected family I can’t connect to”; being “relatively sane in some places” but in getting close to someone “I’m insane”; the destabilizing of her second relationship when she started to have therapy, the angst of separating and moving house; and the creation of “heart-breaking abandonment” as she put it. At the same time, the acknowledgement by English (1985) that certain
characteristics cannot be uniquely attributed to caesarean-born children challenges the viability of attempting to link specific experiences to certain outcomes in a linear way. This is, of course, true of all personality traits: perhaps the only the certainty is, I surmise, that there is no causal link between specific experiences and specific outcomes in the human social world, as each person reacts to similar situations differently. This is where the focus on the use of narrative in self-understanding has a role; the translations of stories into narratives are an important development in a psychotherapeutic translation of life events into personal meaning (McLeod 1997).
4.4 Elizabeth

Introducing herself, Elizabeth told me: “I’m 41, married, got two lovely children … and I work as a teaching assistant at their primary school”, and “I’m a cranio-sacral therapist”, something she had retrained as, after previously being in a corporate services career. “I think it was the birth of my first son, erm, he’s really led me, erm, on this path, erm, for sure, definitely”. Explaining in more detail, “So, we were struggling to conceive … I was diagnosed with polycystic ovaries\(^{29}\), and we ended up, cutting a very long story short, having IVF\(^{30}\), and the second cycle did work”. However, her baby “decided to be premature… he arrived nine weeks early, emergency c-section. As you can imagine” she continued “very distressing, and I can feel my heart going just now”: even the telling of this memory of giving birth, more than a decade before our conversation, causes some stress or anxiety for Elizabeth. “As a consequence of that, and him being so poorly … he was struggling with all the usual, colic\(^{31}\), reflux\(^{32}\) and Elizabeth was introduced to someone who, ‘they said, ‘look, she’s a midwife, but she also does this weird thing, you’ve got to go and see her’.” The ‘weird thing’ was cranio-sacral therapy and Elizabeth’s son had treatments which proved effective. Elizabeth also subsequently had treatments with this therapist and with a cranio-sacral therapist friend, which started her on the “path” to train as a cranio-sacral therapist and a deepening exploration into the pre- and perinatal field.

4.4.1 Unwinding into the field

Elizabeth told me in the therapy sessions with her friend “I could just feel my left ovary, funnily enough, was unwinding. It was the most extraordinary thing… I was getting images of a spinning wheel [making wheel / unwinding motions with her

\(^{29}\) “Polycystic ovary syndrome (PCOS) is a common condition that affects how a woman's ovaries work” (NHS 2022d) “one of the most common causes of female infertility. Many women discover they have PCOS when they're having difficulty getting pregnant” (NHS 2022e)

\(^{30}\) “In vitro fertilization (IVF). Fertilization of an ovum outside the body, a technique used in women with infertility and also for purposes of surrogacy and egg donation” (Dictionary of Nursing, 8th edition)

\(^{31}\) “Colic is when a baby cries a lot but there's no obvious cause” (NHS 2022b)

\(^{32}\) “Reflux is when a baby brings up milk, or is sick, during or shortly after feeding. It's very common and usually gets better on its own” (NHS 2021b)
hands], you know, someone sat there on a spinning wheel, and it was going round”. When she said “funnily enough”, I think she meant it was specifically her left ovary, as opposed to both or the right one, that she felt was unwinding. Two months later, Elizabeth conceived her second son. Even at the time, “I was just thinking ‘my god, my period’s late, I can’t possibly be (pregnant). I mean, don’t be ridiculous. But, you know, my period’s late’. And then I did a test” and she was indeed pregnant. “I no longer have the, erm, you know, the polycystic ovaries” Elizabeth told me “… well that diagnosis, they said, they can’t see any issues. So yeah, it’s just such, such incredible stuff” and “so that’s why I hold cranio-sacral therapy in such high regard because it unlocked something for that”.

4.4.2 Experiencing toxicity and love
As part of her cranio-sacral training, Elizabeth undertook some personal regression work, a womb-surround weekend workshop. “From the moment that I entered that space” Elizabeth started her storying of the workshop, “…you can see I’m doing it now, with my lips, you know, the umbilical [pointing out the pursing of her lips, closing them tightly together]”: Elizabeth, it seems, started to have some kind of immediate embodied reaction from being in the workshop space, as though the atmosphere was itself affective, and she continued, “I started to get a headache and I never get headaches… just here [rubbing her forehead], I was getting this incredible headache”. Elizabeth thought this headache, which persisted throughout the weekend despite Elizabeth “drinking lots of water … It wasn’t getting any better”, was because she was away from home in a hotel and dehydrated. When her regression turn came, Elizabeth lay on her side “… and then it just turned into this [continuously touching forehead]. This part of my head (glabella) was just rubbing against the the futon, or the duvet, whatever it was on the floor. There was just this whole movement like this [rubbing forehead from side to side]”. Supported by the “very reassuring” facilitator, “what came through is my mum, which I knew, smoked quite heavily while, err, she was pregnant with me. Erm, so there was this, which I

33 Elizabeth is referring to Metaphorical Umbilical Mouth Movements (MUMMs) (Appleton 2020).
34 Elizabeth was rubbing a spot on her forehead known as the glabella, just above the eyes and in the centre (Appleton 2020).
get a lot when I’m talking about my birth, is my throat gets very tight, erm, and [voice becoming croaky], I just could get that sense of the toxin”. Here, Elizabeth is noticing the croaky throat she often gets when talking about her womb-life and birth, relating it to the toxins she experienced in the womb due to her mother’s smoking habit.

Elucidating on these “overwhelming senses of toxicity”, Elizabeth told me how “... it just felt very, err, very dark, and almost like I just could not be bothered, like it was just too much effort [rubbing her forehead again] to just, just do this [rubbing her forehead], it was just too much effort, err”. In the moment, then, Elizabeth was overcome with sensations of deflation, almost depressive-like symptoms, wanting to give up on her burrowing motions. However, “something, [continuing to rub her forehead], I don’t know what, but it was just like ‘no I need to, I need to just, I need to just try again’. It was like ‘I need to just try again’” so “I kind of moved, and then started this process again [rubbing forehead]” (presumably on the futon / duvet flow, as before). As she started this movement again, Elizabeth “just got this overwhelming sense of light and love. And I very much got a sense that my mum had just found out that she was pregnant with me”, Elizabeth remembering that “she always said that was the happiest phone call of her life, you know, they rang and said, “oh, we confirm you’re pregnant”. So, [looking upwards, opening her hands to gesture as though light coming down from above] I just got this overwhelming sense of unconditional love and light coming through and it was just beautiful”. There was something euphoric and joyful in Elizabeth’s gesture to show her experience of this love and light; yet in the regression, this warm and tender moment was short-lived as “then it almost went, it almost went a bit dark again. Erm. [pausing] So err yeah [pausing], it was quite, [laughs] quite intense”. Her description evoked in me an image of clouds coming over the sun, a physical darkening in contrast to the love and light, although it could also be a metaphorical, intrapsychic darkness, like the black dog of depression stealing into her affect awareness.

In helping Elizabeth unpack an interpretation of these potent, emotive affects, the facilitator explained to her “‘here, this headache’[touching forehead] … ‘that this is the implantation spot here’ (the glabella area)”. Elizabeth told me “my sense of it was
my mum was smoking and … you think how it must affect the womb, you know, having this this nicotine, this poison, it doesn't give it that lovely spongy, you know, environment, this welcoming environment". Elizabeth has construed that the womb environment she was trying to implant into had been ‘poisoned’ by the nicotine from her mother’s cigarettes, making it difficult to attach to the uterine wall as it was an unpleasant, unwelcoming place, and had interpreted the felt sensations in her forehead and the headaches as being a pre-natal imprint related to this implantation experience of her blastocyst. Elizabeth was left with “the paradox, if that's the right word, of this erm, you know, my mum who has made me, and and loves me, why is she, on the other hand, poisoning me?”. Elizabeth mimicked talking directly to her mother by saying “And kind of confusion over ‘why, why am I being poisoned, when you’re supposed to love me erm, and look after me?’ You know, ‘my source of life is being infected’, literally so”.

4.4.3 Implantation imprints
In connecting these regression experiences of toxicity and confusion with her sense of Self, Elizabeth told me “the big thing for me is the dissociation”, how she thought “the shock, I think I almost, err, you know, removed myself from myself. Erm, I think it definitely displaced, I I I just wasn’t fully embodied. That was the sense of it, that there’s definitely these parts [gesturing away from her body to the side] that I’ve kind of put out there”. My interpretation of this is how, in the womb, Elizabeth, as a prenate both at implantation and afterwards in the womb, wrestled with her felt sense of paradoxically being loved, and at the same time being poisoned by nicotine coming in through the placenta and umbilical cord. I believe she is saying a form of toxic shock caused her to dissociate from her body, to displace or push away the trauma, psychologically, as another ‘strategy’ for dealing with the noxiousness. She reminds me a lot of psychotherapeutic representations of dissociation when she explained “I always say it, when I’m in therapy and things, that I’ve just been over here [gestures to the right of her body at arm’s length], somewhere almost as an observer” and how “I certainly haven't been present for my, for most of my life up, until this point of enlightenment on having [her first child] and going in this, you know, holistic direction”.

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Yet, despite all the negative aspects she had associated with her womb-life, Elizabeth drew on the facilitator’s observation of the regression (and by definition, what may have happened in the womb) that Elizabeth “had to fight really hard” and “didn’t give up as well”, and had extrapolated this to consider how “because I didn’t give up, and not only did I not give up, I tried again, and even though I was in this sort of almost hostile environment, I was determined [rubbing her forehead again], you know, to keep burrowing in, and to implant, and to live”. From these deliberations, Elizabeth derived a narrative meaning, which she presented to me as: “so from that I really took that I have a real purpose in this life…. it really gave me this. I thought I’m so pleased that I’m here because there must be a real reason for me being here”. For her, the regression and the sense-making that came from it, “was quite, quite incredible” and she appeared to me, in the moment, emotionally affected by making this statement.

4.4.4 Thinking with and from Elizabeth’s story
Taking a holistic view of these stories Elizabeth shared, I conclude there are two prevalent themes: of finding a purpose in life through the pre- and perinatal field, something that transformed her life; and, overlapping with the first, the overt embodied nature of her inquiry.

4.4.4.1 A purpose in life
Exposure to cranio-sacral therapy sewed a seed in Elizabeth to explore life beyond a corporate office job - it “just opened up a whole new channel in my life” she told me: “I just felt very strongly that I didn’t, you know, after spending all that time and money, and investing so much into these wonderful little boys, I didn’t want to hand them over to someone else and go and sit in an office”. The experiences of her conceptions through IVF treatment and the challenging circumstances of her first birthing made her think “we’re not just here to, you know, work and earn some money, and have some children and then die, there’s something else going on here”. There is a transcendental narrative here, I believe, an existential inquiry connecting to a greater meaning of life which has been unwound and unlocked, to draw on Elizabeth’s metaphors, through the difficult life circumstances she, her husband and her children have faced. Elizabeth also left me with the equally strong impression of
her narrative re-structuring from this regression work which had led her to follow a path to train as a holistic healer and provided a much wider awareness of connectivity to the world to be, in her words, “as natural as possible and very passionate about the environment”, to be “very keen on anything that happens with the children”. Ultimately, she thought “the world is in a bit of a dim place at the moment and it’s just anything I can do to try and send out some heart energy and some love to make that better”. In developing the narrative of transformation, I posit that Elizabeth is using two of the six therapeutic processes identified by Kaminer (2006, 481), in her meta-analysis of trauma narratives: she is, in effect, “developing an explanatory account” of her implantation and womb-life based on “the creation of linguistic representation” of the regression experience, along with the subsequent connecting links to her embodied ways-of-being; and doing further integration work by realising the “value in adversity” and thereby “the identification of purpose” (2006, 481).

4.4.4.2 Embodied process
In Elizabeth’s recollection of the regression process was a deep connection with embodied process, and non-verbal gestures were very prevalent throughout the conversation, not just when she was demonstrating certain aspects of her experience, but seemingly unconsciously as well. The rubbing of the forehead and the sucking in of breath through pursed lips are both represented in pre- and perinatal literature. In the former case, this site is linked with implantation; drawing on a ‘template of embodiment’, where embodiment is defined as “the movement between non-local consciousness, and biological life and the subsequent biological stages leading to implantation” (Appleton 2020, 66). One theory of why the glabella has been associated with implantation is that “cells from the original implantation site migrate to this area during early embryological development” (Appleton 2020, 91). Elizabeth expressed her wonder at how, in the regression, her psyche, through her body seemed to show her how to respond. Meanwhile, pursed lips and sucking in breath is a characteristic MUMM (Appleton 2020). Elizabeth did these different movements in relation to her experiences of the implantation headache, not being able to breath properly, being stuck in the birth canal, and her sense of dissociation. It gave me the strong impression she still could feel sensations related to her stories.
of the regression weekend, even in the conversation with me. Going further by linking the sensations to her history of feeling dissociated, Elizabeth also told me “just being present, and really grounding myself, and breathing even, you know, as a therapist, being able to just breathe, and be comfortable about breathing in and out deep breaths, that [breaths out, almost a sigh], that is just an effort to me”.

Coming back to my research question, Elizabeth offered an interesting perspective of meaning-making through felt sensation in the body, and the power of translating those embodied feelings into a cognitive-based explanation in the way that Kaminer (2006) and Heavey (2015) suggest.
4.5 Isabella

Isabella was a somatically oriented practitioner based in mainland Europe, who ran a clinic utilising a range of professional training and experience in physiotherapy (her initial training), osteopathy, fascia training\(^{35}\) and pre- and perinatal therapy. As she explained to me: “I work, err with babies and, and from babies to adolescent, and then I work with adults. I work sometimes with the whole family system. And some sessions, just with the kids or just with mum, depends the needs on the client. Um, yes. I work also just with adult and pregnant, also pregnant ladies. I work from conception to birth, yeah”. In telling me how she had become involved in pre- and perinatal psychology, she said “Well, it was a mix in between work and personally as a mum. So, because in work I’ve been deepening in somatic process, err I have seen how birth and early times matters. Even in the adult time [laughs]”. My understanding is her route into pre- and perinatal exploration had unfolded organically as part of her professional practice, because “I had a lot of curiosity, why, you know, because it was [sound issue] always a point where somebody connected into back then, or suddenly you felt it was birth happening through the session, you know? And it was arising and arising, and I was like, why is it always like this, you know?”. I would clarify this reflection as Isabella noticing the presentation of somatic processes in clients during clinical sessions that she interpreted as them re-experiencing, in a regressive way, embodied elements of their birth processes.

The other element of her curiosity was driven by her relationship with her children because “as a mum, err, you know my kids are my master in life, you know [laughs]. I have learned everything from them, you know? So just observing them and how they reflect back things on me… I’m so curious why this is like this, why I connect with them in this way and that way, and why I couldn’t be like this, if I will

\(^{35}\) The connective tissue network—or “fascia system”—is a single integrated, full-body sensory-organ responsible for storing, releasing, and transferring elastic energy. Fascia training describes sports activities and movement exercises that attempt to improve the functional properties of the muscular connective tissues in the human body, such as tendons, ligaments, joint capsules and muscular envelopes. Also called fascia, these tissues take part in a body-wide tensitional force transmission network and are responsive to training stimulation (Schleip 2011).
want to be like this with them, you know?”. Isabella gives me the sense of an acutely attuned mother, who really wanted to, and wants to, understand how to be in relationship with her children and she is curious as to what was going on for her when there seemed to be a disconnect between how she would like to interact with them, and how sometimes, on reflection, she behaves differently.

4.5.1 Giving birth
One of the life stories Isabella told me that led directly to her investigating womb-life and birth in a more systematic way was giving birth to her first daughter. As she related “I'm train in osteopathy and I learned many things in the, in the gynaecologist part, on how important was a natural birth for the baby, for the cranial structures”. It is not completely clear what Isabella meant by ‘a natural birth’, but in connection to her reference to cranial structures, I wonder if she meant births that did not use mechanical obstetric methods like forceps uses. This education in osteopathy, however, meant for Isabella that “…when I got pregnant, I got so curious about this. I learn it before, but I bought even more books, I was reading, getting ready for birth, watching a lot of natural births in England in erm, well, in some places in Europe”. She felt she was “mentally prepared” and “quite open for this experience”, going to the extent of moving home and changing “the place where I was giving birth, OK, because in my hospital, they were not very supported births, they were a lot of interventions and I really wanted to go for a natural birth”; Isabella felt the need to relocate to a place where she had access to birthing practices that more met her individualised needs, giving her more of a feeling of being “so prepared (laughs) I I was super prepared. Yeah. Then birth came”.

Despite it being “a very smooth birth; it was long, but it was it went well” Isabella felt that “after giving birth … I find out that I needed a lot of support to be able to connect with her [her daughter] at some points where I was slee-, where the tiredness was taking me away from the experience, OK?”. Her need for support was because Isabella experienced what she called “pain tiredness, because I didn't take any medication at all … [her daughter] was born with no problems, no interventions, but I felt guilty for not being conscious all the time there, you know? And being drugged by my pain, by my tired- tiredness”. As I understood her telling of the story, after all her
desire and wish to have a birth that was ‘natural’, without interventions – including pain relief - Isabella actually felt as though the pain of birth itself had made her, on reflection, feel the same as being drugged and she felt subsequently she had not been fully ‘present’ or connected to her daughter (psychologically and/or affectively) because of this. My understanding of our conversation is also that she had this experience during the birth, rather than after it; her words “after the birth” I think, in context, refer to her realisation after the event how ‘disconnected’ she had been. This experience caused Isabella to ask herself “… why, why, why, why this happened? Why this happen?” and how “So all these questions is the questions that drove me into PPN work.”

4.5.2 Reliving a “birth sequence”

Isabella told me a couple of stories about her regression experiences, where she talked about her “birth sequence”, which I understand as her pre-conception through to birth experiences (Castellino, Takikawa and Wood 2001). She continued “And well, I have probably, in the beginning, I could get a bit of a stuck place, you know? Maybe in the conception phase or, I would say, preconception phase, OK, like not, not a deep desire to come forward, you know, in life. um hum. I think I was not super eager to come into life, OK? [sighs]”. Isabella was telling me the regressions she had undertaken left her with the spiritually-based ontological belief, that before conception she was a reluctant embodier, able to feel reluctance about coming-into-being, reluctance to be conceived and born as a human. Isabella linked this pre-conception aversion to some of her reluctances in daily life, as she continued, after her sigh, “Erm (…..) how I see that in my life? (…..) err, well, that is represented, for example, when I’m at work, I’m very connected with my deep, like my deepest part of me, you know, I feel myself fully, you know”. Her work, then, allows her a connection to what she identified as the “deepest part of me”, which, she explained further “I feel myself expanded and I can work for hours. And sometimes it’s like waaay [expressing joy and excitement] and feeling a lot of gratitude for what I do … there’s a magic there, you know?”. Her description gives me the impression of this deep attunement to her therapeutic work, incredibly focussed as she practices, almost lost in the flow of the work and the joyful energy it produces is expansive, a liminal space. This ‘magical’ feeling was contrasted by Isabella as “… sometimes when I’m
out of that scene, like (in) a more 3D world, life rushes, (there are) routines to follow, then it’s like ‘oh, I don't like this!’ [laughing]”. So, as I understand her here, outside of the work where she can be connected to the deepest part of herself, in the ‘real’, non-liminal, three-dimensional world, she experiences life as rushing by, where there are routines to follow, and (by inference) she is no longer connected to her deeper, perhaps more spiritually-oriented, parts.

Giving examples of the phenomenon in her personal life, Isabella said “…err, when you have to drive your kids into town, when you have to get them ready, I don't know, there’s so many, when you have to do food because there is no other choice. All these, you know, things”. For her, these worldly phenomena outwith the expansive energy of her workplace, “it's like, ooof, a shock, you know?”. The meaning she makes of this shock is “… probably the, err, not a fully desire to be come into form, you know, into the normal life, into the body structure, OK?”. I believe she was telling me that her reaction to the rush and overwhelm of the ‘real’ world is a recapitulation of her not wanting to embody at conception. Isabella contrasts this with an understanding of her preconception, as explored in her regression work, as a formless, energetic experience - “you know, where we haven't become into form, and everything is more energetic, OK? And I feel really connected, my, like my profound part of me is so connected into that”.

One of the other learnings Isabella had from regression sessions was also related to connections, but this was “something at birth, that I lost connection with mum, OK?”. Explaining this loss of connection, Isabella said “… we have been trying to figure out what kind of, err, anaesthetic she (her mother) had, because it wasn't, it wasn't any strong drug, we are sure about that. We check it with [trainer's name] about that times (in those days, at the time of her birth) and… what they (the medical profession) were using (as anaesthesia), but we think it was just, so medication by the vein, err through the veins (that is, an intravenous drip)”. However, Isabella explained that “only, that mind-chemical imprint, I, like I felt it really bad in connection with mama through, during birth, you know?”. My translation of this is that her mother had had a venally administered anaesthetic which despite, in Isabella's analysis, not
being a strong drug, had resulted in some sort of break in the relational connection between Isabella and her mother, due to Isabella experiencing a chemical interference caused by the anaesthetic.

“Towards this meeting” she told me “it’s been, I’ve been reliving it (her ‘birth sequence’) every single day. The preparation phase, getting ready, going into connection yeah”. Isabella connected “something that happened yesterday” in the run up to our meeting to this understanding of her birthing experience: “Yeah” she said “today was for me like coming into birth”, going onto explain “Yeah, and yesterday I was, err, I had busy day and I was coming a bit down, ‘oh, tomorrow is the meeting’. Yeah, I was feeling a bit of, you know, this memory. I was feeling this memory…somehow I recognize I was losing connection”. If I interpret this correctly, Isabella here is connecting feeling slightly depressed (“a bit down”) at the thought of our upcoming meeting the next day as a reminder of a limbic imprint of losing connection her birth. Yet, recognising these feelings might have been related to this embodied memory, she thought “… but I have choice now, you know, how I want to leave this, and I’m aware this is the memory”. This led her to call a colleague, where, in talking to her, “… everything shifted, and I was even more aware that I did that, after talking to her, how everything shift(ed) in my body, you know, I felt so ready then, you know.” The shift in her body, as she described it, sounds like a form of therapeutic grounding, “And then I made the choice for going into connection and differentiate from the birth imprint.” I see this as Isabella applying a narrative understanding of losing connection at birth with what she felt the day before the meeting with me, and making a choice to reach out for support, recognise a connection to an embodied birth imprint, and make a different choice.

When talking about the birth of her first child and her “pain tiredness, because I didn’t take any medication at all, but I was by myself, so it was my first time, and I had anybody (nobody) there either that could name for me what was happening at each point”. Isabella told me how she considers that “For for me in this PPN (pre- and perinatal) work I found naming is one of the most important things. If you name, you get prepared or you don't, maybe, but at least you know, you know, what's
happening next’. In other words, the second important aspect Isabella sees from pre- and perinatal work and training is an ability to identify and name aspects of our experience, especially shocking or traumatic ones. This, of course, is the very essence of psychotherapeutic counselling and it reminds me of Appleton (2020, 228) saying “There is a deep human need to share our experience. In the telling, the implicit meaning of our experience becomes explicit”. In being able to name these experiences, we can start telling them, turning ‘dead stories’ – the scripts like “I am like this because this thing happened to me” - into ‘living stories’ which are more ‘expressions of soul’, empowering us (Appleton 2020).

4.5.3 Thinking with and from Isabella’s story

The recognising of potential pre- and perinatal experiences in her clinical sessions Isabella reminds me of how Appleton (2020) had explained his own entry into this PPN field, where spontaneous presentations of birth-related processes displayed by his cranio-sacral therapy clients made him start to research more about prenatal and birth experiences. What Isabella did not say – but seems an obvious association for me – is how she felt she had experienced a loss of connection to her mother through the use of drugs when she was born, but she also experienced a loss of connection to her own daughter due to the pain when not using pain relief, reminding me that potentially, “withholding adequate anaesthesia and analgesia is associated with adverse outcome [sic]” (Davidson and Flick 2013, 559).

In Isabella’s use of the “reluctant embodier” concept she echoes Appleton’s (2020, 76) explanation of it as being “trapped within [a] pattern of resistance … not able to go back [to the time before embodiment] but unwilling to go forward”. Reflexively, Isabella’s story, as a whole, strikes a chord with me, yet at the same time, I wonder how (sometimes even if in actuality) we tap into a sense of something much wider, larger, deeper than our own ego-centric selves. Ultimately, I have come to rest in a place, as often in psychotherapeutic territories, to ‘listen’ to what resonates with us at a mind-body-spirit level. Life is a mystery and in making sense of it, we can perhaps be open to a wider field than is currently scientifically understood but also, as Isabella has shown, through incorporating pre- and perinatal experiences as explanatory narratives, we can better understand our ways-of-being.
4.6 Claudine

Claudine was 55 years old when we met and “came into working in the arena of birth quite early in my life”, when she was 23, not long after she had given birth for the first time. She started training then in “active birth” methods, which encourages birthing mothers to trust their “instinct to follow” any need or desire to move and “to be in upright positions to birth to give the baby as much space (as possible)”\(^{36}\). Claudine’s professional life had been varied: she trained as a “yoga teacher for pregnancy”, “running workshops for parents and, erm, helping support women in labour and attending births as a doula - though back in the 80s, we didn’t call ourselves doulas”. She had also studied “long distance … literally with pen and paper”, as it pre-dated the internet, with a woman Claudine described as “one of the early prenatal women … the most incredible midwife, lay midwife”. Latterly, she had trained as a crani-sacral therapist, “my real kind of love” and, in addition, over a period of 3 years, Claudine had undertaken a course working therapeutically with babies’ birth processes although, as she explained to me, she was “only really (working) with (adults) with birth trauma, or (who) want more niche one-to-one workings, or couples preparing (to become parents) but want a bit more bespoke emotional, psychological, spiritual, you know, (support)”. She had also completed four more years of personal regression work related to pre- and perinatal realms. My work with Claudine has left me with the impression that much of her storying fulcrums on birth, in particular her own and those of her children. I will present each of these in turn.

4.6.1 Claudine, the angry, agentic baby

Claudine was born into a Catholic family, the third child “in my family of seven (children), and they were spread out over 21 years, so always a baby, always more birth”; she described her mother as “a very birthy woman”. Drawing on information she had been given by her mother, Claudine described her own birth as “probably out of all the kids, I was the most natural one. Well, I was totally natural… “. Here, by

\(^{36}\) ‘Active birthing’ is now more common in many birthing settings, including under the NHS in the UK (NHS 2023c). In the 1960’s, when Claudine was born, it was customary for women to have to give birth in a prone position, lying on her back in a bed, and follow what her birthing professionals told her to do (Davis-Floyd, Barclay, Daviss and Tritten 2009; Arms 1994).
‘natural’, I infer Claudine means that her birth did not involve any medical interventions, surgical or pharmacological. Claudine was born in a convent’s hospital, attended by nuns, “‘It was so lovely [Claudine]’” her mother had told her “‘cause she loves God, and she’s a Catholic, and she just said ‘the nuns were there, and they were very kind’.” Claudine is suggesting, I think, the importance to her religiously oriented mother of the presence and assistance of the nuns; I surmise that giving birth in the ‘presence of God’ as a Catholic was a significant contributor to Claudine’s mother’s experience, and her mother implicitly assumes this spiritual experience had been shared by Claudine. However, Claudine herself “felt like my experience was very different, and I suppose you could say, through everything I was reflecting on with [the training] and my own, you know, cranio(sacral therapy) experience, that I was discovering something different.”

Claudine produced a counternarrative to her mother’s “lovely” experience by telling me “… what I discovered, you know, and it feels weird saying it, ‘cause it’s obviously your own interpretation of events embodied in you, you know, was that I think I approached my birth in quite a healthy, strong way, but really raging that my mum was so out of contact”. Here is Claudine’s first introduction as an empowered baby able to exercise her agency, that is, a baby who had some direct input into the birthing process. Explaining further, she said “what I felt like I discovered in my 2 years of going to this place (the location of the training) where we would nudge up against “cervixes” and God knows what (in the regressions), erm, was that I chose to be posterior” [my emphasis]. In her storying, Claudine created a staunch ‘anti-narrative’ to the view that her birth was “lovely”, telling me “I flung myself into posterior position, which is an interesting position to put yourself in if you’re a baby, err, because I was so outraged at the lack of contact available. But it felt a bit like ‘fuck you! I will fucking make you feel this, so that you will, uh, see me’ or ‘wake up, I’m here I’m here’, like, ‘I’m I’m here, and I’m charging through’. ” Claudine is telling me that she, as the baby, made an authoritatively personal, individuated choice to change her position from a normal presentation to a posterior position, an “interesting position” because “… it’s difficult to get through pelvis in a natural way as
a posterior baby, erm\textsuperscript{37}, in order to get her mother’s attention, whom she felt was no longer present for her in the birth.

Whilst acknowledging how spiritual connectedness had helped her mother in life, Claudine returned to the contrasting experiences of her birth she had concluded from her regression work because “I feel like it was all \textit{lovely} and spiritual for her (mother) with the nuns, whereas for me, I felt like I was really down in the dark, dank pelvis of her”. Talking about it initiated a strong response in Claudine as she continued, “which kind of makes me feel a bit sick, to even think about it frankly, because it’s almost, like, such an uninhabited place, with an awareness that it was very dark and cloggy”. I take this as her remembering the regression work, giving me a sense of a desolate, oppressive circumstances; it was so powerful for her that she felt a bit queasy voicing them to me. At the same time, she is also making a statement that these recollections are HER embodied feelings – so even if they sound weird, she claims ownership and veracity for herself.

4.6.2 First birthing experiences

“I got pregnant when I was 22 with my first child” Claudine told me “and… I experienced the birth as quite dramatic” because her son “…was born five weeks premature, foetal scalp monitor on his head, erm, they thought he wasn’t growing due to preeclampsia”. Making sense of some of this drama, Claudine continued “When I look back, I was young, homeless (laughing) and was quite stressed and quite unheld in that… I feel like actually, that was a very shocking birth for me”. Claudine can see how giving birth as a young, homeless and stressed woman and perhaps, I deduce, the worry about the baby’s premature birth and potential health issues, would lead her to experiencing it as shocking. Yet, she wondered about her child’s own experience as “well, it wouldn’t appear overwhelmingly traumatic for him”

\textsuperscript{37} Oxorn (1986) suggests a posterior position birth is often extremely long, difficult and sometimes painful for mother and baby, probably because “The head is angled so that it measures larger. The top of the head molds less than the crown. Baby’s spine is extended, not curled, so the crown of the head is not leading the way. Baby can’t help as much during the birth process to the same degree as the curled up baby” (Spinning Babies, n.d.)
whilst also surmising that the “five weeks induced” premature birth “must have been very stressful” for him. Her son’s early working life had been “really pressured … and doing these enormous, long days, and a stressful, induced kind of birth would just fit that, ‘cause he could be very, err, he could do that, really he could be in there, that level of toxic stress really, we could say”. This sense-making of her child’s ability to tolerate a high-level of stress in his job was because, Claudine believes, he had had such a stressful birth, building a form of resilience for him, and gave him stamina to tolerate stressful working environments.

4.6.3 Second birthing experiences
Claudine’s story of her second child’s birth offered a contrasting experience between mother and child, almost the opposite of her first birth, and how that experience had impacted on her child. She “was having a lot of contact through that pregnancy” with a well-known international obstetrician, who was making a film on birth with one of Claudine’s contacts, “and in fact, the night I went to birth, I was having supper with them, and I just thought, ‘no, I can’t really be going into labour. That would just be too weird’. ” Yet, after the meal, “I just went home and had him, without any midwife or anything”. Yet, Claudine’s assessment of this birth, where “he was unattended, totally natural, if you wanna say that, didn’t have a midwife there, erm, just caught by the dad”, had left a deep impression on her child as he “came like a flash and he’s always been in a state of shock ever since”. Explaining this idea further, Claudine told me “I would say he was quite shocked by his birth, and he’s a very sensitive individual, and he’s probably a bit like ‘fuck you’, quite existentially angry”. The inference Claudine is making, as I understand it, contrary to how natural she had experienced the birth, with no interventions or support other than the father’s assistance, because “it was just quite fast” the birth has left her son in a shocked state, and angry at the world because of that.

Claudine goes further in her reflections, telling me “I really don't like when you see things around birth where people say ‘I just want to relaxed home birth, so my baby will be really relaxed’… I do feel like the birth was a very strong experience even in its natural quality. So, when people, erm, write things like that, you know, ‘a home birth equals a calm baby’, I just think, well, let's own our own experience in that”.
Claudine critiques the idea that a relaxed home birth leads, causally, to a relaxed baby, given her and her son’s contrary experiences, telling me “my speedy spat-him-out kind of birth for a very sensitive, like, Aspergic kind of individual, I think that was extremely shocking really, and I don't know if he ever, you know, I think that's quite deep in him, that he can experience the world as very full on, you know and can really push back in quite an angry way”.

4.6.4 Third birthing experiences

The birth of Claudine’s third child, a girl, “really taught me something more again about prenatal stuff”. During her pregnancy, as Claudine had “a horary astrological chart [drawn up], where you ask a question, and somebody draws up a planetary astrological chart in the moment of that question”. The chart “was very beautiful, there was a lot of Venus-y (the goddess of love) things”, which “when I look back is my friends, my lovely woman friends (who attended the birth) and my partner, and the sun shone, and I love the sun, and it was a beautiful birth”. However, there was also an element of the chart that dealt with “the twelve house… this Mars-Pluto conjunction, which is kind of like death”. The friend that drew up the chart “didn’t make a big thing of that actually” because “she couldn't quite work out” what the “smashing death of some sort… would mean when there’s all this beautiful Venus stuff”. Claudine gave birth to her daughter “at around twenty to two” on a Sunday afternoon: “the next day, my brother died” she told me “as he got killed in a car accident … at twenty to two the next day, he was dead”. This, it seems, was the ‘smashing death’ that was in the horary chart. “He was 17 … and I always felt a bit of, you know, connection with him” Claudine said “But what I feel I learned something from that experience is that, um, that (death) was in the field of my daughter”, which I could interpret as the death was in what Sills (2009) might call the “womb of spirit”, our pre- and perinatal field extending from conception to around nine months after birth: “that wasn’t an easy thing to hold” for Claudine, “such joy and such sadness”.

Claudine offered me a narrative understanding of the learning she had derived from the tragedy; this involved her daughter’s desire, when she was between 7 and 10 years old, to regularly re-watch “this favourite film whenever she was ill or low or
couldn’t go to school ‘cause she had a temperature”. The plotline involved a “little girl about 8, 10 (years old) who … had a relationship with this brother, and she was, like, growing this relationship with him, and healing something with him because he had a real difficulty with the father, and he was healing the relationship with the father”. In essence, then, the story was about healing difficult relationships, but “… at the end of the film, it’s the Twin Towers, and the plane comes and kills him (the brother), and then he’s dead”. When Claudine’s daughter reached 12 or 13, she no longer wanted to watch what she then called a “miserable, heavy film”. Claudine’s sense-making of this story was “I felt she was really trying to scratch a soulful existential kind of itch, where she really knew something of loss, and she came in with that”, meaning, I take it, that Claudine’s brother’s death was a loss known and felt by her daughter when she was born, and the film was an attempt to understand this sense of loss, almost a cathartic expunging of it through repeated exposure to a sudden death experience in the film, that for “…this incredibly, like, individual, that there was something incredibly soulful and deep in her post-natal experience”.

4.6.5 Thinking with and from Claudine’s story
Throughout our conversation Claudine offered a variety of critiques of how birth can be seen, seeing herself as “enormously strong in advocating for the fact that we have different experiences from each other, and we need to think relationally and systemically in order to honour the respectable beings”. For Claudine, relational thinking “really includes, you know, just the experience of others as unknown to us, and not to be assumptive in that”. For Claudine, “birth is a relational event and it’s always primary in that… sometimes I feel like the way birth has gone in the last 30 years since I’ve been working in birth is not necessarily always holding a place for the relational aspect of it, and that babies can have really difficult experiences even in beautiful births from the mother’s perspective”. These onto-epistemological statements, seeing that individual’s experiences cannot be known by others, are psychosocial and intersubjective, backed up by Claudine’s dislike of people making assumptions, telling me, “do you know what, you can tell me a narrative about me and my birth, or my family, but I’ll tell you something more truthful from my own perspective”.
In linking the effects of her brother’s death, to whom she had been so close, with an existential “itch” that her daughter needed to process, Claudine was aligned with Menzam-Sills’s (2021, 226) similar observation that “Someone dying around the time of birth may also affect the child’s ability to “birth” new things in life. This can occur if the mother loses someone close to her, but birth itself also takes us close to death.” Claudine said something similar herself, telling me: “And when a baby comes, I do feel enormous kind of sensitivity around the death of one world, and you know, and into the, into the world of form and duality and conditioning”. It made me think of Colum McCann (2020, 286) who says: “When you divide death by life you find a circle”. I really thought about this a lot. He uses it several times in his novel Apeirogon, meaning the countably infinite sides. It made me think we live not in the circle of life, but the circle of death: we are merely bridging two deaths with something we call life. Given that my mother, the person who birthed me, died as I was mid-way through the analysis phase of this thesis, I was also close to this birth-death circle, and how many stories of womb-life and birth are cheek-by-jowl with death.

My conclusion is that Claudine’s narrative re-evaluation of her experience is an anti-victim narrative, an empowered agency and ownership in her conclusion, derived as I understand it from the embodied feelings that came from her regression, that she approached her own birth in a “strong, healthy way”. She was not at the mercy of some biological imperative or somebody else’s own self-focussed experiential process, but asserting her own choices, even as a baby. Claudine made a declarative statement in relation to birth, that “babies can have really difficult experiences even in beautiful births from the mother’s perspective”, a narrative statement clearly referring to the individual differences she felt in all her birthing experience stories.
4.7 Eliza

“Years and years ago I worked in corporate life” Eliza told me by way of introduction, “I was in product marketing and strategy and that was quite a long time”. She continued, “And then I had my children, so I left that job to focus on looking after them, and then at the same time, erm, started exploring my, I guess I call it my ‘spiritual self’ a bit more”. The idea of a career in psychology had first been suggested some years before, as “actually I’d been told, I did a career-, one of those sorts of analysis for the personal, personality match with careers, and it came up with that (psychology)” so “after I had my second child, I decided I would train in psychology” as “then it felt right … I went back (to university), and I did a post, sorry, an undergraduate conversion-intensive thing, which was eight weeks”. Eliza subsequently “got onto this psychology masters’ programme” and the time of our conversation, was hoping to finalise doctoral studies to become a Counselling Psychologist. In the conversation, Eliza used a ‘pieces of the jigsaw’ metaphor that I have found very helpful in my subsequent analytical work, a way of seeing her storying vignettes as pieces of a larger explicative narrative picture.

4.7.1 The building of a jigsaw

Eliza’s introduction into pre- and perinatal psychology came through additional training she undertook “at the same time” as doing her master’s degree in psychology, when she “started doing a spiritual psychotherapy training, which was two years”. As she elucidated, “… the training as a whole was a lot to do with becoming more embodied, understanding self and other, the boundaries, just not just physical boundaries, but emotional boundaries and how we, how we are in the world”. My understanding of how becoming more embodied would coincide with a spiritual training would be oriented around a more attuned sense of mind-body-spirit in relation to the world, including actively becoming aware of the physical sensations of the body through things like meditative practices (Todres 2007; Tift 2015). All the participants “were offered the the chance to have one-to-one (therapy) sessions” with a pre- and perinatal psychotherapist as part of the training course “so I had a few sessions with her”.
4.7.2 The first piece of the jigsaw

Eliza shared how her parents had “married a bit later in life for the era”, with her mother, a medical professional, being “just about 30, so she wasn’t that like 19-year-old that got married at 20, sort of thing”. Her parents “wanted desperately to have children but it didn’t happen”; this difficulty becoming pregnant led her mother to take “clomid, which is an egg-stimulating drug, which was very common at the time”. This treatment resulted in the pregnancy with Eliza, and before she had the prenatal therapy sessions, Eliza had considered the story of her womb-life and birth to follow a simple narrative, saying “I’d just assumed that I just, that she had, she carried me for nine months, then I was born. That was the story [laughing]. And then I was a baby”.

However, the first session with the pre- and perinatal therapist revealed the possibility that things might not have been as straightforward as this: “It was amazing really, because, I would say, the first session, I I kept doing this repeating movement, like this, all the time”; this repeated movement was waving her left hand, up and down in an outward motion, which she demonstrated for me in our meeting, saying “I’ve been doing it all my life. I mean, I could probably show you corporate training videos on presentation skills where I’m doing that”. The psychotherapist “just picked up on that immediately” and so “we, we slowed that down, and we went into the feeling and … just suddenly, I was just in this very emotional place and, erm, really quite distraught and shocking to me that I was having this reaction. Just couldn’t understand what this was”. So, as I understand it, the therapist got Eliza to slow this repeated movement and tune into the embodied sensations that arose; this caused Eliza to be emotionally affected in an intense way. The interpretation offered by the therapist was the possibility that Eliza had been with a twin in the womb: “I mean it

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38 “Clomid (clomiphene citrate) is used in women who do not ovulate (produce eggs) regularly each month leading to infertility. Clomid stimulates ova (eggs) to develop in the ovaries and be released ready for fertilisation” (Central Manchester University Hospitals NHS Foundation Trust 2013, 2)
was there, but it wasn’t if that makes sense?”. During the pregnancy, her mother “had very high blood pressure, which was a problem and … then quite late on, like six or seven months in I think, or something like that, she had a massive clot that she lost, and she had to go to bed rest for the rest of the pregnancy. And that was really difficult for her”. Eliza’s mother once told her a story about this blood clot loss, saying, “… [when] I was probably, like, I dunno, 13 or something. I I remember it, vividly, this sentence: ‘I always wondered if that was a twin’.” Reflecting on this as we spoke, Eliza said “you know, it’s quite something as a teenager, whatever, to hear that there was something a bit traumatic about my coming in, or my my being-born-experience”. Eliza said “… having this piece of the jigsaw, like, just crash into place and fit and just go (together), it was a bit like, it was a bit like having lived all my life with an elephant in the room that I couldn’t see, and I was like ‘how could I not have seen this? It’s so obvious’. And it's been there all the time and it just, it just was like my whole world just shifted”. Eliza was left feeling “… completely shocked. I mean, I was like… I was just, like, [making very shocked look, sitting back in chair] completely shocked and I spent the next two weeks just bursting into tears all the time, in the house, when I was driving, waves of grief and all sorts of um relief, actually”. The relief, she explained, was having the piece of the jigsaw, an unthought known as I might conceive it, uncovered for her.

4.7.3 More pieces: intergenerational connections

There were additional pieces of her history that Eliza was able to make more “complete sense” of, having heard this story about the clot/twin loss; the first of these went to the heart of “the reason why I started on this journey, this psychotherapy journey, but also this spiritual training that I was doing, this spiritual psychotherapy, was following a very bad miscarriage”. Eliza told me, “I mean, I kind of knew, you know, at some level, I knew that that was going to happen. When it happened, it was horrifying but also, like I was like, ‘yeah, I know’. It was something very sort of strange about that fact that I somehow had a knowing”. Looking back, with the knowledge she now had of the pregnancy she shared with her mother, Eliza had concluded this ‘knowingness’ was because her miscarriage “happened around the same time, that I myself was experiencing, when my mother was pregnant with me, the loss, with the same signature, so it's sort of energetically, it's the same, which is
fascinating”. What Eliza means here then, as I understand her, is how her miscarriage was a recapitulation of the intergenerational embodied trauma from her mother’s loss of the clot/twin, a link to her own loss through miscarriage, as both tragic and painful events happened around the same time in their respective pregnancies. Her ‘knowingness’ was a result of the shared ontogeny of her and her mother – or at least, she was able to create a narrative understanding of these two events.

Eliza thickened the narrative plot through which she found understanding by linking these two pieces to a third event. As she told the story to me, “one of the things for me, when I had my son, was, erm, I had an episiotomy\(^{39}\) and that was after quite a long labour, two hours of the pushing stage where I was like ‘Oh my gosh’.”

Recalling the somewhat shocking events further, Eliza continued “it was exhausting, and a bit sort of ‘awwwk’ traumatic. But the thing about it was, when they gave me the episiotomy, he was born almost instantly. But then, there was this horrifying sight of all this blood, seeping out all over the white sheets, just like, almost like, I said to the midwife ‘am I dying?’”, as “there was so much [blood] from this, like, scissored cut”. Despite Eliza being extremely shocked during this experience, “the baby was in a bit of a state, so he got taken away and sort of checked over and everything... the focus was on him, ‘is he OK?’ which” meant that “I wasn't sewn up immediately. So, there was quite a lot of blood all over the sheets, and that, that somehow triggered something in me, which was just absolutely horrified”. Eliza continued “I never really understood it until, it was only a couple of months ago actually” when she managed to make the narrative connection between several parts of her history. This is her storying of how she came to make this connection.

“After I had my son” Eliza went on, “I had what was called post-natal depression, except I was never, I didn't ever feel depressed. I was getting up, I was putting makeup on, I felt like, you know? But I there was something going on that was just

39 An episiotomy “is a cut in the area between the vagina and the anus (perineum)” and “makes the opening of the vagina a bit wider, allowing the baby to come through it more easily” (NHS 2023e)
frozen in me”. I would speculate this frozen something might have been a post-traumatic stress experience of the seemingly, albeit retrospectively unfounded, near-death encounter Eliza had of the episiotomy. At the time, however, the diagnosis of PND led Eliza to have “hypnotherapy for a period of time”. After about “six months or something” Eliza “had this session where I just went into this regressed place of being my grandmother, and saying ‘I’m dying’, and I literally died in in the session… the hypnotherapist held my hand, and I was crying really, and I literally died”. I take the word “literally” to mean that Eliza, in her hypnotherapeutic regressive experience as her grandmother, had what felt like an actual death experience. After this powerfully affective session, however, “from that point, I was fine. I, literally the next day, I was like ‘I’m fine now, I’ve cleared something’. Dunno what it was, but it was, it was like a, like a kind of rebirth. It was amazing. I felt completely different, in my body, from being frozen”.

It was a conversation in the kitchen with her mother, several years later, that allowed Eliza to make a narrative connection between this hypnotherapy session and her grandmother. As Eliza had previously understood it, the grandmother had “died in the flu pandemic. You know, something like that”; however, “recently I was talking to my mum, …and it turned out that, that that grandmother had died of erm, she had a sort of, like I did again, but, but it was a haemorrhaging, miscarriage-type thing. But she had bled to death”. The “like I did again” in the story of her grandmother’s death refers to their shared experience of miscarrying. This, again, was an eye-opener for Eliza, who “suddenly I was like, ‘Oh my God, more pieces of the jigsaw have just made complete sense. Wow!, you know, it just completely, like, ‘kuhk kuhk kuhk’ [making motions with her hands like blocks or pieces coming down and landing]”. Understanding these pieces of her history, Eliza had been able to connect them together as part of her narrative sense-making, telling me “just the grandmother’s experience, then my experience when I have my son, and then this making sense of this whole dra- drama with me, then, having the miscarriage as a recapitulation of this blood loss”. I reiterate, when she says “recapitulation of this blood loss”, I believe Eliza is referring to how her miscarriage was related to her mother’s loss of the clot around the same time in their pregnancies, as noted above. Eliza’s conclusion of the
connection between these three pieces was “You know, it makes complete sense, doesn't it, when you look at it like that?”

4.7.4 Thinking with and from Eliza’s story

It seems clear to me the first regressive experience Eliza explored with the therapist was an emotionally epiphanous moment of the kind Bochner and Ellis (2016) and Chilton (2015) describe as a turning point in our interpretations and perceptions of our own and other’s lives. In isolation, as single pieces, the connections and joins were not always clear but as she did more work, they became a little clearer. My conclusion of the analysis I have conducted is that, for Eliza, much of the benefit of her psychotherapeutic journey through womb-life and birth stories has been about developing a more complete picture of her ontogenesis: the discrete stories that she tells can also be seen to form part of a restitution narrative (Frank 2013), giving her a way of explaining things in her life more holistically, to form a more complete gestalt. Stitching the stories together has been a fundamental part of a restitution of relationship for Eliza, particularly with her mother; this reparative retro-reflection contrasts with Frank’s (2013) interpretation that restitution narratives have a modernist propensity to only look to a future, to ignore the root causes of suffering. For Eliza, awareness of her histories, stretching back through three generations, has allowed her to see the different perspectives and influences on her relationships; in doing so, she echoes Frank’s (2012a, 146) call for a good life as one that tells stories from multiple perspectives, “recognizing how all the characters are trying to hold their own”. This overlapping and merging of “synchronicities and coincidences”, at least in Eliza’s sense-making activities, of her own gestation, birth and in the birthing of her son, shed a more compassionate light on her mother’s way-of-being-in-relationship with Eliza. I would further posit that the whole of Eliza’s conversation with me was a quest narrative in and of itself, if we rest in Frank’s (2012b, 13) suggestion that in quest narratives, “a character encounters a sequence of obstacles and gains wisdom and stature through a process of overcoming these”; in order to gain wisdom, we have to explore, explicate and explain the chaos narratives of our lives.

In terms of my research question, I have shown how Eliza engaged in the conversation we had to present herself through storied experiences of womb-life and
birth as a way of demonstrating the transformative power of these stories, for her self-understanding but also in her engagement with others in her life, through “memory reassembling a past to enact a present” (Frank 2012a, 115).
4.8 Mary

Mary was living in a European country when we met on-line in January 2021; she had originally “trained as a nurse, worked many years ... (as) a nurse practitioner” in a variety of settings, before getting married and moving to Europe, and “because I didn’t speak (the local language), really didn’t practice as a nurse anymore, and then began to sort of explore, err, alternative or complementary medicine”. Mary undertook “a lot of different trainings, reflexology, homeopathy and what really, kind of, what I felt was really for me was cranio-sacral (therapy)”, in which she had maintained a practice since completing the training, despite having “moved around a lot”. Over the course of time, Mary’s practice had “whittled down to working with kids, mothers, babies, that type of thing” and her introduction to pre- and perinatal psychology was when she had “watched one time something on e-health learning and listened to (a trainer in baby therapy) and I just was ‘wow, that’s really cool’.” So, she had undertaken the full training by travelling regularly from overseas to the UK for the modules: “I really wanted to do it (laughs)” she told me. Mary finished the training in 2019, so felt she was “relatively fresh in it” when we met and she had been “trying to get set up, erm, practicing. I’m in a link with a birthing clinic in a nearby town and then working from home. However, after getting all the, the, you know, administration done, the pandemic came so (laughs). Here we are! And I see a few clients but I’m again, just kind of waiting it out”. As with the majority of us, the pandemic had disrupted Mary’s practice and in January 2021, there was still some uncertainty about how it would play out.

4.8.1 Reframing the family

Mary told a ‘setting the scene’ story about her Catholic family, telling me “I guess I should say, I’m I’m from a big family. I’m from a family of 10. So, I’m I’m number 8, and I’ve always had that sort of interest of, you know, birth order, and why we were so many in our family”. Mary had been the eighth child of ten in a family of 12 people and was inquisitive about the size of the family and her place in it. This story became an important part of her reflections, acting as a counter to some of the

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40 I came to this conclusion as Mary later shared about how she thought her father must have been “…stressed by providing for 12 mouths”
“layers of information” the regressions Mary was required to undertake as part of her professional training had provided. “To be able to get your diploma, you have to go through two of, either the birth process, or some other process workshops” she had told me, and had been curious about her resistance to these regression experiences as “at the beginning, it was like 'no way, I won't, I'm not doing that’ ” but then “little by little it was kind of like ‘OK, I’m gonna, I’m gonna, you know (..) push up against it’ ” and to use “that moderate stress, or whatever, that we have to be able to (laughs) to push to do it (laughing)”. It seems to me Mary is unconsciously using the language of birthing here – “push up against” and “push to do it” - to describe the overcoming her resistance. Whatever the resistance, Mary did undertake the regressions and found “the experience was good, but it gave me information”. One of the applications of Mary’s regression experiences was a reframing of how she saw her family relationships, both with her parents specifically and with the whole family unit.

4.8.2 Implantation myths

The first story she told me about her regressions was about a “…kind of a meditation or an exercise on our womb life”. Mary’s experience of that meditation “came out like a very sort of like an arid, dry (womb)”, that is, the womb she was conceived in was ‘arid’. Mary did not explain this directly in our conversation but my assumption she is referring to a womb characterization developed by Terry (2013a)41. Mary told me this revelation had “…stuck with me from the class that, ‘oh yeah, my mum was, she was, yeah, err, yeah, wiped out’ ” before moving on to what I interpret as an axiomatic alternative ‘in-conversation realisation’, saying “I mean my mum was, well I mean I could have caught that (chuckling) in the sense that I was number 8 (laughing), so she was probably pretty whipped out (laughs)”. I am taking from these statements that the womb-life meditation appears - albeit with some hesitancy in her speaking with me - to have helped Mary consider how “whipped /

41 Terry (2013, 285), using “general themes” of “uterine quality” to characterize uterine environments as landscapes, and describing “barren/arid” wombs “from the perspective of the blastocyst… would look like how a dust bowl or desert looks to a farmer” suggested these were “[A] uterus not yearning to grow a baby: it could be an old uterus…”. See also Appleton (2020).
wiped out” her mother may have been from bringing so many children into the world, especially by the time Mary was conceived. In other words, if Mary had thought about it before undertaking this meditative regression experience and the associated interpretation, she may well have imagined that the physical condition of her mother after already having birthed and nurtured seven other children, might have been worn-out and fatigued.

4.8.3 Birth experiences

Another aspect of Mary’s re-evaluation of her early life was from a birthing regression workshop. She told me “What I found out from there was that yeah, my mum was, that that I was alone, and my mum was disconnected”, which she had suggested “all leads into maybe why (...) yeah, I didn’t feel (...) connected”. Mary provided clarifying explanations of this interpretation of how her sense of ‘being alone’, correlated with not being ‘connected’, telling me: “I mean I was born in ’59, so, you know, at the time I think the birth, you know, I don’t think my dad was there, I think it was, you know, ah, she was probably heavily medicated, heavily medicated”. Developing her story further, Mary told me: “so my mum had a kidney infection a week before I was born, so she was hospitalised and was given antibiotics”.

Reconstructing her birthing events, Mary thought “So, certainly this idea of, yeah, I was getting antibiotics, err, probably a lot of drugs, I knew that I wasn’t breast fed because the the time, I think, my mum had mastitis and at the time it was, you know, baby formula was better”. Mary is pointing to three contributory factors in her narrative understanding of this disconnection from her mother: firstly, a link to the cultural influences at the time of her birth, how fathers and other support often did not attend children’s births in the 1950s; indeed “partners (husbands, friends, significant others) … were excluded until the 1970s” according to Davis-Floyd (1992, 79) and if they were present in the hospital, they were not usually allowed in the birthing room. Secondly, she thinks her mother had been heavily medicated during the birth, due to the kidney infection and is acknowledging the transfer of these drugs through the placenta / umbilical cord to her as the baby. She goes further in suggesting the disconnection she and her mother experienced was correlated with the influence on bonding and attachment
that drugs during birth and not being breastfed had. Mary is presenting me with the ‘evidence’ of her disconnected feelings, the “information” her regression experiences and training have provided her to develop her narrative understandings of the ‘disconnection’ and of ‘being alone’. My sense of what she was telling me is further reinforced when Mary continued the story, saying “and same thing relative to my dad. I think my dad, err, yeah, he was stressed by providing for 12 mouths (laughs) and err, I think his connection again, yeah, I don’t, there wasn’t this connection that I say, that to me, means to to be loved”. Mary is bringing in a more holistic perspective, considering how the prevention of her father’s presence at the birth meant that neither she nor her mother were unable to draw on his support, particularly at a time when her mother was heavily medicated, and how the worry and strain of having to provide for such a large family was a reason for her father not being as overtly loving towards her as she might have wished.

Mary summed up her regression experiences by saying “I went through two of them - that’s pretty much what I got from them, that yeah, that I I wasn’t really that connected (to my mother), I was pretty much all alone (due to this disconnection) and, um (..) and yeah, that was that, was what I got from that”. Furthermore, Mary told me “these experiences, whether it be the the birth process, or feeling alone… and it’s just really, to me, just it’s kind of mind-boggling and fascinating”. At the same time, whilst “on so many levels it gives you so much information for, for thought” it was also possible that “Again, you could probably, you know, overthink it and maybe I do”. Mary tied these various layers of together with a concluding statement, saying “So, so I think that that was a real, you know, the work allowed me to, ah, see that”. Mary is saying it was the pre- and perinatal education and regression experiences which acted as a catalyst for Self-and-other understanding, enabling her to reflect on her lived experience of her parents and to open up other possibilities of her “never (being) really close” to them.

4.8.4 Thinking with and from Mary’s story
I feel there is something touchingly compassionate in Mary mentioning her mother being unable to breast-feed through being physically in pain and discomfort due to mastitis, and also being influenced by the prevalent cultural environment of using
baby feeding formula in preference to breast milk. In my analysis, I suggest Mary is connecting current cultural beliefs and published research that breastfeeding babies “is associated with numerous health benefits to offspring and mothers and may improve maternal-infant bonding” (Liu, Leung and Yang 2014, 76). In Mary’s case, she provided me with two reasons why she was not breastfed: firstly, due to her mother having mastitis, “an inflammation of breast tissue that sometimes involves an infection [which] results in breast pain, swelling, warmth and redness” (Mayo Clinic, 2022). I can only imagine, as someone not able to breast feed babies, this is far from being a bonding experience but one of pain and discomfort for the mother, and hence likely to be a difficult experience for the baby too.

Mary also makes another cultural reference to baby formula being more ‘in vogue’ than breast feeding around the time of her birth. It is interesting to note that the NHS lists several benefits of breastfeeding and breast milk (NHS, 2023a) but states that whilst bottle feeding with infant formula still enables caregivers to get close and bond with their babies (NHS 2021a), “… it does not have the same health benefits as breast milk for you and your baby. For example, it cannot protect your baby from infections.” (NHS 2023b). There is also an association made by Mary that intrapartum medication can interfere with the mother-baby relationship: in one study, for example, Brimdyr, Cadwell, Widström, Svensson and Phillips (2019) found that intrapartum medication is associated with altered behaviour, including sucking – key, of course, to being able to feed whether by breast or bottle - in newborns. I interpret Mary’s words as not seeking to blame her mother for what might otherwise be construed as an empathic breach, but rather her constructing a narrative association of the sense of disconnection, through understanding the impact of the conditions which she was born into.

In terms of my research question, it seems to me that Mary’s explorations in womb-life and birth have brought an open curiosity to her ability to reflect on her life, both personal – specifically in making sense of some of her historic feelings about her relationship with her parents – and professional, in her work transition from a ‘western medical’ model to ‘alternative and complimentary’ practitioner. My
perspective is that her reflections in our conversation centred around interpersonal relationships and Mary adumbrated how her overall experience of the course had helped her in this, saying “I see clients in a different way, I see my family in a different way, I see friends (thought unfinished), so I mean it’s really. It it gives another layer of maybe why someone is acting the way they do”. I understand from this that the training had given her an alternative way of viewing others, a ‘layer’, as she put it, of knowledge that allows her to be reflexive about interpersonal relationships and consider her relationships differently to how she may have previously. In her words, “in general, just in connecting with an understanding, in connecting with people, (it) just has been so, err, what do you want to say? Profound”. At the same time, and in the same spirit of reflexivity, Mary qualified these ‘profound’ understandings with the thought “and again, I sometimes think well, maybe, ah, it’s just, you know, I’m getting older maybe (laughs). And a little bit more wiser and, you know, you grow and learn as you get older”.

This criticality, the off-setting of what she may have learnt from the field of pre- and perinatal as alternate explanation to parts of herself and others, is not unique as several participants did this in different ways, but it was more overtly expressed by Mary: here, she suggests the premise that as we grow older, we develop more wisdom, a greater ability to be (self)reflexive. I would agree with her that some people do grow a little more considerate and ‘softer’ in their approaches to life as they grow older (at the time of our conversation, Mary was in her early 60s); yet she countered her own deliberating by continuing “but I think that, specifically, it (pre- and perinatal education), yeah, it just points to things that, even having done the cranio work or understanding, you know, health and wellness and all that, um yeah, just to me adds a really, err (...) yeah, really interesting and and, uh, an interesting layer”. So, she re-emphasises that pre- and perinatal psychology has given additional knowledge to her previous training and experiences in healthcare and as a craniosacral practitioner, something else to consider when being-in-relationship with people professionally and personally.
4.9 Penelope

In her professional life, Penelope was an accredited psychotherapist, craniosacral therapist, and supervisor. “I sort of tripped into being a counsellor very young really, in my early, in my sort of early 20s” she told me, “I worked with young people. So, I worked in a very, very intense project with people as a therapist for about 12 years… on the frontline of, like, their sort of constant sort of despair and distress, and abuse”. She later trained as a craniosacral therapist and supervisor, having met a craniosacral therapist in her first birth regression experience. At the time of our meeting, Penelope was undertaking a break from clinical work, which had included a relocation to another area of the country just before the Covid-19 pandemic lockdowns.

With reference to the pre- and perinatal field, Penelope told me early in our conversation “I feel like I’m partly through my own personal journey around the birth work”, ‘birth work’ being her short-hand term to describe the variety of pre- and perinatal learnings she had undertaken. The beginning of Penelope’s journey, to borrow her word, was a long-held story of her birth: “I’ve always been curious about my birth because I was delivered with forceps. That's all I knew, that I was a forceps delivery, but something about that had always kind of stayed with me, being kind of curious, like it was, kind of, a ‘well I've got this interesting story about my birth’, you know? Like, most people don't have a story and I knew nothing else apart from that”. A forceps delivery, as the NHS (2023d) explains, is an “assisted delivery”. This curiosity was piqued further, she explained, as “my manager… had done a module on her psychotherapy training, erm, around birth” and “she would often tease me about the birth stuff… you know, if I was sitting a meeting doing this [holding palms of hands to both sides of her forehead] or something, … she'd, kind of, always gently tease me about it in terms of, erm, my stickness really, and not being able to make, you know, step forward in in various different places”. Here, my understanding is Penelope is referring to the metaphorical, and possibly actual embodied implicit memory, of a forceps-assisted birth. Her feeling “stuck” in difficult life situations is representational of how she might have felt stuck in the birth canal, of not being able to move forward, so that forceps were needed to help her complete the ‘task’ of
birthing, and the holding of her head seems to represent this stuckness in the birth canal, a representation of the embodied imprint of the actual forceps either side of her head.

4.9.1 “I shouldn’t be here”
The main connection Penelope had made from her ‘birth work’ was, she said, that “I’ve had a sort of had a life statement about ‘I shouldn’t be here’”, qualifying this further with “I suppose, profoundly feeling like, well, I shouldn’t be here… like, being a reluctant embodier, being kind of not present, fully present, not feeling like this was, yeah, my life or my space to be in… “. This, she was certain, “of course, has profoundly affected my life in all sorts of ways so, I think that’s a fairly major life theme that it helped unravel”. When I invited her to explain in more detail, she responded “I think probably there’s a few threads to that”, and rather than her ‘forceps birth’ story being the underpinning of this life statement, she felt it was rather “all that prenatal stuff is really the stuff where I started to make sense of stuff” – the “prenatal stuff” she is referring to is the explorations of prenatal life from pre-conception through implantation to life in the womb. Penelope elaborated on these threads as our conversation unfolded.

She told me that first thread was understanding, through a regression experience that was focussed on implantation, that “I had an experience of twin loss at implantation”; this “really profound learning”, this “profound loss”, contributed directly to why Penelope had the feeling of “I shouldn’t be here” as “it should have been him, not me (that implanted/is here)”; Penelope told me she did feel this twin would have been male, without being able to say why. This twin loss at implantation “got merged”, in her words, with a second thread, a “loss of connection to Divine or Spirit”, a “disconnect from Source” that linked to her life statement. As her use of the concept ‘reluctant embodier’ itself indicates, in prenatal theoretical terms she is referring to a felt sense of connection to life before conception, that part of her did not want to be conceived, that her spirit or soul was left with a sense of grief at having to ‘unmerge’ and separate from the Divine realm (Sills 2009).
Penelope had explored a third thread of the life statement in a regression focussed on sperm and egg journeys. In those regressions, her experience was the sperm “is what carries are really strong imprint of not, of not wanting to be here”. Explaining further, and describing the embodied feelings from her regression, she told me how she felt the ‘sperm’ was “a place where, in my whole body just was like ‘I don't want this, I don't wanna go towards that’ (whatever represented the ‘egg’ in the regression)”. Here, Penelope was speaking as the sperm in her portrayal to me, continuing “‘I wanna check out into the, dissolve into the uterine wall. Thank you very much.’” So, as I understand it, during the regression where Penelope was manifesting as her sperm, she had a deeply embodied resistance to moving towards, and therefore subsequently merging with, the egg; her sense was at the time she would have preferred to have died, as so many sperm do, by dissolving into the uterine wall. Illustrating this further, Penelope described how “the egg was like screaming at me. It was like, the need of that egg, Keith, was like drawing me [making a gesture of grasping something towards herself] so I felt like I had no choice, you know, as a, on a sperm level, I felt like I was, yeah, like I was, I really didn't want to know”. So, there seems to have been a dichotomous dialectic between the egg that really wanted to be fertilized, to welcome in the sperm, whilst the sperm actively try to resist being ‘the one’ that did.

Penelope made meaning from this pre-conception experience as an imprint which had “carried in my life as a kind of quite depressed place and a kind of ‘I don't, I, I don't want to be here’”, and “there's a kind of suicidally feel about that, that I've never felt like I wanted to act on in any kind of big way, but it's felt like it's it's been there”. Moreover, bringing in a further embodied element, Penelope told me “I would say in my body is a kind of collapsed place that has, sort of, its origins there”, how “the experiences in the regressive sperm work, it's like I had some really strong experiences in the sperm of, you know, just wanting to collapse”. This sensation of collapse, I believe, is her explaining the felt senses of the depressive and suicidal moods that she had. However, Penelope, recognising herself some of the overlapping elements of regression work, wryly commenting “I mean, it’s a bit of a head fuck, isn’t it… when you do the sperm journey and the egg journey
(regressions) and then you realize you’re both of those things … it’s quite hard to
differentiate”.

Her fourth thread of the ‘I shouldn’t be here’ narrative was how she had come into “a
family field” that was “full of … unprocessed … trauma and grief, and there was no
space for me”. The “understanding the impact of my, my female ancestral line” has
been “a massive bit of learning for me in my, in this, all this journey”, she explained.
Penelope briefly, though candidly, told me, without explaining either in detail nor how
she had come to this awareness, her maternal line had experienced violence and
abuse that went back at least two generations, making the observation that at “the
cellular level of experiencing of, and holding of, that unprocessed, unacknowledged,
unacknowledged in some ways, or certainly aspects of it, really unacknowledged and
denied (intergenerational trauma)”, Penelope felt “impacted on that feeling … of
disconnection”. Here Penelope is referring to the PPN concepts of cellular memory
and epigenetic imprinting.

Penelope had learned in the trainings about the biological connection of the egg that
we come from is already formed inside in our mother’s body whilst she herself is in
the womb of her mother, saying “So when I discovered that thing about the egg, that
I was, was in my mum when she was in my grandmother, just like, you know, blows
your mind”. Penelope remembered a supervisor “saying to me at one point, like you
literally, you’re just staying and marinating in that environment, in the the toxicity of
that field that was full of this stuff, that wasn’t um, yeah processed, acknowledged,
held in any way”. Describing further what she meant, Penelope said, “… your body,
like your nervous system, like everything develops in this place of, erm, trauma. And
what does that mean, you know? But what has, what has that meant for my, yeah,
my physical body. My nervous system, let alone the psychologist, psychological
impact of that”, the inference being that the cell that subsequently formed her had
also experienced the trauma(s) her grandmother and mother had been through by
the time she was born. “So there’s a kind of really heavy darkness around that, erm,
and it’s taken me a long time, I still, like I still feel I’m in some of that stuff trying to […]
err, like both process that, but also recognize the impact that has on me”, of which
the pre- and perinatal explorations and education had enabled her to start to develop a narrative understanding.

4.9.2 Thinking with and from Penelope’s story

It seems clear in my reading of Penelope’s expansive exploration through the lens of pre- and perinatal psychology that she has added to her repertoire of explicatory narratives through each new regressive experience and the associated education around that, linking these back to this existential feeling of, essentially, not belonging – which manifested in her life statement of “I shouldn’t be here”. She herself used the word ‘journey’, a process she was still only part way through. At the same time she also told the story of her origins that forms a complete journey: a pre-conception place her soul felt connected to Divine Source; a maternal field of intergenerational trauma into which the separate and affectively paradoxical experiences of the egg and sperm were merged through conception; the loss of a male twin at implantation, reinforcing this lack of belonging as an almost imposter-syndrome-esque affect; and a final ‘stand’ against the forces that brought her into being by refusing to emerge from the womb without an intervention to, literally, pull her out.

This creation and creative narrative, for me, echoes of the archetypal monomythic narratives that appear the Hero’s Journey (Campbell 2008), built on and supplemented in the The Heroine’s Journey (Murdock 2013) and The Virgin’s Promise (Hudson 2010). Here, in my analysis, Penelope’s journey starts with “a separation from the world” (Campbell 2008, 28) – her reluctance to come into being from a world-beyond-the-world in her case, followed by a set of “trials and victories of initiation” (2008, 28; italics in original) – her conception, implantation and birth were all trials, although there is less evidence of victory within that, other than the building of her framework of understanding perhaps. Given her self-declared part-way-through-ness of the journey – her “return and reintegration into society” (2008, 29) is only a partial re-birth into a new Self. Yet she has identified how important her

42 Campbell (1949/2008) used the term ‘monomyth’ to denote the commonly occurring template in stories that involve heroes who goes on an adventure, overcoming difficulties, usually in a decisive crisis and return to their former lives changed or transformed.
learning about the impacts of womb-life and birth have been to the understanding of the Self encapsulated in a “I shouldn’t be here” life statement, where “there’s such a kind of wrongness and badness and shame and so much stuff carried in that”.

Leaning into the idea of a heroine’s journey caused me to reflect on the psychoanalytic elements that Murdock (2013) discussed, especially how there was a clichéd division between the male, father-archetype of the sperm and the female, mother-ness of the egg. The psychological and physical separation from a mother is a fundamental part of a girl becoming a “viable human being” (Minksy 1996, 53) and “To accomplish this split from the mother, many young women make their mothers into the image of the archetypal vengeful, possessive, and devouring female whom they must reject to survive” (Murdock 2013, location 516). Penelope’s description of the “screaming, needy egg”, representative as it is of her mother, does evoke this unconscious perspective. At the same time, Penelope’s narrative speaks to me, poignantly, of “the ache of a life orphaned from belonging” (Turner 2017, 14), how “this longing to belong is at the heart of so many people’s inquiries” (2017, 16), both in the lifelong feeling of not belonging she expressed, and in the sense-making narrative that this lifelong feeling was, albeit partly, due to a felt disconnection from Source. So, there is a paradox in the need to separate and the need to connect more in relationship to Self, to others and to the world that Penelope is working through, reminding me also of Ettinger’s (2006, 218) invitation of “rethinking desire and the unconscious by reference instead to the transgressive encounter between I and non-I grounded in the maternal womb/intra-uterine complex”.

In terms of my research question, Penelope’s various explorations, through regressions and the subsequent educational explanations of prenatal womb-life had helped her make “complete sense” of her forceps-assisted birth, how although she thought it was the central element to her story, she realised the other threads – “sperm, egg, conception and implantation” – were the precursor to how “they had, kind of, literally, had to pull me out”, that “the forceps was the end of something that was, sort of, inevitable”. For Penelope, the “framework for understanding” that pre- and perinatal learnings had given her, “understanding the impact” of her womb-life
and birth, and the major theme she had of a feeling that she “shouldn’t be here”, was allowing more self-compassion “to, kind of, counter that critical harshness about myself”.
Catherine trained as a cranio-sacral therapist and tutor, had been in the profession for more than 15 years when we met, and had completed training as a baby therapist after being introduced to it through a close friend at the cranio-sacral college. She was undertaking a course in compassionate inquiry. “I’m not religious” she explained at one point, “I don’t know what I am, I suppose I’m spiritual, definitely”. These paradoxical words - if I take a definition of ‘spiritual’ as being inherently associated with religion - are a good introduction to the analysis of the conversation that I had with Catherine, as much of what she shared of her life including, and inspired by, her explorations and learnings of womb-life and birth had, in my opinion, both spiritual and paradoxical elements.

Catherine’s route in to exploring pre- and perinatal psychology had unfolded over the course of her various trainings, but her initial sense of a connection to the field was “… unconsciously, I’ve always been in the field. You know, I think there's always been - if I really track back into my life and I track back to very, very early, my earliest memories, there has been a communication with myself, and a connection, as [a PPN trainer] would put it, to, erm, a sense of divine homesickness, actually”. She added, “And I can always remember when [the trainer] named that, it was like, ‘oh’, I had this flooding inside my whole system of like, ‘Wow. Yeah. I've had divine homesickness all my life’. In terms of her training in the field, she reflected “there was a kind of organic (..) gravitation”, towards the territory of pre- and perinatal explorations. “I did write my thesis (in her craniosacral training) on, erm, a bit of pre and perinatal and the notochord43 and looking at kind of you know, embryological development” but, although she had never heard of working with babies to heal womb-life and birth imprints, “… I kind of always knew that, when I was working with people's bodies, I'm working that way, that what I was tuning into was something from a long time ago”. As I understand craniosacral treatments, the practitioner uses “finely-tuned skills of palpation and perception to sense the body’s subtle rhythms

43 “a rod-like structure situated ventral to the neural tube in vertebrate embryos” (de Bree, de Bakker and Oostra 2018)
and any patterns of inertia or congestion... the practitioner can read the story of the body, identify places where issues are held and then follow the natural priorities for healing as directed by the patient’s physiology” (Kern, n.d.), so I believe Catherine was telling me she picks up, in her body work as a craniosacral therapist, when clients were expressing some form of pre-natal or birth imprint in their psychosomatic presentations. So, when her friend told Catherine she had decided to train as a baby therapist, “… I just knew I had to do it, that was it”, and Catherine also signed up to do the course.

4.10.1 Perpetual liminality
The birth process regression Catherine did as part of the training came with experiences of disorientation, and as she said “I never, had never really thought about how much disorientation I had during being born, and I’ve carried with me all my life that I didn’t want to be here”. I felt she was re-iterating her belief here of experiencing divine homesickness, and how the disorientation is an embodied sense of not understanding why she had been conceived and born. She also links this sense of disorientation to a strong resonance with the words “liminal and liminality”, as she told me “… so it's just like I'm permanently in this liminality, you know” and “my sense of having such strong connection with where I'd come from, and just not wanting to be born [laughs] Or how I made that, I made that into not wanting to be born”. This interpretation seems to fit Catherine’s narrative of ‘divine homesickness’. Liminality in the context of pre- and perinatal psychology, I believe, can be seen as a transitional rite of passage, a place that is temporarily ‘somewhere-in-between’ two dimensions (Stenner 2017): the spiritual world, extending the continuum of consciousness of a unifying and eternal sacred energy; and the human world of embodied form after conception. Thus, as I understand it, Catherine feels she has retained, in her body-mind, a ‘strong connection’ to existence in the spiritual world; this makes her feel like she is not fully in either dimension, manifested as a reluctance to leave a secondary liminal space, that of the womb, to come into the world beyond it, which has resulted in her resonance with the naming of ‘divine homesickness’.
4.10.2 The shining, darting light

Catherine told me a deeply personal story of loss and reparation, and her developed narrative understanding of that in connection to pre- and perinatal experiences. Catherine explained that her first born child, "she's always had a really, really (..) deep deep attachment to me (..) Of course, you know, I'm her mum.., but at times it would, you know, it would be very difficult for me to go off and do a course for two days". Catherine’s words seem to suggest a daughter whose attachment led her to protest if Catherine wanted to leave her for a number of days. Continuing the story, Catherine told me "Before I got pregnant (with this daughter), I got pregnant and had a miscarriage, and, um, and then I got pregnant exactly a year later (with the daughter she is talking about) and my husband used to, um, see this little shining light flickering and darting around our flat in London, and he always used to say ‘God, that is the spirit, that, isn't it? that is, you know’. “This revelation shows, I think, a sharing of the spiritual elements of creation between Catherine and her husband; the narrative here, as I interpret it, is that following the loss of a child through a miscarriage, when Catherine’s pregnancy started “exactly” a year later, she and her husband talked openly together about the spirit of the child that was lost visiting them as a shining light around their home.

Catherine developed the divine connection story further, relating how her daughter, when she was born, “came out with such urgency… and she came out with a hand in a fist and opened her eyes, she was almost in shock and she, the first thing she did was open her eyes look around [making gestures of surprise, demonstrating with wide open eyes, looking quickly around] really like ‘I am here now’ [laughs]”. Catherine and her husband “always felt (..) that she tried to come in (..) and then had been waiting (..) And I've always carried that, and I've never told her”. This is quite a complex narrative, in hindsight, which appears to confuse some timelines. However, attempting to translate Catherine’s story, and remembering stories of children having the ability to choose their parents before conception (Appleton 2020; Carman and Carman 2019; Chamberlain 2013; Kalef 2014), I think she is intimating that the rapid birth was a result of her daughter having had first to wait to be (re)conceived, almost as a reincarnation of the lost child, as the “she had tried to
come in .. and then had been waiting" suggests. Her daughter therefore had a sense of urgency in being born, because her spirit or soul had been waiting to be born for nearly 2 years, an estimate I have calculated from being told by Catherine the original baby miscarried around 2½ months, followed by the 12 months before the pregnancy with her daughter was conceived and confirmed, and that pregnancy going to term of 9 months. Her daughter therefore had a strong desire to connect to the parents and had initiated a rapid birth.

Catherine made sense of her daughter’s strong attachment style, the longing to always be close to her mother when she was younger, through this divine narrative: one of the courses in pre- and perinatal brought up a strong need in Catherine to tell her daughter the story, so “about six months ago I told her and (..) so interesting how it just totally made sense to her (…)”. Catherine had explained to her daughter that “you know, sometimes when you get really anxious [daughter’s name], you feel like I’m not there and you need to know I’m there (…) And I think, you know, maybe that’s just me making sense of something but it was like I said ’well you know, I got pregnant and I lost a baby, you know, we’d lost the baby’… but somehow (..) it felt to be true, you know, it feels true, that all of that what she’s carried up until that moment, in her body memory was that (…) ‘Where are they?’ you know, like. So (…)”. Again, in the telling, the story and the narrative are somewhat fragmented here. However, I would posit in suggesting that her daughter had an embodied, implicit memory of the lost baby, Catherine is obliquely referencing the ‘haunted womb’ concept, the idea that child loss before birth is retained as a cellular memory in the uterine tissue (Appleton 2020; Menzam-Sills 2021); I accept, however, this is my post-interview interpretation of Catherine’s words as she did not mention the concept directly to me.

For Catherine, however, this story of strong attachment arising from the loss of another baby before her daughter was conceived “it just totally made sense to her (daughter) (…)”. Catherine’s offering of her narrative insight of the events around her daughter’s journey into the world, she believed, reduced her daughter’s “intense anxiety and worry”. Moreover, for Catherine, “It was such a relief to tell her … And in
all honesty since then, that kind of intense anxiety and worry has really dissipated”.

Catherine is suggesting here, I believe, that she herself felt a relief to be able to share this narrative around the miscarriage and how she constructed meaning around the strong attachment her daughter displayed.

4.10.3 The Angel on the Stairs

Catherine another spiritually oriented memory, “which is very very vivid, and again, a very very early memory, and very womblike actually” which, by way of conclusion at the end of her story, she wondered “I don’t know why I’m telling you this memory, but I guess, again, it was that connection (..) to the divine homesickness”. Catherine had worked out this event happened when she was about three years old. “And my sister… woke me up and said, “let’s make mum and dad a cup of tea”, um, and so she made the tea … and I carried this little white jug of milk up this gigantic staircase, which obviously, as I was very small, but it was red, and it was luscious, and it was a red velvet staircase, and there was also this red kind of embossed wallpaper”. Reflecting on Catherine’s offering up the idea of archetypal ‘womb-like’ qualities of this setting as she describes it, her description of the setting gives me the idea of the red uterine wall in which we, as a prenate, implanted. The story continued “And I remember, really well, climbing up … I’m climbing up the staircase (..) and I dropped the jug of milk and the white milk bounced down the red staircase (..) And, I absolutely froze because this voice penetrated me so loudly (.) And it said ‘Don’t be afraid’ (..) right? And my sister, at the time, froze as well and she saw form, of some sort”.

Catherine then explained the narrative of what this voice meant to her, associating this voice on the stairs telling her not to be afraid to a sense of connection to the divine by telling me “But yeah, and interestingly, I did read a book, erm by ah, I can’t remember, I think it’s called “The Physics of Angels” and it’s erm, it was written by a theologian and a scientist debating angels”44. It was at this point that Catherine rejected the notion that she was religious, but supposed she was “spiritual,

44 I believe Catherine is referencing “The Physics of Angels: Exploring the Realm Where Science and Spirit Meet” 2014, by Matthew Fox, a theologian and Rupert Sheldrake, a biologist.
"definitely"; “But they (Fox and Sheldrake) said apparently the first thing, if someone encounters an angel, it's petrifying, which I remember being the first page, and I thinking 'gosh, like, I really relate to that'. So, again, that sense of connectedness and you know…”.

4.10.4 Thinking with and from Catherine’s story

The stories I have presented above related to what I see as Catherine’s personal relationship with the world, an existential pondering of affective, emotional, and cognitive processes in her psychotherapeutic evaluation of her own and her family’s existence, something which have been given deeper and wider meaning for her through explorations of (pre)womb-life. The linking of a spiritual dimension of existence to her creation gives her, in my view, comfort and a form of healing: understanding why “I've carried with me all my life that I didn't want to be here” has its roots in her narrative use of the divine homesickness concept. I interpreted her words about being spiritual but not religious as meaning she does not necessarily follow an established religious tradition, such as Catholicism, Islam or Buddhism, but does have a sense that there is more to existence in the universe than only a human dimension – that there is something larger at work in the reality of living a life. Yet I also sense a tentativeness in her words, an uncertainty of her belief position, most especially in the “I suppose … definitely”, even though all the stories she told me had a spiritual element to them. This signifies to me how, in my analysis, I see she had come to retrospectively make sense of, and develop some of, the narratives of the life she had led, and which she was living, partially through the lens of pre- and perinatal psychology which had definitively spiritual connotations (to repeat the juxtaposition).

I am left wondering several things in relation to the story about the Angel. The first is how strongly Catherine had felt the experience, so strongly in fact that she told me she had created a version of it for her degree show. She has also, in the conversation with me, made a narrative link, a retro-reflection, between the vocal apparition telling her not to be afraid with her sense of divine homesickness: this is a post hoc, post-education sense-making of this “very very vivid” memory where she is linking what she believes might have been the voice of an angel to her belief of still
being connected to the divine, to that sense she has long held that “I didn't want to be here”, and to what I sense as grief in the form of homesickness to having left the spiritual realm to become embodied form. Her words about feeling terrified and “Don't be afraid” are also reminiscent of stories in the Christian Bible of angels: for example, Luke Chapter 2, verses 9 and 10 (BibleGateway.com; my emphasis): “An angel of the Lord appeared to them, and the glory of the Lord shone around them, and they were terrified. But the angel said to them, “Do not be afraid. I bring you good news that will cause great joy for all the people”.

This story appears, in my analysis, to be a widening of Catherine’s prenatal narrative around divine homesickness, how she is using the concept to make sense of the memories she has of childhood as part, in her words, of a dysregulated family.
4.11 Violet

Violet introduced herself to me as “I'm 51. I have two children and married, and a dog [laughs], and I'm a psychotherapist and supervisor … and I did my, started my clinical training in 2002”. She was working in private practice and “had a previous training in psychology, so I previous previously worked … as a health psychologist, and so I've got a degree and Masters in that approach”. Her first experience of pre- and perinatal psychology came in her main training as a therapist and she had subsequently undertaken several regression-based experiential courses in the intervening years as personal CPD: she was enrolled on a course to explore birth (through experiential regressions) when we met, but this was “on hold because of lock-down”. As an experienced psychotherapist whose main training had required her undertake many years of personal therapy and CPD to deepen self-inquiry, Violet, over the course of our conversation, told stories pertinent to her interest of relevant pre- and perinatal experiences that contribute to her “own personal process”.

4.11.1 Implantation: Violet’s primary wound

Violet identified an understanding of Self that arose from the introductory pre- and perinatal psychology work she did on her main psychotherapy training where, she said, “what happened for me was around the implantation process, I went into a quite traumatic reaction”. Violet “took this to my therapist” and had worked on “something around difficulty with implantation” with them, and had concluded that implantation had not been “straightforward, or the experience of it wasn’t as straightforward for me”. So, she thought, “There's something around, you know, working with the implantation process”, continuing “and the recognition of how, how little we can be, and how early we can be in our beingness, that can leave such, um, deep imprints and deep affects within our process on so many levels”. Violet is, I believe, drawing on pre- and perinatal psychology’s ontological position of the cellular level of 'knowingness' before brain consciousness comes into being, and limbic imprints, including at an affective level, can be left that can be later accessed through regression work. She explained that this difficulty around implantation was
“my primary wound”, and “my early patterning around that was one of very early self-reliance”, naming what she considered to be her “secondary pattern” as a strategy to deal with this wounding, explaining “… it was very much around, um, being on my own, doing it myself”. Thus, as I understood her, from this primary wound Violet had developed what could be called the “defensive and defended processes and positions” (Sills 2009, 162) of ‘self-reliance’ and a need to ‘do it all herself’ / ‘on her own’, and when feeling vulnerable, she is unable to allow others to support her.

4.11.2 Umbilical affect
Violet had enrolled on a birth process workshop after her main psychotherapy training experiences. For the first one, she said, “I went on that workshop thinking there was something in my birth history, but then (it) was quickly again, it was something around the umbilical affect”. Having expected something different from the workshop, Violet thought “So so so again, so then kind of, that's curious, and kind of the layers within the birth process and getting curious about, you know, what resonates with me? What, you know, where, you know, what’s unresolved for me? What needs attention for me? How is it playing out?”. Her curiosity had been stimulated to recognise there were different aspects of her prenatal experience that seemed, it appears unexpectedly, to relate to her, allowing her to wonder what has not psychologically been worked through or settled. A further workshop, specifically focused on “umbilical dynamics” followed, and in that, Violet came to an understanding that “again, it’s all about this primary wound, so there’s something in the womb with this primary wounding, around my self-reliance when I’m most vulnerable, people can't hold me, and and so there’s this, there’s this repeated pattern where it does get enacted out in my life”. Here, Violet is saying that the affect and effect of the primary wound she experienced at implantation carried into, or continued to influence, her womb-life, and her psychological defences developed

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45 Emerson uses the term “primary wound” for the first psychological hurt or damage that we experience (Linn, Emerson, Linn and Linn 1999). Firman and Gila (1997) use “primal wound” in the same sense, in the words of Sills (2009, 162, *italics* in original), “an early breach or failure in the empathic relational field is the foundation for the deepest personal wounds [and] leads to what is called basic or primal wounding.”
around her vulnerability such that she cannot allow people to support her in times of need, that she strengthened, in that defensive approach, her self-reliance.

Building on this idea of “people can’t hold me”, Violet reflected that “… even on the (main psychotherapy) training … there was something around the umbilical affect (regression), of just not wanting anything to come in, because anything coming in was just not going to be helpful”. Here, Violet is suggesting she associated her sense of the umbilical affect with not being able to allow support from others because she experienced that affect as negative, and so wished to ‘block out’ incoming ‘badness’. Violet told me a story related to “what came out of the umbilical affect (regression) weekend”, which she had subsequently discussed with her mother: “I asked her about this because I can, and she’s open to talking about it”. I take Violet’s “this” here to mean she and her mother had discussed what had arisen for Violet – thoughts, images, feelings - in the umbilical affect regression weekend. In that dialogue, Violet had been told that “when mum was pregnant with me, my dad’s dad died”, that is, Violet’s paternal grandfather had “died when I was three months in the womb”, and her mother had told Violet “she had such a strong urge … she had such a strong urge to bear down when when I was three months (in the womb / first trimester), because, you know, the, you know, the shock and the grief and and what was happening with (Violet’s) dad losing his dad”. Violet did not explain explicitly what she meant by “bear down” but explained her mother had described this feeling as “involuntary, mum (said) it wasn’t a conscious thing she said she was doing, it was something, it was a body reaction”, that her pregnancy felt like it was “just too much”. I think, in the context of our conversation, Violet was telling me that her mother was in a field of shock and grief when her father-in-law died, her husband’s and her own, which led to an unconscious, embodied reaction that felt like a wish for the pregnancy to be over, as it was “just too much” in Violet’s words, to tolerate or deal with at the same time. Her mother’s explanation of the historic events seems to have accorded with Violet’s regression, illuminating what Violet had experienced there.
Conversely, reflecting on her childhood rather than the pre- and perinatal period in relation to her defensive process of self-reliance, Violet observed “it would have something of a longing for more attention from my mum”. Violet told me she had “a close relationship” with her mother nowadays, and she “can look back with compassion for her” as, with hindsight, Violet can see how “she was overwhelmed, she was 25, she had four kids and on her own, with dad working away”. Yet “there is that pattern there, of of a child, of kind of, wanting more of mum”, as Violet having “some early internalised, you know, decision that, you know, if I was better, if I was, you know, I was better. If I was good enough, if I was prettier, duh duh duh. So, there was something around feeling a repulse-, being repulsive in some way”. This feeling of needing to be better, of not being good enough, even feeling as strongly as being revolting and not attractive enough, seems to be related directly to Violet’s feelings of not having enough attention from her mother. This has been internalised as something that was her ‘fault’, as she continued “I wonder, if it’s s- shame, but it didn’t, I’ve never really articulated it as shame before, but it it just feels like, I was too much”.

4.11.3 Thinking with and from Violet’s story

The narrative(s) Violet constructed in our conversation wove together many elements in and around a theme of bonding and attachments, centred primarily – it seemed to me in the analysis – on Violet’s experience of her attachment relationship with her mother, and how that has played out in other areas of her life. In our conversation, Violet expressed what she herself recognised as being “just so stuck in that rage, (and) then the anger towards her (mother)” recognising “that blaming element” because “I really didn’t get the quality of attention (from my mother)”, and recognising “that pattern there, of of a child of, kind of, wanting more of mum”. Violet seems, however, to have at least partially escaped what Caplan (1989, 2000) called the ‘psychological prison’ of mother blame: I say partially because despite, in the conversation with me, her assurances that “I don’t have that blame. I don’t have the anger towards her”, there seemed to be an on-going tension within her, and the relationship with her mother, as the conversation was also interspersed with comments like “But you know, I really didn't get the quality of attention and I was thinking about that” and “there's something around where (…) it feels like I lose her
quite easily and um, and then that really pisses me off”. It was Violet’s mother who
first began to shift this negative spiral: in response to Violet’s “protest” expressed
when she was in her early 20’s that “I was like really cross at her and really kind of,
you know, letting her know how she wasn’t there for me (laughing)”, her mother had
responded: “‘Look’, she said ‘you come to an age where you really need to start’,
you know, you know, ‘looking at it yourself now, I can’t change what I didn’t do. I
know that’, you know, ‘there were failings’.” This push-back on the mother-blame
was for Violet “… actually, that was really helpful” and that “… something shifted in
me then and it’s just something that you know this is, you know, wasn’t helpful to
blame”. Violet then recognised “when you can’t be angry at somebody (…) then you
need to find another way (….) So that was useful when, you know, that something
shifted in me about taking more responsibility for my own path then”.

When she offered me the commentary that “I think there’s part of me that just
doesn’t want to let it go because there is the fear, the fear of just being dropped
again”, it see it as suggesting that her self-reliance, as helpful to her as it is, also has
a basis of anxiety at not being met-in-relationship, and in hypothesising shame as
emotion that arose from her not feeling good enough, her words reminded me of
Karpman’s drama triangle (2014), how the “victim” can internalise “badness” in
relational contact as “shame”, a defence mechanism to enable the maintenance of
relationship with primary caregivers (Sills 2009; Crisan, Canache, Buksa and Nechita
2022), and also the psychoanalytical concept of repressed negative affect, how “a
needy-self may feel shame in its wounded need for another” (Sills 2009, 74). She
also gave another reminder of the effects of death within the family field affecting the
baby’s sense of Self, how shock and grief can be transmitted to the prenate and
leave an imprint (Menzam-Sills 2021); I wondered if part of Violet’s shame response
is connected to this.

Returning to how Violet has contributed to taking me further in answering my
research question, Violet believes it is through her explorations into pre- and
perinatal territories that have deepened her understanding to the perceived breaches
in the relational field with her mother and others and widened her understanding of
Self-in-relationship. She has brought a narrative understanding to her sense of Self, citing this growing awareness coming from her womb-life and birth regression work that has “massively informed why I am like I am, erm, and why I do what do, and why I defend myself with such tenacity. I’m just, you know, really skilled at looking after myself”. Moreover, this awareness comes with the observation that in healing our ways-of-being, a relationship with others is actually needed, that it cannot be done on one’s own, nor can we expect others to do it for us. This was something she learned in the prenatal regression workshops: “I think I need some support to do it with… it's not so much like thinking someone else can actually fix it for me, 'cause I know they can't, but there is something around - it's the ‘and’ isn't it? They can't fix it. And, actually, there can be others, 'cause it needs, I think it needs to be relational. And something in the relational, um, exchange that needs to be part of the healing”. For Violet, because womb-life and birth is “a precognitive space” and “a preverbal space”, a “process that isn’t (fully) formed but … a continuation of that which cannot be tolerated will be fragmented and, not even be formulated”, “the only way it can be expressed is in the experiential relationship”. To conclude, for Violet, there is “magic in enactments”, and regression work offers “a real opportunity for transformation” through “the embodied, psycho-emotional, psychospiritual territories”.
4.12 Martha

Martha told me her professional background included her longest role, for 14 or 15 years, as a career’s advisor; she had started this job when she had a consultation with the career’s advisor at university and expressed an interest in the role: “I said, ‘I just, I’d quite like to do what you do, just chat to people’.” She had worked in this role in different organisations with different responsibilities, as well as training in some different healthcare-oriented modalities including shiatsu massage\textsuperscript{46} and psychotherapy though “I haven’t managed to make it my vocation as such”.

Her entry into pre- and perinatal explorations unfolded over a period of time. She had experienced chronic fatigue symptoms in her teenage years; these returned in her late 20s and she started to see a shiatsu practitioner for treatment. This practitioner also offered meditation groups which Martha joined, explaining “I realized subsequently later on, that some of the things that I was experiencing, and especially when I was doing meditation, were to do with the pre and perinatal period” although “I didn’t know that at the time, and I’m still I guess making links, in a sense”. These early meditative experiences led her to move overseas and “when I came back from the year in (that country), I wasn’t happy with what I was doing with the career’s advisor work and I wanted a deeper connection with people in my work, in what I was doing with clients, and so I actually erm, was wanting to train as a therapist, a psychotherapist”. She started to train in psychotherapy but “I realized that they (the course providers) didn’t really cover childhood and earlier, and I think some of the things that was coming up for me seem to be about the childhood… I was getting sort of thoughts that I need to actually go in more into childhood”. Dissatisfied with the approach in her training not covering childhood, Martha experimented with “holotropic breath work … that was actually going straight into the (laughs) pre and perinatal, but I found that quite overwhelming actually. I didn't like the modality, with the loud music, although I sort of like persisted with it a few times, erm”. She then

\textsuperscript{46} “a non-invasive therapy originating from Japan. It uses a combination of kneading, pressing, tapping and stretching techniques. These gentle techniques aim to reduce tension and re energise the body” (Cancer Research UK 2022).
found out about an introductory course to pre-and perinatal psychology and "so I actually ended up getting to do (the full training course for practitioners) in the end". It was during this time that she started to undertake experiential regression work.

4.12.1 In search of the lost twin
One of the experiential regressions was a womb process workshop, which led, as she explained it to me, to some powerful insights into her personality "I mean it brings tears behind my eyes really cos, I found out that I’m a womb twin survivor". Martha’s initial scepticism about this, "cos when you find these things out, I think, well for me anyway, there's doubt, there's kind of ‘really? Really?’", was altered when she discussed it more with the facilitator “… and then, of course, a big piece came, of what I’d been struggling with, you know, became more clear to me, d’you know what I mean, because once, then I started to, kind of like, read about it and I realized that I ticked (many), you know, if not all of the psychological sort of characteristics”. Having done some research on womb twin loss, then, and making associations between her ways-of-being – the elements she had been finding it hard to make sense of - and the sort of psychological traits that womb twin survivors are reported to have, Martha “… started to kind of get involved in womb twin - there’s some forums on Facebook and things like that, so I was kind of, um, did come across quite a few womb twins”.

During the workshop weekend itself, Martha realised there were a couple of things she could connect to the idea of losing a twin in the womb. The first of these, as she explained, was “… when I went home, I just saw this bird, this pigeon and it had been all attacked, it was feathers everywhere sort of thing, and I just wanted to gather them all up. And then I walked down the road, and I saw this kind of pot, and I picked this pot up and it looked like an urn to me, I put the feathers in, and it felt like to me “Oh, this is what happened to me I’ve got fragmented” and you know, I’m kind of ‘these are the fragments and, and this is the twin’ you know ‘this is the twin’. “My understanding is this incident happened after her regression, as she was on her way back to the accommodation, which she had also noted “just sort of seemed significant because it was coincidental”, because “I was actually staying on a street called, oh what was it? erm [town name’s] Street, and then that connected me in with
the, erm, the lady’s whose written all the books about the twin womb twin survivors”. So, the street name where her accommodation was happened to be the name of the hometown of the author of womb-twin survivor literature.

Following these events, the following weekend Martha was attending another pre-and perinatal workshop; a few days before the workshop, she had gone to the town it was in: “I was just there for a little break” she told me “I was wandering around [town] and, um, I saw this this woman and always kind of walking in the same direction, and this woman, we were kind of like walking parallel to each other in the same direction”. They both came to a wall and had to turn around and ended up sitting in the same park near each other and, it seems, “kept bumping into each other there”. Some days later, Martha was in another city, “it was really raining very heavily so I decided to go into the cathedral to shelter, went into the cathedral, and I thought “oh I’m just going to light a candle for my twin and do a little prayer”. Martha “was doing this prayer, I heard this little boy’s voice, say, ‘can I light a candle for my egg mummy?’ [laughing] So I opened my eyes, and this little boy had half an egg, right, [continuing to laugh] and I just thought ‘it’s just so amusing to me’. ” As Martha moved away, “I took a few steps, and I saw this woman again”, that is, the woman she had encountered several times in the other town and “…we both had acknowledged, maybe nonverbally, we kept bumping into each other, so we were, both, responded in this way [mouth wide open in surprise expression], we both did that, we were both really curious about the fact that we kept bumping into each other”.

Martha was so curious about these meetings that she asked the woman if she was a twin, “And she said ‘no’”, but asked Martha why she had asked: “and I said, ‘well, I just recently found out that I had a twin in the womb, and I like lost the twin’ and she said that she found the same out (laughing). So, it was just like, it was just amazing”. Martha concluded “But I did have this intuition about her from the beginning…I could see the signs, I could see, yeah, some mirror, mirroring around how she was sort of thing you know”. I assume from this last statement Martha had identified certain characteristic ways-of-being the other woman demonstrated that reminded Martha of things she had read about womb-twin survivors.
4.12.2 Making connections

I asked Martha how she felt this discovery of a ‘vanishing twin’ had showed up in her life. One of those was her realization that “… there’s been these men in my life that have, kind of, been almost erm (…), kind of, quite spiritual, they’ve been sort of, quite, quite spiritual but not, not really kind of, not really fully showing up, sort of thing, erm, and then kind of just disappearing, sort of disappear, yeah [laughs]”. Martha did not define “spiritual” for me, but explained what had been missing in these relationships was her “real need to communicate, and to really kind of understand the other person, can be understood myself” but she had found these “spiritual connections with [pauses, seemingly realising this in the moment] with men, in particular” where there had been “no words, it's wordless, it's kind of like this, there's this connection, which is an energetic one, erm, but then kind of for me what's missing is the communication”. She related these experiences to “this kind of push pull dynamic” (as she called it): “I realized from the womb twin stuff that that’s why I have this deep need, a deep need for intimacy but at the same time, I also have this kind of fear as well. So, which makes sense, makes complete sense from what happened in utero”. Martha, it appears to me, has made sense of why these ‘wordless, spiritual men’ ‘disappear’ from her life being related to her loss of a twin in the womb. Moreover, she identifies her deep need for intimacy, which she also fears, a lack of trust-in-relationship perhaps, arising from having lost a sibling in the womb – an intimate relationship that was lost quite suddenly, without explanation, words, or understanding. She went on to reflect how this made sense of the “real neediness that I had”, how “sometimes when I’m with somebody, being physically close to them, that I’m like [bringing her hands in towards her body, crossed over, close to her chest] I have this kind of real need to attach myself (laughs) … my body is actually kind of wanting, wanting to do that, a real strong desire to do that”.

4.12.3 Thinking with and from Martha’s story

The conversation made me ponder, given her perception of womb loss and how this connected to men in various ways, if her twin had been a male twin. In the audio, she clearly emphasises “men” after the pause. Thinking with her, the loss of a male sibling seems to be what she is implicitly trying to convey in her illustrations of this deep mistrust of intimacy. It is only a wondering, building on her in-conversation
reflections, especially as she also told the story of meeting the woman who, coincidentally, had also found out she was a womb twin survivor. Martha had also lost touch with this woman, as “I gave her my details, but she’d for some reason, she didn't give me hers and then she never contacted me”. Reflexively, Martha also noted how this was “kind of the lost twin thing again”.

In thinking from some of the interconnections between some of her storying, given it was Martha’s presence at the workshop in which she discovered she might be a womb twin survivor, I was reminded of Beitman's (2016) belief that heightened emotions increases coincidences, which also has a link to Appleton (2021, 368) asserting that “Synchronicities may also occur in the days and weeks following a [pre and perinatal regression] workshop”. Indeed, Martha’s words that pre-empted the pigeon feather story as the first of narrative coincidence had been “there were a few signs, really there were a few signs”, and she herself had noted the co-incidental nature of her meetings with the other woman. I was very struck by these demonstrations (albeit unconscious to Martha) of Jung’s principle of synchronicity, the occasional manifestation of archetypes in both states of the mind and physical events at the same time (Storr 2013) and especially synchronicity in the sense of “the concurrence between a psychological conflict and a symbolic environmental event that helps a person make sense of a significant psychological change” (Beitman 2016, 122). The coincidences Martha relates are resonate for me with Jung’s unus mundus, the ‘one world' condition of unitary being, which suggests a connecting network between everyone and everything, giving structure and order to ‘reality’ (Dourley 2011; Le Mouël 2021).

Related to this, much of Martha’s storying has a spiritual element to it, and the Buddhist philosophy of dependent origination (or reciprocal causality) that urges us to “transcend the conventional notions of levels of existence or of dualism between self and the world or between conscious and inanimate” (Huizar 2020: 78); nothing, the doctrine suggests, exists exclusively in and of itself: there is a “mutual causality in which everything ultimately touches” (Keefe 1997, 64). Perhaps, like Kafka Tamura thinking in terms of karma, in Murakami’s novel Kafka On The Shore, “things
in life are fated by our previous lives. That even in the smallest events there’s no such thing as a coincidence” (Murakami 2005, 33).

An alternative proposition, from a position critical of the idea of coincidence, is Johansen and Osman (2015, 34) stance that seeing and experiencing coincidences are “an inevitable consequence of the mind searching for causal structure in reality”. This position would explain the idea of coincidental interconnectedness as a form of assemblage, showing “human interactions, thoughts, language/discourse, matter (materiality), and nature are all occupants of this world” (Greene 2013, 751); as everything is connected simply and purely by existing in the world, it allows more scientific objectivity that accounts for chance events or meetings through the ideas of probability and Fisher’s Law of Truly Large Numbers (Cambray 2009; Tunstall 2014; Main 2004). Ultimately, real or imagined, seen ego-centrically as coincidences often are (Falk, cited in Main 2004), and building on the idea of making sense of our world through creating narratives, Johansen and Osman (2015, 35) quoting Henry (1993) seems relevant: “A coincidence experience may be defined as the occurrence of two (or more) odd, surprising, out-of-the-ordinary or personally meaningful events connected in the mind of the observer’.

Returning to my research question, I posit Martha is using these various ‘discoveries’, presented as stories, as a part of a narrative re-construction of her ways of being-in-relationship, translating the embodied explorations in womb-surround regressions into an understanding of her push-pull dynamics and ambivalence in relationships, retro-reflecting on those elements of her life before the discovery that she could make an alternative interpretation of, armed with the pre- and perinatal knowledge. Indeed, along with the quest for the lost twin, Martha contemplated “it did give me a little bit of an insight into, maybe, if I’d had a twin, I think that there might have been a difficult relationship with the twin, erm, you know this kind of disappointment and kind of yeah, there's kind of who's in charge, who's in, who's who's the leader, sort of thing”.

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4.13 Findings summary

My research question was aimed at discovering how knowledge derived from pre- and perinatal psychology, learnt from both formal educative trainings and experiential regression sessions, had been incorporated in Self-understanding, and understanding of relational ways-of-being. What the findings in this chapter shows is the depth and breadth of the "frameworks", "layers of understanding", "naming", "jigsaw pieces", "nuggets", "information" to borrow some of the descriptions used by participants, these pre- and perinatal explorations provided them. Moreover, the potential impacts of womb-life and birth have been framed within the storying of their experiences, turning the rich creations into transformational narrative knowledge. All of them learnt things about their own histories that contributed direct aetiological power to their Self understandings. In the Discussion chapter that follows, I will examine this meaning-making from a more holistic viewpoint, drawing on the narratives my participants so willingly expressed in our conversations.
Chapter 5 Discussion

5.1 Introduction

In this chapter, I take a wider view of the analysis conducted in the Findings chapter regarding the questions that led my inquiry to critically examine and demonstrate my over-arching thesis. My intent is to show how my project has achieved its aim, in bringing to the fore the importance of the pre- and perinatal field in narrative explorations of Self-in-relationship ways-of-being in the counselling and psychotherapy profession. In the literature review, I outlined aspects of narrative use within a therapeutic context, and my methodology rested on a constructivist-interpretivist paradigm that considers the undertaking of pre- and perinatal psychology education and associated regression explorations as being, in essence, a psycho-somatic-socio-therapeutic endeavour. To support my discussion, I return to the information sheet I distributed to participants, in which I stated, “I am particularly interested in how an awareness of our womb-life and birth helps us develop a different or deeper understanding of our personalities and our “ways-of-being”. This includes how we have been in our relationships with parent, siblings, partners, work colleagues and others throughout our lives. I am interested in how we use this understanding through the stories we tell ourselves and others, and how those stories might have changed through learning about womb-life and birth”.

In the Findings chapter, I showed how my participants, at an individual level, engaged with this request. All of them produced rich and detailed stories, filled with what McLeod (1997) might recognize as a late/postmodern reflexivity of possible selves through the epistemophilic impulse, the urge for knowledge (Britton 2000). This resulted in narrative interpretations which enabled opportunities for change and allowed “for the larger transformation of the self within the narrated interpersonal field” (Anderson 2004, 319). The stories told to and through me constitute the narrative structures in which the participants explain how pre- and perinatal learning experiences, including their personal regression experiences, have helped them develop a better understanding of themselves, their relational ways-of-being and
how they want to change, to heal and develop “what it is to be human in a world that requires adaptation” (Frank 2012a, 46).

From this focus on the individual, I now expand outwards to discuss, at a more holistic level, the commonalities across the narratives. Examining the ways in which my participants used their storytelling of womb-life and birth, I see how there is a constant dialogue between Self (that is, individual identity, a sense of ‘who I am’) and ‘Self-in-relationship’ (that is, ‘who I am in relationship to something or someone else’). Hence, the positionalities of Self and Self-in-relationship overlap, and moreover are amorphous and pliable, dynamically interacting with each other. In my analysis, I see ‘social’ as incorporating both interpersonal (Self-and-other) and wider societal and cultural implications, where the psyche and the social “each permeate the other in ways that are not fully predictable” (Butler 2016, ix); as McAdams and Janis (2004, 169) have also noted, “Life stories are always psychosocial constructions, co-authored by the person and the person’s world”.

In this way, in the stories I heard, I see how my participants’ narratives “move back and forth between the personal and the social, simultaneously thinking about the past, present and future and to do so in an ever-expanding social milieu” (Clandinin and Connelly 2000, 2-3). The participants’ creative creations created through essential portrayals of themselves and others, the telling of stories and the imaginative production of ‘I am this (because of this)’ narratives, I would argue, are akin to an in situ, spontaneous, though possibly previously rehearsed, form of autobiography. Halton-Hernandez (2023) cites Philips (1994) who likened psychoanalysis to autobiography due to the narrative component of self-telling and Rycroft (1983) who saw the therapist as co-constructor of life narratives in the therapeutic relationship. I find these perspectives resonating with the stories I heard from participants. These portrayals are produced in the interaction of a conversation, and therefore have much less form than normal autobiographical methods of the kind Milner employed, the major difference being that autobiographical work is often more ‘solid’ – be it written diaries, books, artworks and so on: my participants have
no record of the conversations they have with me, and any produced by me are, by definition, not autobiographical, but are, at least, biographical.

In working with the data that the interviews generated, I am therefore drawing on a transdisciplinary approach in this discussion chapter, building on narrative therapeutic theories and incorporating psychosocial and psychoanalytical critiques of the narratives I heard when exploring the meaning and identifying the importance of the findings. Here, I am using Stenner’s definition of transdisciplinarity as “a concept that has been used in efforts to describe integrative activity, reflection and practice that addresses, crosses and goes through and beyond the limits of established disciplinary borders, in order to address complex problems that escape conventional definition and intervention” (2017, 2).

5.2 Narrative wreckage, reclamations and transformations
From the stories of womb-life and birth that I heard, I take the position that the pre- and perinatal learning experiences that my participants have undertaken are, at the very heart of it, psychotherapeutic in intent, content and action; the various experiences the participants have engaged in have an aetiological explanatory power, a means by which to make better sense of their Self-in-relationship modalities through a ritualised, psychosomatically-experienced enactment of returning to the womb. How much these experiences are taken up by the participants can vary; for example, subtle differentiations can be seen in the cool and grounded appraisals offered by Mary, the integration of multiple threads into a self-declared framework by Penelope, the turning over and slotting together of jigsaw pieces by Eliza and the energetic ‘spiritual autobiography’ (Frank 2013) of Patty. Yet all the narrative reconstructions of their histories are, at some level, offering the participants the opportunity to consider and initiate change based on the Self-storying they do. This allows the emplotment of compelling, alternative futures that could, albeit with effort, perseverance and sometimes with difficulty, arise from such reflexivity (Frank 2012b; Greenberg and Angus 2004; McLeod 1997).
As I listened and relistened to my participants, however, and read and re-read through the transcripts of our conversations, as I worked with their stories and developed my narrative analysis, I was strongly reminded of Frank’s (2013, 69) words when he wrote “Each of these self-stories is grounded in some form of narrative wreckage and each has its own act of reclaiming”. In my view, the wreckage is scattered across the participant landscape in subtly different ways, contrasting Phillips’s (1998, 1) suggestion that the stories we tell are oriented towards differentiating “the world as we would like it to be, and the world as it happens to be”, and these stories of womb-life and birth undoubtedly form part of healing journeys the participants have and are undertaking. There are stories that involve loss, most prevalently loss in utero - Eliza, Penelope, Martha and, indirectly in her story of battling the fibroid companion-enemy, Helen - all name the loss of a twin in the womb as fundamental to their own intrapersonal and intersubjective experiences, whilst Catherine weaves the story of her miscarriage into the explanation of attachment dynamics with her daughter.

Stories that suggest an impact on attachment dynamics with their mothers also show up in a physical way in the depictions of implantation issues that Violet, Mary and Elizabeth told. Reciprocally influential empathic failures in intersubjectivities are incorporated in the stories told Claudine, Isabella and Patty: the drama of Claudine’s vengeful, expletive-filled, agentic self-posterior-positioning in birth was, ironically, in the service of trying to connect relationally, an attempt, as she described it, to make contact with her mother; in Isabella’s more temperate and regretful reflections, she explored the loss of connection to her own mother, due to medication, as well as her own daughter, due to pain, during birth; and Patty’s brief yet all-encompassing naming of being a “premature baby,… an incubator baby… a C-section baby …with a general anaesthetic” led to, as she saw it, the resultant “betrayal” and “abandonment”. There are other stories I interpret as the naming of self-perceived unhelpful character traits or flaws, such as Helen’s insistent inner voice frequently telling her she had “got something wrong” and her wondering why she seemed to stick things out in unhealthy relationships, and Martha’s deep mistrust of intimacy that showed up in relational misconnections with “spiritual men”. There are also
stories of dissociation from embodied presence juxtaposed with a corresponding connection to the ‘divine’ told by Penelope, Catherine, Isabella and Elizabeth, and of the intergenerational influences and linkages to their ways-of-being told by Violet, Eliza and Penelope. The commonalities of loss heard in the stories is also, paradoxically perhaps, to be found in the myriad complexity between them, the uniqueness of each telling emphasising and highlighting the theme.

The narrative wreckage exposed through the pre- and perinatal learning practices I perceive is, more often than not, a revelation to participants, forming the ground from which the process of reclamation of Self can begin. Thus, in a reversal of the proposition put forward by Botella, Herrero, Pacheco and Corbella (2004, 127), the entry by my participants into the therapeutic space of womb-life and birth is not arguably because “some life event … introduced an unexpected discontinuity in them” but is more often presented as an organic gravitation towards the field, although Eliza’s shocking ‘dying experience’ during hypnotherapy to treat post-natal depression could be considered a notable exception. They are, therefore, not seeking a “‘narrative rewinding’ ” (2004, 127) through therapy, rather it appears that the spaces of learning have provided an opportunity to uncover and reveal, especially through the experiential archaeology of regression, the ontogenetic roots of felt but unexplained pre-existing discontinuities. What ought to be, although of course not always is, an emotionally positive event such as the creation of new life or the birth of a child is soured and disrupted through ‘contamination sequences’ (McAdams and Janis 2004), underpinning the exposition of narrative wreckage. It is this uncovering, through the deep exploration of personal ontogenies, by the participants that provides the basis, or at least the opportunity, for narrative reclaims.

I would also note it appears to be the inherent and historical reflexivity of participants of their intrapsychic processes - the wondering ‘why I am like this?’, ‘why is the world like this?’, ‘why do I feel this way about certain relationships / situations / experiences?’, and sometimes emotional pain caused by loved ones begging the question “‘Why did they hurt me?’ ” (Angus et al. 2004, 97) that drew them all,
sometimes via other therapeutic modalities, into the pre- and perinatal field. There was in this, it seems, a perception of the narrative wreckage that lay behind this draw to inquire, a sensing that there was some form of explanation to be found and as previously observed, this draw was experienced in different ways among the participants. Helen and Penelope, for example, both had a long-held curiosity around the area, the former as a child hearing her father talk of his own birthing experience, the latter from being teased by her boss about the physical and emotional imprints of her forceps-assisted birth, whilst Isabella, Catherine and Mary all had their inquisitiveness sparked by the processes of others through their professional practices. In Elizabeth’s case, her own physical condition of polycystic ovaries, IVF-related craniosacral treatments along with her birth and care experiences of her first born caused her to wonder about her own womb-life and birth, and Eliza’s therapeutic treatment following her personal trauma experience of miscarriage led her onto the pre- and perinatal path.

There is an overlap, I would suggest, in how therapeutic approaches within the pre- and perinatal realm rely both on Self-analysis derived from the learnings undertaking in training whilst also providing the analytical and theoretical framework that is offered through the administrations of the therapist/trainer. The regression and other work my participants undertook is another form of ‘internal work’ that does not rely on ‘couch analysis’ but relies more on another form of artistic self-expression that is dramatic recreations. In my analysis, I draw a line between the necessity of some form of holding field or reflective analysis that psychotherapy offers those inclined to be reflexive about their lives and the creation of a ground from which the self-expression and self-exploration can develop. The notion of “self-cure” that Milner pursues, in her creation of different methods and resistance to traditional forms of psychoanalysis (Halton-Hernandez 2021, 2022, 2023), is thus an interesting notion to consider in relation to pre- and perinatal regressions, as non-analytical forms of psychotherapy might consider the client to be the expert on themselves and thereby the architects of their self-healing (Rogers 1990, 2004; Sills 2009). It is noticeable, however, that despite her conviction of her own method of self-analysis, Milner herself also had personal analysis, even if she felt these, at times, in the Freudian
perspective were not true analysis and despite what some might see as her complicated (and even potentially unethical) boundary issues with the analysis she conducted with Winnicott (Halton-Hernandez 2023). Moreover, Milner, trained as a psychoanalyst, was exposed to all the theory and practical application of analytical techniques, which she could both judge to be ‘not (good) enough’ for her and which therefore helped her develop her own methodologies, suggesting that some form of analytical reflection is an important part of Self-awareness, definition and exploration. My position is these self-stories of wonderings, of loss, of the lacunae in their life histories, and of being drawn to a modality that offered the promise of deeper insight, are all part of the active processes through which participants are reclaiming their Selves. They give a demonstration of how narrative re-construction is in the service of “‘consciousness fighting to achieve sovereignty over its own experience’ ” (Blaise 1993, cited in Frank 2013, 70), and show the beginnings of integrating pre- and perinatal mind and body experiences through languaging in story.

5.2.1 Wreckage uncovered: rituals, (anti)aesthetic moments and rites of passage
The ability to start reclaiming Self and re-constructing narratives from the wreckage is initiated through regression experiences, backed up by other education and learning in the field. The stories told of regression events by my participants has allowed me to hypothesise these occasions in three interconnected ways. At an intrapsychic level, I theorise regressions offer participants an object relations through “aesthetic moments”, as conceived by Bollas (2018), where unthought knowns are made manifest. At a psychosocial level, regressions can be seen as a form of group ceremonial, ritual practice which supports individual transformative potential, whilst at a more conceptual level, these two combine as nascent figurative rites of passage for the participants, that lead to a symbolic re-birth from a Jungian perspective (1950/2014). All three conceptualisations allow for regressions to be “thought of as a kind of technology for producing moving experiences that are conducive of psychosocial transformation”, called “liminal affective technologies” by Stenner (2017, 24; *italics* in original). Furthermore, and in the same manner, Stenner’s description of Dilthey’s definition of *an experience* which has to be gone *through* as “a matter of passage or of transformative becoming… occasioned by liminal,
transformative circumstances” (2017, 48) seems to accurately portray the “betwixt and between’ worlds” (2017, 30) of regressions that the participants describe; “it is precisely in liminal experiences” Stenner (2017, 49) elaborates, “that new ‘representations’ are formed, and with them new ways of proceeding”.

In exploring regressions as aesthetic moments – or as I alternatively re-conceive them, as anti-aesthetic moments, as I will go on to explain - Bollas (2018) posited that in adult lives, objects are often sought for their function as a signifier of transformations of the kind participants have expressed in the nature of their ways-of-being. I have found thinking with and from his concepts, and particularly in relation to the unthought known, “the reliving through language of that which is known but not yet thought” (2018, xv), especially helpful in considering the therapeutic nature of womb-life and birth storying that my participants engaged in.

Transformation of Self-understanding, indeed transformation of Self-in-relationship, is the objective of self-developmental activities. In particular, the descriptions I heard of womb and birth regressions echo Bollas’s concept of “aesthetic moments”, which he posited as representational of an infant’s first object experience, that is the mother and “her own particular idiom of mothering” (2018, 3), as a process of transformation, rather than as a discrete Other. Where I diverge from Bollas, at least in my conceptualisation of regressions as aesthetic moments, is that it seems to me rather than being purely representational, womb-life and birth regressions directly symbolize, and are symbolized in the participants’ material-discursive practices, their experiences of those early object relations. Therefore, to build on my hypothesis of the intrapsychic nature of pre- and perinatal anti-aesthetic moments and offer up a complementary intersubjective perspective (Benjamin 1990), I identify a clear inter-relational element to the participants’ experiences that is drawing on, and working with, a relational unconscious where previously unacknowledged relational bonds are also brought into consciousness. This dynamic interaction between subjective experience and intersubjective relationalism as expressed in the stories of regression present “a co-production of two intersecting unconscious structures” (Woodward 2015, 86); this “third space – somewhere between the psyche and the
social but that nonetheless involves both” (2015, 88). As I conceive it, this third space appeared in the conversations when participants ‘re-created’ the ‘conversations’ they had with their mothers in the womb: Elizabeth, for example, saying “why am I being poisoned, when you’re supposed to love me, erm, and look after me?” shows how her regression experience of a toxic womb – very much an intrapsychic perspective of the impact that she came to believe her mother’s smoking had on her, physically and psychologically – also has an intersubjective, relational element in the conversation with the ‘m/Other’. What is more, Stenner (2017) for liminal experiences, Halton-Hernadez (2022) for Milner’s ‘pliable medium’ and Bollas (2018, 16) in different ways list things like art, poems, sculpture, religion and music as exemplars of where “subject and object appear to achieve an intimate rendezvous”. I therefore temper my proposition further by noting I do not see a direct parallel between pre- and perinatal regressions and aesthetic moments, liminal experiences or pliable medium in the way Bollas, Stenner and Halton-Hernadez do, as the latter ideas appear to be pleasurable, spiritually uplifting experiences through the arts and religions. Regressions do not appear to provide pleasing, rapturous or reverential symbolisation of the mothering aesthetic moments but, sometimes graphically, all “the phenomenological reality of the maternal aesthetic” (Bollas 2018, 19) before and during birth itself.

The kinds of descriptions I heard of regressions seem more like anti-aesthetic moments and disruptive liminal events; although he did not develop this thread in much detail, Stenner’s (2017, 49) suggestion that liminal experiences can also be where “depths are disturbed and the soul is stirred … never more than a hair’s breadth away from destructive chaos” seems more accurate. The subsequent narrativization of these pre-verbal, pre-representational recordings of experience that provide “a psycho-somatic memory of the holding environment” (Bollas 2018, 21), fundamental in the formation of Self and relational ways-of-being, are often presented as troubling, difficult and problematic: Mary’s representation of the arid/dry womb; Violet’s reflecting on her sense of negative umbilical affect; the descriptions of disconnection during birth that Claudine, Patty and Isabella offered; and even the intergenerational trauma experiences that formed a part of Penelope and Eliza’s
work stand as prevalent examples. In addition, even after the events and Self-and-other understandings have been transformed, the negative, embodied affects of these anti-aesthetic moments are recollected and sometimes present for the participants: Elizabeth’s head-rubbing, breathing difficulties and choking at the regression weekend carried over in the conversation with me; Claudine feeling queasy at recollecting being stuck in her regression in a “dark, dank pelvis”; Helen bursting into tears at the thought of not having warmth, and comforting close contact with others due to being in an incubator; and Penelope feeling slightly dissociative when recollecting her sperm and egg journeys are all germane. My analysis of the narratives provides evidence that “The unconscious form, or idiom of the ego, evolves from the inherited disposition, which is there before birth, a design that distinguishes and differentiates the ‘personalities’ of neonates” (Bollas 2018, xvii). These are existential memories, remembered through affective liminal processes of becoming rather than through direct cognitive recall; these memories are then made available to cognitively construct a narrative understanding of Self and Other in new ways.

I do agree with Bollas that in adult life, and in particular those individuals who are seeking therapeutic understandings of themselves and their relational worlds, there is a quest for an “object as envirosomatic transformer” (2018, 4). Pre- and perinatal regressions, quite deliberately “preoccupied with the emergence into thought of early memories of being and relating” (2018, xv), appear to offer just such “a medium that alters the self” (2018, 4), where participants have had the opportunity to be recipients of what Bollas (2018, 5) calls “the memory of the ontogenetic process” rather than the “thought or phantasies that occur once the self is established”.

Accessing embodied, pre-verbal memories requires an appropriate facilitating field to develop the opportunity for intrapsychic, envirosomatic, therapeutic transformation and as such, it is my hypothesis, regressions are also a form of psycho-social ritual. Humphrey and Laidlaw (1994, 3) hypothesised that “Ritual is a distinctive way in which an action, probably any action, may be performed”. As Humphrey and Laidlaw (1994, 5) perceived, it appears to me regressions are directed ritual actions in which
there is a subtle alteration between intention and action, in which the participants have an “agent's awareness of his or her action, and indeed an aspect of this awareness is distinctive of ritual action”. Participants, at the same time, hold a conception of regressions as externally perceived and confronted; actions and the purposes for which they are directed are “ontologically inseparable” (1994, 4). Sometimes this needs to be pointed out to participants as an active choice, as Penelope discovered when one of the rituals at her regressive experience was to pass through an arch of people representing the passage of a prenate through the body, such as a fallopian tube, or into the cervix at birth. When Penelope was invited to do so, “the minute I started to move into it, my whole body starts to go into shock and then I collapse … a very familiar pattern for me”; the therapist-facilitator brought her out of the arch, “she just said, you know, step away and I'm, I can remember that because I, so clearly, because it was like “what I can, I can move away from this stuff?” like I can, I can”. Here, cognitive distancing from the embodied action, adroitly facilitated by the therapist, could be allowed as part of the repatterning process the directed ritual provided. As Penelope put it, “it was completely like, err, like a really profound learning around you don't have to stay in that collapsed state”. Just as Stenner drew a connecting line between his concept of liminality and Deleuze’s concept of an event, in a similar way I associate my proposal of the ritual of regressions with the nature of the transformative possibilities that pre- and perinatal regressions appear to offer. In essence, they create, using Stenner’s description of a Deleuzian ‘event’, “a rupture or deviation from prior causality and chronology which opens reality up to a new set of possibilities” (2017, 60).

Violet also spoke of the “magic in re-enactments” as fundamental part of the intersubjective, psychosocial relational aspect of therapeutic regression interactions, conjuring up a link to Jung’s “magical procedures” (1950/2014, 128) where some form of practice is specifically used to effect a transformation in relation to a rebirth, and equally as a symbolic medium through which alternative modes of collectivity and subjectivity can be expressed (Stenner 2017). The portrayals of regressions produce images of literal rebirths, of course, reminding me of Polyakov’s (2020, 24) exposition of the aesthetic qualities of (religious) liturgy being “not simply mimetic
reenactments, but creations or performances of distinct realities”. Nevertheless, the regression descriptions also depict deeper understandings of the origins of Self structures, the kinds of experiences induced by ritual that Jung discussed, a form of “renovatio, renewal, or even of improvement brought about by magical means” (Jung 1950/2014, 114). In yet another blurring of the categorisations, however, such renewals are facilitated through the social rituals of regressions, well described by Jung (1950/2014, 115) when he writes that indirect rebirth can occur when participation in a “process of transformation” that takes place outside an individual, invoking the social element of such processes as “one has to witness, or take part in, some rite of transformation”. The witnessing of, and participating in, others’ regressions seem to be part of the participants’ emerging transformations. Elizabeth had described the ritualized process of being in the centre of the circle of participants at regressions, how this being witnessed was both difficult at first but had led to her powerful implantation experience, and Mary’s aversion to the idea of taking part in regressions as part of her training, found “pushing up against” her resistance to unlock parts of her psyche that led to her informative dreaming.

Stenner’s idea of disruption to prior timelines and causality in the nature of being I heard being reported through participants’ regression stories prompted me to develop my conceptualisation further and consider – briefly - how these anti-aesthetic liminal regressive experiences, with their inherent intrapsychic processing generated through psychosocial rituals, form what I would call ‘nascent figurative rites of passage’. They are not rites of passage as typically conceived, for example by Turner (cited in Woodward 2015) as sequential stages, or by van Gennep (1977, 2-3) as a “series of passages from one age to another” where “progression from one group to the next is accompanied by special acts”, such as puberty, marriage, occupational progression - even though he, and Davis-Floyd (1992) after him, specifically identified pregnancy and birth as just such a progression marked by special acts. However, they do have much in common with Davis-Floyd’s (1992, 17) synopsis of a rite of passage as “a series of rituals designed to conduct an individual (or group) from one social state or status to another, thereby effecting transformations both in society’s perceptions of the individual and in the individual’s
perception of her- or himself”. Patty offered me a powerful example of this when she described how she had taken the formal regressions and learning experiences and continued them in the “dance” of weekly pre- and perinatal triad meetings with her partner and sister, how “so much growth has come out of that, that just staying in the dance, staying in the dance. And not staying when you highly activated, but you know, like, going away, finding ourselves again, coming back”, how “that trust and safety and commitment to ourselves, to each other” had been fundamentally “important in my life”.

Linking ritual to rites of passage, Davis-Floyd (1992) proffers that ritual offers a sense of control over natural processes that communicates core societal values to participants: I conceive them alternatively in the context of pre-natal regressions as an individualised progressive step towards transformations, albeit with identifiable phases of separation, transition and re-incorporation (Stenner 2017; Fogelin and Schiffer 2015), just as Patty described. I call these rites of passage ‘nascent’ in the sense of ‘emerging’ or ‘embryonic’, and ‘figurative’ in the sense of ‘symbolic’ or ‘rhetorical’. This is because they initiate, rather than conclude, a process of separation which “denotes an existential departure from what the person was before the event” (Stenner 2017, 63). His description of “scary moments that feel purely destructive”, guided by “an experienced master of ceremonies or Shaman” (2017, 63), as the facilitators might be thought of, also offer the potential of exhilarating freedom that seems to fit well with the description of regressions. Just as Penelope described to me, the fear and collapse that her regression started with had led to an on-going process of discovering more of her Self through her womb-life and birth experiences, and their life-long influences on her ways-of-being.

Likewise, regressions themselves are the “transitional phase of becoming which, in a sense, is always an incompletion in process” (2017, 63) and hence the re-incorporation phase requires the sort of creative imagination in fabulation that I explore later. As Penelope, concluding our conversation, had said “I really do hold that it's not just that these other beautiful people I've met in groups and who've held these spaces can see that and reflect that back. Actually, I really hold that for myself
now. And I hold that with the care and love and compassion, and sacredness that it deserves". As Stenner (2017) also notes, and as reflected in the stories I was told, such processes of becoming are fundamentally unpredictable, ambiguous, unstable, partial and therefore ongoing. My argument here is that the creation of creative narratives in combination with the (anti)aesthetic moment(s), produced in the rites of the womb-life and birth regressions, become the vehicles (objects) through which lives are reclaimed and transformed.

5.2.2 Reclamation: knowing-in-being
An interim step towards transformation of Self and relationship begins, I believe, with a reclamation of Self. Frank’s (2012a) standpoint of having the ability to tell stories differently, and the choice to start living in accordance with that different story, is one of his human freedoms that participants take seriously. Just as Frank (2013) suggests, there is a finding of their voices and a reclaiming in their understanding of Self, and in particular their understanding of Self-in-relationship as (a) way-of-being(s), through the telling of their stories. This reclamation, in my analysis, is one of the steps my participants make towards transformation: first, there is the wreckage uncovered through the pre- and perinatal learning and regression experiences, then there is a re-positioning, a reclamation of a more grounded sense of Self. This grounding through storying gives shape and matter to thoughts of ‘this is/might be/explains why I am who I am’, a voice of reclamation that says: ‘once I can make more sense of my Self through the stories that emerge, once I can reclaim that which felt unknown but was there all the time, as well as that that was known but as yet unthought, I have the opportunity to change, to transform the unhelpful, unneeded, unwanted in my ways-of-being’.

I saw how participants are working with these reclamations which new knowledge of their womb-life and birth offers, seeking understanding of the intra-actions between Self-and other. I construe this as “onto-epistem-ology” (Barad 2007, 185) in action, Self-study of the “practices of knowing in being”, a seeking to incorporate and integrate the “inherent difference between human and nonhuman, subject and object, mind and body, matter and discourse” (2007, 185, my emphasis). I will
illustrate how I see this reclamation of Self in the participants’ storying, applying a conceptual integration of Barad’s bifurcated differences.

As Barad spoke of the nonhuman impacting on the human, in terms of pre- and perinatal understanding I thought of the stories I heard involving scientifically delivered technologies, like medication, incubators, IVF treatments, forceps-assisted and caesarean births. These forms of nonhuman technologies are incorporated into participants’ storying their sense of Self and their intersubjectivities, highlighting the psychosocial and the “tensions it presents between the naturalisation of embodiment and the promise of reconstitution through the possibilities offered by technoscience” (Woodward and Woodward 2009, 72). I thought, for example, of Penelope’s forceps birth and her developed understanding of the much wider history that came with that storying, producing a more complete narrative; it was through understanding the ‘nonhuman’ intervention of the cold steel of forceps that she accessed her narrative of change.

Another prevalent example of such tension was provided by Helen’s narrative sense-making around the blurring of boundaries in an incubator, a technology necessary for her healing and survival, yet which left her and her mother, she perceives, with maladaptive attachment issues, separating them at a crucial time from what they both wanted and needed most, physical contact with each other. I also see just such a tension in Elizabeth’s narrative expressing a reclaiming of her natural embodied functions, the resolution of her polycystic ovary syndrome through cranio-sacral therapy, after the joy and happiness – and opportunity to grow and transform – that her first child, conceived through the miracle of ‘nonhuman’ technoscience that is in vitro fertilization. These interventions highlight the “interrelationship between embodied gendered identifications and cultural interventions and between certainties and insecurities” (Woodward and Woodward, 72). Part of Elizabeth’s and Helen’s reclaiming of Self, I would evaluate, rests in their acceptance of this interrelationship between the social perceptions and expectations of ‘natural’ childbirth experiences on women (in particular) versus ‘non-natural’ medical interventions, of the kind Arms (1979) and David-Floyd (1992) contested. The nonhuman elements that present the
technological advances of humankind to both co-operate with and manipulate, perhaps even subvert, ‘nature’ as part of pre- and perinatal journeys are also, of course, human-generated, so the tautological tension is not moot. What I saw in the narratives, as I have exampled, is the transformative aspect of understanding the human part of the nonhuman the participants had encountered.

In the progress towards transformation through reclamation of Self, there is also a complex tension at the edges of subject and object, Barad’s (2007) second onto-epistem-dialectic, a complexity which I have grappled with onto-epistemologically, theorising it as a psychosocial wrestling with the blurring of boundaries between knowing-as-subject, knowing-the-object and the intersubjectivity of experiencing. I would suggest my participants are also wrestling with this complexity. Firstly, in the stories, there is often an attempt to reclaim Self-as-subject, even as Self-as-subjected-to-by-object: I think again of Helen talking about babies being ‘done to’, of having no boundaries. This viewing of “birth from the baby’s perspective” (Appleton 2020, 133) adopts pre- and perinatal psychology’s own reclamation from what is perceived as the cultural shadow of birth, where the subjective experiences of prenates and babies is ignored, denied or refuted.

At the same time, in the stories, subject and object ‘practices of knowing in being’ are often seen to collapse into a relational dynamic that is the intra-action of me-and-other, with mother-as-subject, and sometimes as well as mother-as-object. Arguably the most powerfully presented example of this tension, in my opinion, is Claudine’s posterior-positioned birth story. In this, she reclaims her sense of Self as the subject, using her agency to choose her own difficult birth position, attempting to make relational contact with her mother. Here, then, mother is subject, the other that was not-present, whom Claudine sought to create an intersubjective experience with – even if her ‘tool’ of doing so was the blunt instrument of a difficult and painful posterior positioned birth. Yet in the same narrative reclamation, Claudine presented her mother as Object, the “dark, dank pelvis… an uninhabited place”; here, her mother becomes an object, a personified landscape rather than a human subject -
but, to underline the complexity in my argument, a landscape with which Claudine had a subjective experience in, and with.

In my theorising of the reclamation process I conceive that mind and body, the next of Barad’s (2007) groupings, are often seen as an experiencing whole. Although narrative requires the primary semantic units of the word, it seems to me the narrative explorations of womb-life and birth that arise out of pre- and perinatal learning, especially in regressions, are “material-discursive practices through which (ontic and semantic) boundaries are constituted” (Barad 2007, 141) – matter being, for Barad, “a stabilizing and destabilizing process of iterative intra-activity” (2007, 151, italics in original). As I have shown, the regression work connects all the participants with embodied sensations that are understood as cellular memory imprints experienced in the activities and, sometimes, as part of their daily lives – such as Penelope’s head-holding, or Eliza’s hand movements captured on corporate videos. These sensations are accessed through the activity the regression, felt but also thought about and verbalised by the participants as these sensations are identified, a mind-body connection itself. Subsequently, the mind-body experience is interpreted both by the trainers and the participants during the regression workshops, and after the event, reflexively, by the participants.

Elizabeth provided an interesting insight into the mind-body thought process during a regression when she told me as she was experiencing her implantation sensations, rubbing her head on the futon and thinking, “…this is, this is your body demonstrating what actually happened”. I will also tentatively link ‘soul’ to the mind and body category, given that perhaps the strongest form of reclamation was in the stories of disembodied dissociation and connection to a divine beyond the material world of the human had been made sense of by Penelope, Isabella, Catherine, and Elizabeth. Their storying showed how the pre- and perinatal work had allowed a better sense of mind-body integration, however unfinalized that was, and however much this still could be sensed as a metaphysical tension that fragments the becoming world of which Barad speaks. The various integration processes are, it seems to me, never finalized, but an on-going becoming-in-the-world by the
participants, coming into a more informed, more aware, intersubjective relationship with the world. This offers the opportunity to transform Self and Self-in-relationship from that which it was, to that which it could be.

5.2.3 Re-imaginings: Pourquoi stories, myths and fabulation

Mitchell (1988) discussed how experiences are structured through language, where establishing a semiotic matrix allows for preverbal and nonverbal dimensions of experience to be retrieved. My supposition is that the stories produced from these liminal affective technologies, these material-discursive moments, that participants have taken part in are forged by their inventive imaginations in response to the psych-somatic-spiritual processes of becoming. They not only language their experiences within a simplistic semiotic matrix, but they also harness their creative ingenuities to use the art of fabulation, a concept first developed by Henri-Louis Bergson (Bogue 2010). Fabulation, an activity of the imagination (Bogue 2010), is “not simply an inadequate or distorted representation of reality” but “a symbolic means through which human beings gain imaginative access to the world... a core ingredient in the emergence of novel forms of individuality and collectivity” (Stenner 2017, 37).

Imagination is distinct from memory, which presumes something in the past that has happened, and from perception, which presumes a co-present reality (Stenner 2017) in analysing sensory information (Pike and Edgar (2005). Imagination plays an important role in the construction of sense-making narratives (Sarbin 2004; Lightfoot 2004; McLeod 1997; Greenberg and Angus 2004; Speedy 2008; Dubourg and Baumand 2021) and imagination and myth, drawing on an “older, stricter use of the word” myth not meaning “something untrue, but rather an image in terms of which people make sense of life and the world” (Watts 2006, 49) are part of the art of fabulation. In the conversations we had, my participants were languaging the liminal affective technologies or material-discursive moments, which I am arguing womb-life and birth regression experiences are, using fabulation: the stories are forged by the participants from creative re-imaginings in response to the psycho-somatic-spiritual processes of becoming that resulted from the regressions. The stories brought to my
mind a form of individualized versions of the ‘pourquoi stories’ used in many different cultures to explain the origins of the creation of the Universe, of Nature and of all phenomena, including humans, the basis of why and how something came to be (Mallette 2013). ‘Pourquoi’ stories have, rather pejoratively and in a similar way to rites of passage, been associated with lower-level, semi-civilized or ‘primitive’ societies (van Gennep 1977; Stern 1940); yet, in their creative, imaginative fabulations, I witness participants drawing on genres of narrative that use sophisticated monomythic structures (Campbell 2008) to translate their affective and embodied experiences in regressions into meaning-making stories. In the stories, my participants become the heroines on journeys of Self-discovery, challenging the nature of the societal impositions on them, going into the unknown to return home with a more enlightened perspective on Self, and other, and how to be in the world. So much of what I heard drew me back to Jungian archetypal re-constructions of myth and fable, a patterning of self-making stories in conventional genres, modelling the pathways of heroic journeys (by heroines) through trials and tribulations in the seeking of the universal transformation of understanding (Jung 2014; Bruner 2004; Campbell 2008; Hudson 2010; Stenner 2017; Murdock 1990). Unlike Stern (1940, 213) who concluded ‘pourquoi stories’ represent “the germ and origin out of which scientific concepts were finally developed” and a child, going through a similar cycle of “observation, seeking for an explanation, imaginative interpretation” will come to “the discovery of a scientific point of view, of accurate observation, and inductive reasoning”, I more accurately advocate that the use of imagination and fabulation by participants in therapeutically generating their origin stories leads to a deductive reasoning of the world, and their life encounters in it, as some examples below will illustrate.

The use of imagination was especially present in storying pre-conception, the resistance to embodiment and the loss felt through a sense of divine homesickness, as told by Isabella, Violet and Penelope amongst others, reminding me of Stenner’s (2017, 29; italics in original) supposition that the sacred, grasped “experientially as an inherently ambiguous and ambivalent wavering between worlds” is “… a way of making sense of experiences of liminality”. Stenner expressed a temptation to
“propose that liminal experience is the experience of the sacred” (2017, 179, *italics in original*) though goes on to say it is probably more correct to consider liminal experiences are made understandable, and thus able to be communicated, through the symbolization of what is called ‘the sacred’. Rank (2004) was adamant that it is the power of human imagination that creates myths which are projected onto the heavens because a heaven-to-earth migration is contradictory to the psychology of myth-formation, a fundamentally human activity. It is clear, I believe, the imaginative interpretation of liminal experiences through narratives of the sacred are fundamental to the sense-making of many of my participants. Arguably the most poignant articulation of this ‘double-worldedness’ I heard was Catherine’s story of the “little shining light flickering and darting” around her flat when she became pregnant with her daughter, which she and her husband saw as the spirit of a previously miscarried child, and how her daughter’s urgent, speedy birth was a manifestation of her daughter having been waiting in a liminal place, a world-between-worlds, to come into embodied being.

However, far from adopting or promoting a linear, ‘coherent’ narrative with a beginning, middle and end, the narrative structures of womb-life and birth my participants produced were fragments of different somatic, psychological, physical, relational and (for some) spiritual happenings that emerged from the training and regressions, reminding me of Sarbin’s (2004, 11) words that “individuals actively combine bits and pieces of experience to form rememberings”. Indeed, fragmented storytelling is often a feature of therapy (McLeod 1997) and the ability to still make meaning and deepen self-understanding from these fragments lends weight to Liu’s (2019) argument that narrative coherence is not ultimately and solely necessary for people seeking healing, change and understanding of Self and Other. There needs to be acknowledgement of “the unknowingness of the unconscious and the human psyche” (2019, 130). Liu’s words have a narrative parallel of Frank’s (2012a, 9, *italics in original*): “to learn about stories and the effects of storytelling, trust the storytellers”. In Liu’s work, and in my own presented here, I believe there is a direct contesting and troubling of narrative therapy theory that identity relies on “coherent integration of emotionally salient personal narratives” (Angus *et al.* 2004, 88) or that
“The good life story is internally coherent” (Singer and Blagov 2004, 231) even whilst it might still be presented with “a richness of themes, characters, and events” (Singer and Blagov, 231). Such fixity through language becomes too substantializing and goes against the notion of material-discursivity and the processes of becoming; even if identity is “strangely coherent”, it is still “inherently unstable, differentiated, dispersed” (Barad 2007, 184). It is still possible to recognise the importance of storying in identity development and action from the sometimes-confusing fragments in the overlap and merging of different somatic, psychological and (for some) spiritual stories. This importance can be seen in the troubling by my participants of their own narratives, balancing – or at least producing – both positive and negative aspects of the prenatal influences on their personalities: Helen’s comparing her strength and determination to stick at things alongside the need not to stick with unhealthy relationships; Elizabeth’s sense of her fighting hard to implant after the darkness and wishing to give up an indicator of her purposefulness; and Violet’s consideration that the strength in her self-reliance is also a defence against her vulnerability. Such paradoxes are, as Kirkegaard said, “‘the source of the thinker’s passion, and the thinker without paradox is like a lover without feeling: a paltry mediocrity’.” (cited in May 1996, 3).

The fundamental basis for transition towards transformations of Self and Other interactions, then, is laid down in the ritualized regression experiences along with other pedagogic learning of womb-life and birth constructed through imaginative fabulations that reclaim a deeper understanding of Self.

5.2.4 Transformations
Although there could be many other considerations of how participants might have developed the character traits and the relational ways-of-being they all spoke about that are not related to pre- and perinatal experiences, my participants have demonstrably and specifically used womb-life and birth stories developed over various trainings to deepen understanding of Self and its relationships to others. Patty provided an effusively worded ‘impact statement’ when she told me “I don't know what else to say about the pre- (and) perinatal work, I mean this, yeah, you
know, beautiful, wonderful, amazing, amazing, amazing work” whilst Helen was able to elucidate the awareness this therapeutic exploration had brought: “I think, just even understanding where it comes from has really helped, there’s been that awareness there”, awareness which, referring to her inner critic and the negative voices that sometimes arise in her, has enabled her to “take my foot off the peddle sometimes in those statements, you know, like it loosens the relationship with it a little bit”.

Beumer’s (2020, 21) words on Edward Tyler’s work on the experiential side of ritual could quite easily have been written about my participants’ explorations of Self: “These are not “intellectual” issues, they are issues pertaining to embodied experiences … clear and emotional, existential and interpretative problems for sentient beings such as humans”. As Greenberg and Angus (2004, 333) noted, “the reflexive construction of new personal meanings involves the self-organization and articulation of felt emotional experiences”: personal change in psychotherapy, they suggest, relies on “the narrative framing of emotional processes, at both tacit and conscious levels of awareness”. As I would put it, the psycho-somatic-affective storying of participants works in such a way as to form non-finalized, semi-coherent structures of (re)identity by allowing an understanding of the chaos that brought about splitting and fragmentation of Self. Although there is integration of Selves that were previously fragmented, as evidenced throughout the individual narratives and storytelling, it is on-going and partial, and there is variation across the participant group as to how transformative their deeper knowledge of womb-life and birth has been. In this, I bring to mind Martha saying “it’s got to be about that, it’s just got to be” when referring to the impact of her twin loss on her ways-of-being compared to Mary holding the prenatal alongside family dynamics and the growing wisdom-mind of aging. Even within participants, this dichotomy might be seen: Eliza told me prenatal psychology had almost become like a religion for her before later expressing her sense of healthy scepticism, and the need for explorers in the field not to get too lost in the causality principle of the theories, much as Appleton (2020) advises. Appleton (2020) also wrote of his own personal and professional experience in the pre- and perinatal psychotherapeutic fields, wholeness is a path to be lived,
not a goal to be achieved. What I am proposing in this thesis is that it is the narrativizing of the liminal affective technologies of pre- and perinatal pedagogical experiences that is a fundamental part of my participants’ healing. In the terms of my research, the narratives of Self and Other that are constructed reflect complex interactions of thinking and feeling through various intrapsychic objectifications (Bollas 2018), psychosocial intersubjectivities (Woodward 2015, Stenner 2017, Benjamin 1990) and post-structuralist/post human perspectives (Barad 2007).

I would argue that my participants are using storytelling, or storying, as a function of problem-solving, “re-casting chaotic experiences into causal sequences” (McLeod 1997, 37) to produce alternative understandings not only of why and how something happened, but also why and how the ‘something’ has left some form of impact – a wounding, an imprint, an impression – that manifests in material-discursive practices. A starting point for these transitions, and in acknowledgement that the inner worlds of our psyche demand some form of conceptualization of the Self (Woodward 2015), all the participants spoke, in various ways, of what could be conceived of as patterned ways-of-being formed in relation to their pre- and perinatal experiences. In these constructs, there often appears to be a perceived ‘fixity’ when participants use the term ‘pattern’; I think particularly of Helen, for example, saying “I’ve broken that pattern to at least some degree”, and Violet talking about her secondary pattern of self-reliance: both are referring to their propensity not to seek support and help from others when they need it, tending to do things on their own. These are Self-stories that pre-existed the womb-life and birth work, examples of the typical and repeating, familiar Self-forms - the Me as self-as-known (Abram 2007; Hermans 2004) - which had an established sense of coherence and stability. It is the regression work, in particular, that brought a different perspective to these Self-views, and at least has offered the self-reflective ability that holds the promise of reinvention (Woodward 2015).

Prenatal therapy – like other forms of therapy – surfaces a “dialogical array of often contradictory self-representations” showing how “the self experientially is a set of complex self-organizations in constant flux” (Greenberg and Angus 2004, 345). What
appears to be an important shift in the participants’ perceptions of Self, an offering of a redemption, is evident in rejections of the proposition “that the problem [only] rests with them” based on an introjection of the “modern narrative of the individual as a microcosm of the world” (McLeod 1997, 26). This refutes perspectives that medicalizes or pathologizes an individual who ‘has’ a ‘disorder’ or ‘condition’.

Catherine explained how the work had reduced the negative aspects in her ways-of-being as “Lately, there’s less activation than there used to be”, suggesting how the deeper understandings had helped integrate as “there’s much more of a landing with it, and more of a kind of expansiveness of connection to it, rather than reacting to the experience”. The participants, through the regressions, have experienced the intersubjective, relational – and occasionally the intergenerational – influences on their ways-of-being. A form of critical scrutiny of the previously held, repetitive and habitual ways of making sense (Speedy 2008) is therefore verbalised in the telling of these womb-life and birth stories. The intra-psychic internalisation that happens through the telling of stories, integrating both consciousness and action to corroborate and/or contest implicit beliefs of Self and Other (Angus et al. 2004), influences new constructions of identity. The process of change and transformation is never complete however, as Haug (1987, cited in Speedy 2008, 123) suggested, because “Once we have begun to disentangle the knots, the process becomes endless”. Yet in Eliza’s slotting the jigsaw pieces of understanding into place, in Penelope’s construction of a framework for comprehension and even in Mary’s more cautious considerations how pre- and perinatal psychology “gives another layer of maybe why someone is acting the way they do”, there is a transformation of the previous senses of fixity, a recognition that something novel can created from “the transformation of patterned arrangements and ... the emergence of new patterned arrangements” (Stenner 2017, 3).

The participants’ presentations of their narrative wreckage – the flaws, failures, losses as well as their strengths - the light and the shade of their experiencing, relational Selves - contrasts the supposition of Bruner (2004, 4) that “our self-directed self-making narratives early come to express what we think others expect us to be like”. Rather, it is the process of understanding the powerful forces of womb-
life and birth in the construction of their becomings that gives the participants agency to change, to use the positive contribution in fabulation to transition away from that which was and begin a re-incorporation (Stenner 2017), a new way of seeing the world and themselves in it. Thinking with Bollas (2018, 24), I see how the participants often look at themselves in the conversations with me as though from the outside, as an object, thus supporting his idea that the “constant objectivation of the self for purposes of thinking is commonplace”, bringing what Sills (2009, 264) might call an aspect of “witness consciousness” to their storying. They are utilising the part of our “mind that speaks to us as its object” (Bollas 2018, 24) and I see how through the anti-aesthetic liminal moments of regression that which was previously known but unthought becomes open and available to be language. As acknowledged by my participants, the use of language is only an approximate correlation with the aesthetic, liminal moments in which they began to become more aware of their seminal preverbal experiences. Yet, it is the narrativizing of aesthetic moments as myth-like fabulations which develops the transformation of these objects, and hence allow a transformation of the subject.

Again, to reiterate, what I have called the retro-reflections of my participants, looking back how they feel they have been in the world, shines a light onto the character traits they sense they have always had, and which have some origin in their conception, womb-life and / or birthings. This process of transformation, then, is “the art of everyday life; it is a set of stories about how we can nourish ourselves to keep faith with our belief in nourishment, our desire for desire” (Phillips 1998, 13). In Violet’s words, working with unformed process from a preverbal, precognitive space was to work “as a continuation of ‘that which cannot be tolerated will be fragmented’ and not even be formulated, so the only way it can be expressed is in the experiential relationship”. It is also the dialectical (re)arranging of the world; humans find randomness difficult to tolerate and thus we attempt to impose a sense of order on the phenomena we encounter or observe (Yorke 2013). To paraphrase Yorke (2013, 27) talking in a different context about the repetitive underlying patterns that form storytelling tropes, but whose words reminded me of the personal growth that can occur in telling stories: “We exist; we observe new stimuli; and both are
transformed in the process… My participants encountered something of which they were unaware, explored and assimilated it, and by merging it with their pre-existing knowledge, have grown”. For Violet, this translation was through “the magic in enactments…. as being a real, you know, opportunity for transformation…. That’s why I work in this territory of the embodied, erm, psycho-emotional, psycho-spiritual territories, because it needs something more”. The pre- and perinatal experiences, containing the promise of repair, provide the explanatory power that participants are seeking to make more sense of their lives. This is, of course, a teleological analysis, explaining the phenomena of the aesthetic, liminal moments in terms of the purpose they serve in the therapeutic process of becoming transformative objects through narrativizing the unthought known, rather than the cause by which they came to be.

5.3 Seeing the Shadow

In this section, I want to acknowledge three specific negative aspects of pre- and perinatal psychology that sit with and in me, because not acknowledging there is a shadow side to the field, to “keep unacceptable traits hidden or repressed” (Stevens 2001, 64), would be neglectful at a minimum, and disingenuous at worse. Appleton gives the following clear warning of the shadow side of the self-awareness that can come with therapeutically exploring womb-life and birth through pre- and perinatal psychology:

“… it can solidify into a story that we identify with and become limited by. There is a tendency of some practitioners and students of pre- and perinatal psychology to develop a reductionist attitude, whereby all life’s struggles are accounted for by specific pre and perinatal ‘issues’ [which] can become a refrain which closes down further exploration or development… Our emergent sense of self cannot be reduced to a linear cause and effect narrative”.

Appleton (2020, 12)

Eliza was one participant who gave a similar appraisal when she told me, “I think it like anything it can become unhealthy. It becomes, can become, ungrounded. Can become very myopic, you know, and it can become a bit of a vortex and you have to be careful”, recognising there is a potential that “It can become narcissistic, it’s ‘all about me and my process’.” Eliza had met people on trainings who appeared to fall
into the vortex, or over-identified with the theories, “people who are, literally going, on that training, “Everything is (about this experience), everyone's a twin”…”, making her wryly think, inwardly, “Should we just have a cup of coffee and relax?’ You know, it can’t all be about that…”.

I also reflexively own the discomfort of which Appleton (2020) forewarns, as it sometimes arises when I have engaged in critical evaluations of all psychological theories, including pre- and perinatal psychology. The critiques in this section are therefore personal ones, as this is part of a reflexive ethical practice, not just as a researcher but as an experienced and practicing psychotherapist and clinical supervisor. They are, at the same time, also reflected in the interactions I had with participants, as I will example, even though the thrust of my research question was pointed towards the deeper Self-understandings that PPN offered. In addition, although not specifically intended as a feminist review, my critique effectively fulcrums on what I would respectfully call feminist perspectives, as all womb-life and birth theory is inexorably and definitively tied up in the feminine, in women’s bodies and in the relational field of mother and prenate. Whilst also recognizing there is no universal feminist theory, as feminism is a pluralistic concept with diversified opinions, tensions and contradictory points of view (Avis 1988; Stainton Rogers and Stainton Rogers 2001; Woodward and Woodward 2009; Gay 2014; Hollway 2016; Frances-White 2018), in the context of womb-life and birth, I think there are three areas that also have a feminist dimension to them worth examination: the foundations of psychotherapy itself, especially psychodynamic theory and power evaluations; mother-blame; and female bodies. These three have links and overlap with each other but separating them out provides a framework for my discussion.

Given limits of space, my analysis will be unavoidably brief and incomplete, but will provide critical perspectives on the field I believe warrant attention. At the same time, to borrow from Holten (1990) and her critique of mother-blaming in family therapy, but applied to my thesis more generally, I am not, in this section or elsewhere, seeking to undermine or question my participants’ powerful experiences of change, and I am significantly moved by the depth of personal psychotherapy work they have
undertaken. Nor am I denigrating the authors, therapists, and theorists in the field as a whole; I have personal experience of, and therefore great faith in, the power of pre- and perinatal psychological therapies to contribute an increased depth and breadth of intersubjective Self-understanding. Paraphrasing Holten (1990, 54, my words in parenthesis), then, “No imputation is made nor intended regarding the motives of any of the authors, [participants, therapists, or theorists] cited herein. Their words are used merely as examples, but those examples are neither isolated nor unrelated to the issue [of the potential shadow within pre- and perinatal psychology. If they represent the traditional thinking, the unexamined assumptions … must be challenged if [PPN theory] is to become part of the solution to the dilemma faced by its clients and participants”.

5.3.1 Psychotherapy, psychodynamics, and power

Psychoanalysis gave birth to a variety of therapeutic approaches that for simplicity I will call psychotherapy in this section. As general background to my exploration of the shadow, it is worthwhile initially to consider the effectiveness and power dynamics inherent in psychotherapy, as so much of the profession is grounded in psychodynamic mother-child dyadic relationship theory which has, of course, direct relevance to the womb-life and birth study I have undertaken.

The effectiveness of psychotherapy remains controversial (Woodward 2005; Eppel 2018). Jeffrey Masson’s (1989) polemic against all forms of psychotherapy, in essence a critique of the traditional thinking and personalities of the early psychoanalytic thinkers such as Freud, Klein and Jung, along with Grunebaum’s (1986) study of harmful psychotherapy experiences certainly give pause for thought about the shadow aspects of psychotherapy in general. Some feminist commentators have been positive towards psychoanalysis, at least in terms of the attempts of Objects Relations theorists, such as Winnicott, Bowlby and Fairbairn, in bringing the relational aspects of the mother-child dyad to the fore and differentiating internal and external experiences to highlight how the environment of care influences the developing Self (Woodward 2015; Ernst 1997). However, in terms of my critique here, ‘traditional’ views in psychoanalytic theory have been criticised as male-centric,
father-centred, and phallocentric (Avis 1988; Minsky 1996; Parker 1995; Rose 2019; Stainton Rogers and Stainton Rogers 2001; Howson 2005). Pre- and perinatal psychology is not immune to similar critiques of its psychoanalytically-informed and psychodynamic-based theories (Sills 2009; Janus 2021), and how it works with repressed and unconscious aspects of Self and self-in-relational dynamics (Bateman, Brown and Pedder 2010) manifesting through psychological and embodied/somatic experiences of life before, during and immediately after birth. In addition, although nowadays there are many prevalent female practitioners who have published in the field - Cherionna Menzam-Sills, Kate White, Marcy Axness, Wendy-Anne McCarty and Robbie Davis-Floyd to name five - the early thinkers on which the theories are founded – such as Freud, Otto Rank, Ray Castillino, William Emerson, Frank Lake, Thomas Verny and Franklyn Sills amongst many others – were all (white) men.

Claudine obliquely referred to this male-centred bias when she told me early in her career she had worked with “one of the early prenatal women, not men, and I feel like let’s hold a place for women elders in that community too”. Ironically, it could be also argued pre- and perinatal psychology might, in some ways, answer Holten’s (1990, 58) call to place “women at the center of inquiry, not in order to blame them, but in order to better understand them, their lives and their families”. At the same time, Levitt and Whelton (2023, 2) note, “The possible abuse of power in psychotherapy is an issue of recurrent importance, vitality, and debate in psychology because of its gravity for the well-being of vulnerable clients”. My inference of the shadow side of some presentations in the PPN literature is that power differentials between client and therapist could replicate such biases and thus, like other forms of therapy, pre- and perinatal psychology has the potential to exercise societal (Proctor 2017) or cultural power (Levitt and Whelton 2023, 4) that might “replicate forms of oppression related to identities and social statuses” such as ethnicity, gender, language, and race.

Therapists, whether willingly or unwillingly, have role power, being able to define and interpret a client's experiences and issues (Proctor 2017) or the interpersonal power
that comes from their professional status as therapist (Levitt and Whelton 2023). Martha demonstrated this power in the conversation we had: when she was told by a regression facilitator that part of her regression experience might have been related to amniocentesis\footnote{removing and testing a small sample of cells from amniotic fluid, the fluid that surrounds the baby in the womb (uterus) where “a long, thin needle is inserted through your abdominal wall, guided by an ultrasound image. The needle is passed into the amniotic sac that surrounds your baby and a small sample of amniotic fluid is removed for analysis” (NHS 2022f)}, “I had this like emotional reaction to what he said … to me, it felt like, that, that it's true, that there was something there was a needle, you know, there was a needle”. However, she asked more details from another, medically trained, facilitator who, rather than confirming the first perspective, suggested Martha remain curious to what was arising in her: “then confusion happened, confusion, it was so weird” she told me, “it was like invalidation of what I thought (the other trainer) was validating, and so I kind of went into this confusion”. Getting what appeared to be two different opinions from those with role power had created a lot of confusion for Martha.

Aligned with role power is the potential perceptions of a “healthy psychotherapist and sick patient” (Althoff 2017, 105) and the “so-called healing mania, the furor sandi” (Freud 1915, cited in Althoff 2017, 106, emphasis in the original). This is arguably more so in the pre- and perinatal field, given it is a relatively unknown area of therapy both by clients but also in the wider therapeutic profession, so therapists and facilitators can be seen as the ‘knowing experts’, even if they themselves resist this characterisation. I thought about this sort of power when Mary had told me a story of a PPN therapist interpreting part of one of her dreams where “he kind of, maybe intimated, “well, maybe you weren’t, maybe you were a twin” and I’ve never had that sense or feeling, but it, but it’s kind of been running around in my head”.

At the same time, Proctor (2017) did suggest that power in psychotherapy might not be unidirectional, unitary, and monolithic and expert positions were, in my analysis, partially resisted by clients. Eliza, for example, again drawing on the “dry sense of
“humour” she tried to bring to balance pre- and perinatal psychology theorists and clients’ tendency to over-emphasise pathological elements, “because I think yeah, yeah, yeah, it's big stuff, but at the same time it's not everything. You know, I was functioning pretty well before all this”. Yet Martha, whilst showing a cognitive questioning of what happened in regressions, also shows how it is her taking up of the therapist-trainer’s input and interpretations of the embodied and affective experiences that led to her a narrative understanding of being a womb-twin survivor, telling me “when you find these things out I think, well for me anyway, there's doubt, there's kind of “really? really?” you know” but “The fact that it was with (therapist-trainer) and the fact of how, what actually unfolded, and the fact that I had a, a short chat with him afterwards, and the emotion involved and the confirmation how, he said to me, is very clear”. Holding this in the wider field of psychotherapeutic interventions, as a psychotherapist myself, I know that clients are looking for, and often need, alternative interpretations of their experiences, and in this pre- and perinatal psychology is no different than other forms of psychodynamic, psychoanalytic therapies. My point is, as Appleton (2020, 10) has noted, theorists and therapists – and one could posit participants and students of the field too - need maintain a “perspective of mindful scepticism”, remaining reflexive of the inherent power in their roles and their theoretical assumptions. This should guard against the kind of accusation Maguire (2004, 210) made in suggesting “Today psychotherapy seems almost to be viewed as a new religion, a contemporary bastion of truth and morality. Its practitioners are subject to the same type of idealisation/denigration associated with much religious belief (and infantile emotional states)”.

The power of truth, therefore, can also play out in pre- and perinatal psychology. Notwithstanding regression experiences are a very distinct and powerful form of personal exploration, I suggest they are also potentially open to the kind of confusion around “historical truths” that Kohut (1971, cited by Barth 1989, 194) wrote of, where “a single incident in childhood, no matter how traumatic, is less influential in forming psychopathology than is a general atmosphere and ongoing experience of relating and being related to”. The blurring of the memories of the child who experienced and the adult attempting to reconstruct those histories with a therapist in order to
understand the impacts on the developing Self is a potential issue during therapy (Schafer 1983). In essence, as Barth (1989) has pointed out, psychological theories suffer from the need to reduce the complexity of complicating and confusing personal material in order to find ways to better understand ourselves; such reductionism, tautologically, loses the complexity of human experience, thus has the potential of becoming oversimplistic. As Woodward (2015, 18: emphasis in original) suggested, “Rather than revealing the truth about ‘who we are’ and our ‘true’ feelings, psychoanalysis might produce those feelings and anxieties and complexes and give them a label that thus makes them real and makes it possible to think that this is what is real”. I was reminded by this potential to make things ‘real’ through interpretations when Elizabeth also brought in an intellectual critique to her regression. She said to me that part way through, when actively engaged in burrowing her head into the futon, her cognitive mind had caused her to pause and wonder, internally, “‘I don’t think this is real, I don’t actually think this is happening, I’m making this up’…”. Yet, as she lay there thinking this, she also brought an alternative rationale to what I interpret as the strangeness of these embodied feelings that seemed to be guiding her actions, as she “thought, ‘No, this is your body demonstrating what actually happened’”, showing how trusting in her own bodily-felt acceptance of what was happening was an important part of integrating the experience in her narrative sense-making. Again, this resonates with the kind of embodied trauma work that therapists like van der Kolk (2015), Rothschild (2000), Ogden, Minton and Pain (2006) and Levine (2015) have brought into the therapeutic profession.

To re-emphasize: I am not suggesting pre- and perinatal psychology, its modalities of therapeutic intervention nor its practitioners are deliberately complicit in enacting power in the ways I have described; my point is that – like all therapy – there is a potential shadow side of bringing new experiences and knowledge to bear that is inexorably related to power dynamics.
5.3.2 Mother-blame

From this background of issues with psychotherapeutic approaches in general, a related shadow aspect of psychotherapy looms large - how aspects of the theories and approaches can be perceived, interpreted, or indeed understood as ‘parent’ or ‘mother blame’. Barth (1989, 186) put forward the view that because objects relations and self-psychology theories were developed to counter the “instinct-blaming” premise of Freudian drive theory and turn the focus towards environmental causes of psychological issues, the language used can lead to “a superficial understanding of psychodynamics which can easily be interpreted as ‘parent-blaming’.” This has also led to “the mystifying character of the language of psychology with its references to maternal deprivation, the bonding of mother and child, and the maternal instinct” (Rose 1999, 155), stemming from the basic premise, almost a *sine qua non*, that most, if not all, counselling and psychotherapeutic approaches rely on, or offer the chance for, “[a] third position … from which object relationships can be observed” (Britton 2004, 47) where clients or patients break filial reverence and express hurt, loss or disappointment with their parents in the confidential space of a therapeutic setting. This ability to evaluate and understand our parents’ imperfections is part of developing tolerance of those same flaws in ourselves (Barth 2010).

In the stories I heard, sometimes blaming aspects are overt, such as Violet specifically speaking about how she had historically blamed her mother for aspects of her own personality and ways-of-being, and in Claudine’s narrative about the felt absence of her mother during birth resulting in explosive rage as a response. Sometimes they are more indirect, such as when Eliza offers a more subtle consideration in her inability, prior to her pre- and perinatal work, to understand her relationship with a “slightly cold, detached, distant” mother. A feminist perspective might note how it is mothers *specifically* who are the target of blame for deficiencies in care of offspring; as Jacqueline Rose (2019, 26) warns, “The subject of mothers is thick with idealisations”. It is this shadow aspect that presents a problem for pre- and perinatal psychology precisely because, by definition, there is such an emphasis on the role of the mother, both overtly and inferred, within the explorations of
psychological, physical and/or spiritual impacts on prenates - from the embodied and embodying processes of conception, womb-life and birth through to the associated implications for child-rearing and childcare beginning from pre-conception, in utero and perinatally. For pre- and perinatal psychological theories, there is no escaping that those women who become mothers are the only ones who, ultimately, through pregnancy can give birth (Woodward 2015) and are therefore inexorably at the centre of pre- and perinatal explorations, whether acknowledged intersubjectively or not.

“Why are mothers so often held accountable for the ills of the world…? Why are mothers seen as the cause of everything that doesn’t work in who we are?” Rose (2019, 6) asks. Part of the answer might lie in Violet’s narrative sharing her young mother, extremely busy caring for four pre-school children and trying to cope with them all whilst her husband was working away, had not been as available to her as Violet wanted. Her father, in his absences, seemed to be treated more lightly in Violet’s storying than her mother in her overwhelmed presence, as the terseness of her “dad working away” comment combined with her sense of being “dad’s favourite, because I was the first girl” suggests. Violet’s narrative, for me, demonstrated how mothers are required to make choices in childcare are often emotionally divided (Estés 2008; Badinter 1981; Parker 1995; Ernst 1997) due to the socially-constructed trope that to be a good mother, you have to be present, whereas fathers do not, that it is ok for them to be away working and leave the mother to deal with the childcare.

Holten (1990, 55) was fierce in her critique “… mothers have, since time immemorial, been scapegoated” she wrote, adding “Mothers are repeatedly, almost routinely blamed for the dysfunction in their families, and most especially in their children” (1990, 58). Caplan and Hall-McCorquodale (1985) suggested the propensity of professionals and lay-people to find mothers at fault for everything that is perceived to be wrong in their children is through the legitimization of mental health professionals. It is all too easy, perhaps, when resting in the ‘comfort’ of long-established theories such as Bowlby’s on attachment (1969/1997; 1973/1998;
1980/1998) or Winnicott’s “good enough mother” (Abram 2007) for example, to get lost in a dynamic of hearing and replicating accusatory voices. Yet when Claudine admitted to me “maybe that's the bit of me that wants to keep it real or (is) still angry with my mother or whatever”, how she had published a paper on birth in 2007 and a PPN therapist read it “and he was just like 'you are all, honey, you know, you're really angry with your mommy still', you know and I was just like, ‘yeah, probably actually’, you know?”, it did make me think of Caplan’s (2000, 1 and 2) warning that mother-blaming can become a “psychological prison [where] you can't get free, you can't grow up” and you can become “overwhelmed by rage”.

The conversations I had with Mary, Claudine, Violet, Eliza, and Helen showed how, when they were brought up as children in the 60s, 70s and 80s, it remained the case that women were the parent more responsible for childcare, despite any shift towards more egalitarian parenting attitudes that might be evident in recent decades (Lupton 2000; Chodorow 1978). So, another part of the answer to Rose’s question might lie in how socially constructed mother-blame is, a construction in which daughters have been taught to blame their mothers (and vice-versa) by the hegemonic paternalism that pervades society, as noted most powerfully by Paula Caplan (1989, 2000). For the very reason that mother-child relationships are “central to an understanding of inner worlds as well as social practices and culture” (Woodward 2015, 97), this construction functions within what Estés (2008, 172; italics in original) called the “entire maze” of “the mother complex … one of the core aspects of a woman’s psyche”: the mother-archetype is the foundation of this complex, creating a dialectic between “the loving and the terrible mother” (Jung 1954/2014, 82), or casting mothers as Irigaray’s mythical devouring monster, an “indication of unanalysed hatred from which women as a group suffer culturally” (Whitford 1995, 25).

The potential for mother-blame, then, needs to be recognised as one of the shadows of pre- and perinatal psychology, as the development and strengthening awareness of intra-psychic processes that arise out of exploring our earliest experiences
alongside maternal subjectivities and the intersubjectivity of mother-child relationships paradoxically presents.

5.3.3 Bodies
One other aspect of the shadow in pre- and perinatal psychology I wish to acknowledge concerns bodies. There is a plethora of academic interest in bodies (Stainton Rogers and Stainton Rogers 2001), and although the ‘corporal turn’ is something feminism has taken a specific interest in, as part of understanding difference psychosocially (Howson 2005; Woodward 2015; Woodward and Woodward 2009), my main focus here is on the use of metaphors to describe the physical bodies of women as an experiential milieu, as these also have the potential to shame and blame mothers.

For example, when Mary presented her experiencing of womb-life as being her mother’s “whipped” and “wiped out” “arid, dry womb”, drawing on Terry's (2013a) classification of uterine environments as landscapes, it made me recognise how I feel the presentations of the female body as something other than human whilst also being part of nature, “to see in women a mystic continuity with non-human processes” (Dinnerstein 1987, 105), replicate patriarchal bifurcations associating woman with nature and connecting men to culture “with all its connotations of superiority and rationality” (Woodward and Woodward 2015, 63). It is clear Mary took some value from the analysis given to her as it helped her frame something in the relationship with her large family and her parents. Yet Terry provides a good example of my own dilemma in the work of pre- and perinatal psychology. On the one hand, I can resonate with the view that psychological therapeutic interventions, including pre- and perinatal psychology, exist “so that we can continue to evolve and better know the human condition as well as our individual selves”, the Self that “is the unexplained mystery behind individual human consciousness…” (Terry 2013a, 277). Therefore, developing theoretical definitions of the physical spaces of womb-life and birth might help us better “…understand the forces that shaped us, [so that] we have a better chance of catching a glimpse of the "Self" behind our persona”
(2013a, 277) as an additional layer to any explorations of our post-birth psychosocial experiences.

At the same time, reading descriptions like a “frigid” womb would “literally feel cold… a chemical stew [that] arises, as it does in all the uterine environments, because of the emotional state of the mother…” (Terry 2013a, 286) makes me feel deeply uncomfortable, as such descriptions “other” women’s bodies, and could easily be interpreted as reframing them as ‘non-human’, paradoxically even in their Natured metaphors, and this for me is the antithesis of developing deeper relational contact in pre- and perinatal work.

In a similar (literally umbilical) vein, whilst toxicity in the womb has a biomedically-based scientific ground, especially smoking and stress (NICE 2014; Verny and Kelly 2010; Håkonsen, Ernst and Ramlau-Hansen 2014; Wong, Barra, Alfaidy, Hardy and Holloway 2015; Beversdorf, Stevens and Jones 2018), the conceptualisation of toxic wombs also has potential negative connotations. For Elizabeth, she had been left, through her regression experiences, feeling where “it’s kind of organically come up, where I do feel very small and in utero, it’s always about the toxicity and the nicotine”, leading to her express out loud, albeit obliquely, to her mother the “confusion over ‘why, why am I being poisoned when you’re supposed to love me erm and look after me?’.” As Dinnerstein (1987) identified, a mother seen as a representative of Nature is also dichotomously split into being nurturing and unsatisfying, tempting and menacing, soothing and undependable, a biological reductionism that supports Luce Irigaray’s argument that:

“women have been allotted everything in culture that men have to deny in themselves – nature, biology, the body – to protect them from knowing their continued unconscious dependence on the mother and women in general…. For men, women represent only nature, the bodies from which they were born” (Minsky 1996, 193).

Irigaray noted, in the primal womb, the mother and child are both whole, “bound together, albeit in an asymmetrical relationship, before any cutting, any cutting up of their bodies into fragments” (in Whitford 1995, 39). Related to this, Dinnerstein
(1987, 106) empathically stating “The mother is first experienced by every one of us as ‘It’ ” reminded me of the use of ‘it’ by Appleton (2020, 95) to describe the uterus when describing an arid womb-type: “it may not be getting the nutrition or energetic potency that it needs to welcome and support new life”. Thinking of Claudine’s “dark, dank pelvis” description in relation to her birth, two alternate and diametrically opposed perspectives still arise in me when I read Appleton’s words. Firstly, the use of ‘it’ could be construed as a depersonalisation of the mother, another dehumanisation of the womb, her body and her overall lived experience as caregiver, the kind of dualistic quasi-human that Dinnerstein (1987) speaks of, an essential guardian and a deadly enemy at the same time. The use of “it” could thus be theorised as a mechanisation of the reproductive process, something that Davis-Floyd (1992) denigrates as the ‘technocratic model’ of childbirth, the kind of fear Hollway (2016, 138) expressed about “squeezing the creation of new life into an instrumental neoliberal paradigm where everything revolves around notionally non-gendered individuals as productive workers”. The “it” uterus is not being ‘fed’ with the right materials or in the correct way (causing a malfunction), another presentation of a woman’s body as “a form of debilitation or illness” (Rose 2019, 23). The opposite view to this is the possibility that in dehumanising the biological environment, using ‘it’ disconnects - in a positive sense - mother as subjective, feeling, breathing person, as caregiver, from the biology: in other words, I might say ‘these are the biological conditions, not a negative statement on mother and how she is as a person’.

In my analysis, the value of my participants’ explorations are clear from the narrative understandings they have been able to construct; yet when participants are introduced and take up PPN’s metaphorical creations, such as Mary and Elizabeth have done, there exists for me a danger of fragmenting women’s bodies, and a forgetting of the “primal womb, our first nourishing earth … where the child was whole, the mother whole… bound together, albeit in an asymmetrical relationship, before any cutting, any cutting up of their bodies into fragments” (Irigaray, in Whitford 1995, 39). Even though it may be unconscious or unintended, when female bodies are re-conceptualised in this way – Mary as the product of an arid womb, Elizabeth as the product of a toxic one, for example - it could be seen as another form of
violence that reduces and disenfranchises the female body, and by association women themselves. This returns me to the male bias in psychoanalytic thinking. Maguire (2004, 211) noted, “There is still a clear male bias in all mainstream psychoanalytic theories, a tendency to view female sexuality as structured through a ‘lack’ or as inextricably linked to reproductive and mothering functions”. Links between sexuality and mothering had been explored by Malacrida and Boulton (2012, 750), who found contradictory discourses between “women’s bodies as heteronormative sites of pleasure and sexuality on one hand and asexual, selfless sources of maternal nurturance on the other”. Implantation experiences, womb environments named as toxic, dry or ‘unwelcoming’, negative umbilical affect and the inference that medically-assisted births are ‘unnatural’ are certainly linked to the reproductive and functions of mothering that Maguire spoke of, highlighting the psychosocial construction of female bodies, reconstituting them as definitive, fixed forms of an experiential environment, separating out the reproductive from the sexual as though they are “Machines to serve the man-father in private ownership, and to serve the State” (Irigaray, in Whitford 1995, 50).

Apposite to my thesis, such thoughts take me back to Bollas’ idea of mother as transformative process rather than a discrete object, and an endless and inevitable dialectic in the ‘mother spoken of’ as a composite of actual and fantastical, the historical and the imaginary (Bollas 2018). Here, I see Bollas echoing Jung’s (1954/2014, 83) call to recognise the aetiological difference between actual character traits of a mother and those “composed of more or less fantastical (i.e., archetypal) projections”. Mother as a ‘transformational object’, as an infant’s first object – and pre- and perinatal psychology would argue, as a prenatate’s first object – are “known less as a discrete object with particular qualities than as a process linked to the infant’s being and the alteration of his being” (Bollas 2018, xv). At the same time, there remains a tension in how pre- and perinatal psychology presents a complex and complicated mix of objectification of bodies and intersubjective relationality between mother and child, of potentially replicating ambivalent attitudes towards the feminine as represented in the nature of the body whilst also bringing the embodied experiences of women to the fore.
5.3.4 Summarising the shadow

In summarising my perspectives on the shadow, I am reminded by Frank (2012a) how narrative authenticity in the telling of stories becomes what I would call an action-orientation for the narrator, the driver of understanding and change. In this sense, some of the stories of suffering that are presented by my participants rest on this dilemma of narrative authenticity, where from the outside it could be easy to critique their storying as mother- or other-blame, egocentrically in danger of denouncing characters in their stories. There is an evident dilemma in that in the explorations of womb-life and birth that people use to broaden and deepen their stories, these can be either good or bad companions (Frank 2012a) – and sometimes both. Creating a bigger picture, a deeper understanding of the potential origins, real or imagined, of our suffering can just lend weight to potential victimhood, more evidence of wrongs perceived and/or received in childhood having their genesis in pre-birth. To be transformative, these stories need to become good companions (Frank 2012), I would suggest, to metamorphosise self-perception, or other-perception, or both, into more understanding. If stories are actors in socio-narratology, they need to act for the greater good in therapeutic settings. This is not axiomatic: not all explorers on the path see or experience a greater good, but may entrench their victimised selves, their persecutory blame, their need to rescue others over and above their own needs. Stories can be dangerous, to use Frank’s (2012a) word – for the teller, for the listener, for the translator-researcher and for the silent others that are told of in the stories. Expressions of authenticity may have a precarious relationship with stories of advocacy and witnessed events (Frank 2012a), yet in trusting the storytellers, in trusting the deeper transformative power my participants have developed through their womb-life and birth explorations, we are – I am - allowing for narrative authenticity and see the good companions that the narrative healing has produced.

5.4 Narrative healing: the contribution of womb-life and birth storying

I wish to conclude my discussion chapter by returning to the healing potential of narrative, and – notwithstanding some of the potential shadow elements outlined above - how the telling of womb-life and birth stories have been transformative for
my participants. Similar to Stern (1985, 257-258) describing the process of exploring our histories in order to find “the key therapeutic metaphor for understanding and changing the patient’s life… the narrative point of origin of the pathology”, the womb-life and birth stories told by my participants are narrative points of origin of their relational ways-of-being and Self-formations that have caused them difficulty if not actual psychological suffering. Pre- and perinatal psychotherapeutic approaches offer what Kohut (cited by Barth 2010) saw as a need to appreciate and communicate experiences from the client’s viewpoint, or as Appleton (2017) would put it, from the baby’s perspective.

Thus, I have explained how my research, essentially a narrative inquiry, was informed by the therapeutic value of narrative transformations and in particular, drawing on the ideas of socio-narratology, driven by the call to understand how the stories that are told act on and, in so doing, animate human lives (Frank 2012a), what their function might be in terms of the work they do (Chandler, Lalonde and Teucher 2004). The womb-life and birth stories came from regression experiences that had much in common, I feel, to Chilton’s (2015) analysis of transformative experiences as epiphanies, the discoveries or sometimes abrupt manifestations of the principal meanings behind their ways-of-being, like Eliza’s jigsaw pieces clunking into place, or Elizabeth’s amazement at her implantation regression are prime examples. As Frank (2012b) tells us, rather than provide a de facto access into the storyteller’s mind, stories do something to inform how we have lived, and continue to live, in a dialogical way with other stories. At a minimum, I suggest, we are constantly telling ourselves our stories when we are alone, contemplating our lives, be that in the wee small hours of the night, on the bus commuting to work or walking in the wilderness. In this, we create an audience for ourselves, internally in our minds, or perhaps externally in the autobiographical writing of private journals or diaries as Milner did (Halton-Hernandez 2023), specifically for the performance of storying our lives, to assist in the building of the narratives by which we live.

This was evident in the sorts of ‘life statements’, which I posit are an intrapsychic Self-talk, that participants told me about – Helen’s inner dialogues of “the strongest
"will survive" and "I’ve got something wrong", Penelope’s “I shouldn’t be here” script and Violet’s “early patterning” around “self-reliance” and “being on my own, doing it myself” stand as exemplars. Yet shifts, modifications and transformations can occur in the dialogical space of telling a story to someone else where, as Hermans (2004, 175) notes, we are also listening to it ourselves, so “new relationships are established between existing story parts or new elements are introduced. The dialogical space functions as a field of tension in which gradual transition is realized between the assessment of the story and its change or innovation.” Again, I would suggest that the dialogical space extends beyond the intersubjective interaction and continues in an intrapsychic way once the innovation has started. My participants and I were, therefore, also epistemologically active in a dialogical albeit research space, not specifically a therapeutic one, as we explored their self-and-other interpretations, employing intra- and inter-subjectivities co-constructed in the interactive dialogical conversations we had. This built on, I believe, the process of group witnessing of process that regressions themselves offer. Mary had found that taking part in the regressions, despite her resistance, had helped her understanding and Elizabeth explained how the environment of the regression group had a direct influence on her embodied implicit memories, which also arose again as we were speaking about it, that “From the moment that I entered that space… I’m doing now with my lips, you know the umbilical [showing MUMMs]”.

I have discussed how my participants all presented compelling stories from their learnings in the field of pre- and perinatal psychology, weaving back and forth amongst diverse aspects of personal and intergenerational histories, experiences of parental and family care systems and how the embodied sensations and affects of the stories are a critical aspect of bringing authenticity to their experiences. In this moving back and forth, I have argued that the three dimensions of basic relational configuration (Mitchell, 1988) – Self, relationship, and the spaces in between – are evident. Some of the narratives created have helped participants solidify answers to questions they had of who they are, how they have been and how they might be in the future with a reflexivity pointed at Self, whilst other narratives are focussed specifically on relationship with other, and others revealing the overlap between. The
bodies that appear in this space of relationship include the physical body of Self and, inevitable when we think of womb-life and birth, the body of m/Other(s), along with the embodied affective sensations recollected from regressions and in conversation with me. This deeper understanding of their lives is not only existential in nature, especially as I see participants bringing “an attitude towards human beings”, including themselves, “and a set of presuppositions about these human beings” (May 1979, 111) into an inquiring light, they are also constructing narratives with the aim of healing, seeking “the underlying ground in human experience in which both reason and unreason are based” (May 1979, 151, *italics* in the original). My participants are generally not trying to recover from physical illnesses through these stories (though Catherine’s exposition of the restitution and repair of her previously polycystic ovaries through cranio-sacral therapy is a worthy exception), but they are, in essence, looking to heal an uncomfortableness, an uneasiness – a ‘dis-ease’ - in their intrapsychic and interpersonal experiences of themselves and their relational ways-of-being in the world.

To close my discussion, I want to bring back Martha’s story of the pigeon feathers that illustrates, powerfully and poignantly, her narrative sense-making of her prenatal history.

To recap, Martha had made the discovery during a womb-surround workshop that she was a “womb-twin survivor”, that she had lost a twin *in utero*. During the weekend of the workshop, she was on the way back to her accommodation and, she told me, “I just saw this bird, this pigeon and it had been all attacked, it was feathers everywhere sort of thing, and I just wanted to gather them all up”. Martha gathered up the pigeon feathers “And then I walked down the road, and I saw this kind of pot, and I picked this pot up and it looked like an urn to me, (so) I put the feathers in”. Reflecting on the experience in the workshop, and the idea of losing a twin *in utero*, Martha reflected “and it felt like to me ‘Oh, this is what happened to me, I’ve got fragmented’ and you know, I’m kind of ‘these are the fragments and, and this is the twin’, you know, ‘this is the twin’.”
This is, I believe, an exemplar narrative in the service of bringing meaning, and therefore healing, to Martha’s life as a womb-twin survivor. As I interpret her story, whilst resting in her sense of loss after the workshop, she sees the pigeon feathers scattered on the ground; they symbolize for her the fragility of life and death in the natural world, how life in it can be cruel, where beings are attacked and injured, just as life in the womb can be fragile, as it was for her and her twin. More than that, she metaphorically associates the fragments of the pigeon as representing how she and her twin were broken up, not only in the division of cells that created them both, but that then her sibling was lost and scattered, just as the pigeon feathers had been. Within her sense-making process, seemingly intuitive and heart-led rather than cognitive, Martha created an opportunity to honour her lost twin in a ceremonial way, gathering the feathers together in an urn-like container, restoring them to each other, and to her.
Chapter 6 Conclusion

In this chapter, I will conclude my study by providing a summary of how my key findings contribute knowledge to the fields of pre- and perinatal psychology, psychotherapy and counselling and, more generally, narrative inquiry. The summary will lead into the potential implications for future research, whilst I will also provide some of the limitations, as I see them, to my research.

6.1 Contribution of the thesis

In this thesis I have examined in detail eleven participants’ narrative understandings of Self, and their being-in-relationship ways-of-being, that stemmed from their experiences of looking at their womb-lives and births in pre- and perinatal psychology workshops and trainings. The storying they expressed of these experiences through the dialogical, interactive conversations I had with them, and the resultant narrative analysis I conducted, show how their Self-development was enhanced by the therapeutic change made possible through such explorations and explanations.

I have illustrated the storied interpretations of their experiential work and educational learning through the words of my participants, documenting their journeys of Self-development, and investigated how the deeper understanding of their womb-life and birth provided a greater awareness and meaning of Self, changing how they could be in relationship to themselves and others in their lives, such as children, parents, partners and their therapy clients. This thesis also shows how the ability to extend the stories we tell of Self and ways-of-being in relationship talks to the meeting of psychosocial intersubjective relationality of womb-life and birth and the narrative constructions people create to better explain themselves and their worlds. These psycho-somatic-socio-therapeutic explorations of womb-life and birth in my study have been shown to facilitate change in the ways my participants think and behave, enabling them to alter their approach to their own patterned ways-of-being, to better cope with their emotions, to improve their ability to communicate with others and tolerate difference and thereby improve relationships to Self and to others.
As I set out in the closing section of the Literature Review, my aim in this study was to explore how people were able to story their womb-life and birth after having undertaken pre- and perinatal psychotherapeutic regression experiences and associated learning or education programmes. More explicitly, I wanted to find out how this storying, the dynamic activity of making of stories (Polkinghorne 1988), influenced and augmented clients’ personal therapeutic processes of self-understanding and meaning-making of being-in-relationship to the world. Within the conceptualization of the aim, whilst the storying in my study was of personal therapeutic experiences, they also supported the intersubjective nature of my inquiry because womb-life and birth is a shared experience, not least between mother and prenate, but also involves – as my thesis has demonstrated – fathers and previous family generations. Thus, another part of my aim was to highlight how the validation of our experience of living, the knowing and interpreting of our relational worlds (Mason 2018), through narrative-based constructions is undertaken in relationship to and with others. My aims, then, were focused on conveying the importance of pre- and perinatal psychology through narrative explorations to the psychotherapy and counselling profession, as I feel pre- and perinatal psychology more generally, and the role of psychotherapeutic narrative inquiry specifically within it, are both little understood and under-represented in counselling studies and professional practice.

To frame how I believe my research contributes to these fields, I will briefly review here my realisation, as explored in this thesis’s literature review and discussion chapter, that pre- and perinatal psychology and health, as a profession and field of education, research, and therapeutic intervention, is moving towards more integration of bio-medical science with therapeutic techniques. The two professional institutions of pre- and perinatal psychology, ISPPM and APPPAH, also demonstrate this: the ISPPM declares itself to be a “Specialized society for the scientific research of the earliest phase of human life” (isppm.ngo) and the subtitle of APPPAH’s most recent congress in October 2023 was “Exploring the Science of Nurture”

48 By ‘clients’ I mean the participants of the regression experiences; I use this word to avoid confusion by using ‘participants’, which refers to the participants in my study.
(birthpsychology.com). This congress had keynote sessions on intergenerational trauma, the neurobiology of nurture and the neuroscience of stress as well as workshop streams on birthing practices, attachment, and midwifery. Likewise, Wilks (2017) collated a multidisciplinary guide to treating babies and children, following McCarty (2012) who declared exactly this integrative intent to PPN in her book *Welcoming Consciousness*. This was her “attempt to address and resolve core paradoxes and apparent disagreements between mainstream infant development models” and pre- and perinatal psychology and bring them “together in a model that can hold the essence of the full spectrum of perspectives” (2012, 3).

This is a noble position for the PPN profession to adopt, of course, so that interdisciplinary knowledge about early life and its lifelong significance on individuals through research, publications and therapeutic practice can bring greater self-awareness and attention to the psychosocial bonds, especially between mother and prenates/neonates during pregnancy, birth and the first years of life. It has developed new, one might even say revolutionary, therapeutic techniques such as working with babies and very young infants, reading baby body language, and resolving birth trauma (Castellino 1996; Appleton 2020; Terry 2021; Emerson 2001). These have built on the directed and organized womb-life and birth regression techniques adults have been undertaking since the early 1970s (Ridgway and House 2006; Lake 2005; Feher 1980; Laing 1976) which have developed more recently into womb process or womb surround workshops (Castellino Trainings n.d.; Menzam-Sills 2021). From my standpoint, therefore, I see the profession moving towards a more evidence-based approach as a way of legitimizing itself within the domain of healthcare more generally.

My thesis therefore offers a very different take on the value that can be derived therapeutically from pre- and perinatal psychology, focused as it is on the narrative constructions that come from individual storying of experiences in PPN regressions and education. Rather than producing general principles which can be incorporated into therapeutic practice, such as the theories of (for example) umbilical affect, implantation, birthing dynamics and the epigenetic impacts of intergenerational
stress, I deliberately focussed my project in the opposite direction, on the unique individuals who became my participants, wanting to better understand how they had experienced, in effect, the psychotherapeutic processes, what this had brought to their Self-awareness and how this awareness had transformed their intersubjective relational ways-of-being. My own recognition that I had been storying my pre- and perinatal experiences, and how I had managed to transform my own perceptions of my ways-of-being as well as how I came into relationship with others, especially my own mother, drove this inquiry. The therapeutic potential of narrative now has, of course, a relatively long history since the “narrative turn” in the 1980s (Polkinghorne 1988) and been elucidated very effectively by narrative therapists such as Speedy (2008), Bruner (2004), McLeod (1997), and Greenberg and Angus (2004) and there are some autobiographical accounts of womb-life and birth, such as Hayton (2011) and English (1985), but there is, at least in my research efforts, a relative dearth of academically-focussed personal narratives collected and analysed in the way I have in this thesis.

My detailed examination of the womb-life and birth storying that my eleven participants contributed to the conversations we had highlights just how important storytelling and storying is as a fundamental mechanism for explaining our lives. Although not a specific aim, I would suggest my research presents an example of “how poststructuralist, co-constructed interviews with people” can be “ethically and engagingly carried out in practice” (Speedy 2008, 59, italics in original). As my findings demonstrate, in their storying my participants verbalised humour, pathos, trauma, anger, confusion, curiosity, awareness, both of Self and of relational others; they did this with relative openness in a dialogical interaction with a stranger, me, the researcher. That they could produce such rich and personally meaningful content in this way, I posit, demonstrates the value of both human interaction and narrative construction. They also display one of the functions of narratives, to develop “general principles we can apply in future circumstances” (Boyd 2009,163), as before our meeting, they had taken the stories and done something with them, they had used them as actors to elucidate and deepen their understanding of how they had been in the world before this knowledge (Frank 2012). They then showed me how their
stories could become good companions to transform how they were in the present and in the future (Frank 2012).

At a holistic level, for me, this shows the power of narrative reconstructions, irrespective of the veracity of the narrative content, how there is an ability to use the stories we tell so that we may live (Didion 2017), and for the purposes of greater understanding and healing. It is very interesting in this context to consider my participant Catherine’s own reflexivity around the narrative, the wondering of “maybe that's just me making sense of something”, yet at the same time “it felt to be true, you know, it feels true”. Particularly in relation to my research, this subtle juxtaposition of a narrative that is being used to make sense of events in a life (in this case, her daughter’s rapid birth and its relation to her deep desire to be always close to Catherine) versus something that feels itself to be “true”, shows this is more than a retrospective sense-making activity, a construction only after the event, but is also the revelation of an embodied truth explained through narrative.

One other facet of the participants’ process is worthy of consideration, in terms of the narrative therapeutic elements of their explorations: all of them were – as far as I could reasonably establish – in their forties to early sixties, and, as noted by McAdams and Janis (2004, 164), “generativity becomes an increasingly important issue in narrative identity during the midlife years”. This propensity to speak about the generative motifs and the development of personal imagoes, “an idealized personification of the self that functions as the protagonist in the narrative” (2004, 164) within the stories is evident – the wish to leave a positive legacy, to give something back to society, to develop themselves and contribute to therapeutic modalities that encompass the whole of the life span.

6.2 Implications for future research
As I see it, the narrative constructions that feature in my research can be seen to reflect for my participants a trajectory of growing awareness that mirrors typical psychodynamic therapeutic journeys, where in each session, over months and sometimes years, we unpeel the layers of our psychologies. In a similar way, I feel,
the ability to tell, and re-tell, to story and re-story our lives in different settings, whether a therapeutic setting, in a conversation with a researcher or even in internal sense-making dialogue with ourselves, gives us an increasing sense of why we are who we are, and therefore explains how we are is, or has been, getting in the way of who we want to be. This, in my analysis, provides solid support for the importance of narrative therapy approaches to womb-life and birth explorations and, by definition, for future research in the field.

By providing an insight into how storying, and the narrative constructions that can flow from it, could offer the potential for working therapeutically with clients who have undertaken regression therapies, it strikes me there is an opportunity for future research to develop, more explicitly, narrative therapy practices for womb-life and birth explorations, continuing and extending the integration of different disciplines with the inclusion of narrative inquiry. I am not suggesting that clients of PPN therapy do not story their experiences with others. Indeed, from the conversations I had, some participants told me how they had taken their experiences into their personal therapy in order to integrate them, although this was not the case for all of them. I am suggesting that the pre- and perinatal field should be open to narrative approaches in its research efforts and aims of bringing this formative period of our lives into greater awareness. I also think there is specific scope for deepening and extending the inquiry into the use of fabulation, myth-making and imagination in the field, though quite how that would manifest has not yet formulated in my mind.

Pre- and perinatal psychology is still a relatively unknown area across the ‘talking therapies’ yet based on the profound therapeutic transformations that I have detailed in this thesis, I also wonder about the scope including pre- and perinatal awareness in more mainstream psychotherapy and counselling training curricula. Whilst I would not envision regression experiences of the kind undertaken by my participants be incorporated in every programme, as they are a specialism that takes some years to develop and deliver, I can certainly see room for the theories and principles to be incorporated alongside other psychodynamic concepts in lectures, presentations and literature reading lists. Extending this hope, I believe broadening and deepening
practitioner knowledge of pre- and perinatal psychology would enable them to hold the potential significance of clients’ womb-life and birth experiences in greater awareness to consider how the pre- and perinatal period may be a contributing factor in clients’ character strategies, ways-of-being in relationship, or their presenting challenges and issues.

Like all research, there are some identifiable limitations in my study. Perhaps most important to note is that all my participants were female, were middle-class as far as I could ascertain and, although one participant had West Asian roots, all were ostensibly white. My selection process, of first-come, first-selected, meant that the one male who did respond to the invite was excluded, as he replied after I had already closed my quota. There is, therefore, room for more research with men in particular, and additionally Black, African and Asian people. A related, and equally important, issue is that my participants had self-avowedly transformed and changed through greater awareness of their womb-life and birth, and in some cases their extended intergenerational histories. All of them participated to share their stories of how pre- and perinatal knowledge had deepened understandings of Self, and how they were in relationship to others in their lives. In this sense, they were a self-selecting sample and thus not representative of everyone who has undertaken pre- and perinatal regression experiences and trainings. This thesis cannot, therefore, comment on outcomes of pre- and perinatal trainings or experiences for all participants. In short, it is not an effectiveness study and should not be read as such. This, of course, opens up the possibility for potential research that is oriented towards effectiveness of the modality, should researchers be interested in this angle.

Related to the issue of gender, I had to face the dilemma, as a man, that the referencing by my all-female cohort of mother-daughter relationships meant I was cautious writing about such relationships, given I have no ability to have personally experienced the dynamic interaction in a mother-daughter dyad. Additionally, whilst I have, over the years, tried to develop a deeper understanding of feminist perspectives, and indeed had written a feminist critical discourse analysis in a previous research dissertation for my occupational psychology masters, I am
indebted to my supervisors, especially Dr. Murray, for frequently challenging some of my inherent unconscious and unintended biases in languaging certain perspectives of the pre- and perinatal psychological concepts I presented. I have endeavoured to reduce these biases in the work I present here, but cannot claim to have completely done so, and the inclusion of the shadow elements of pre- and perinatal psychology was deliberately included to express the concerns I do hold, despite the incredible and powerful personal transformations the field has given me.

6.3 In closing

I wanted to close this thesis by selecting a pertinent expression of how important PPN work had been to my participants so that, amongst the detailed academic work I have conducted and written, I could end it with the voice of one of them. I heard many expressions of the influences and impacts exploring womb-life and birth had on my participants, some very effusive, some more reserved. In re-visiting Penelope’s storying, however, the following moments in our conversation spoke deeply to me, not just because it demonstrates how powerful and intimate knowledge can be co-created in conversations but more especially because, in her pauses and her expressions of affect and profundity, she tenderly and poignantly captures how important it is, in the art of being human, to have stories of our truth heard:

“We all have a story” Penelope said, “and we all have a story that isn't told, and it's really important that it gets witnessed, and heard, and seen and, um, yeah, I feel like that's - to have that recognized and, um, reflected back to you, and honoured, is is profound, absolutely profound”. Pausing for 9 seconds, Penelope continued, “I feel very emotional when I connect with like (...) um, when I connect with the truth of that (...) ... actually, as I'm talking to you, it feels like, yeah, I really do honour my own story now, and I think yeah, just the experience of talking to you about it, it's kind of um (...) um, firmed that up somehow... And that's, yeah, I feel very emotional speaking with you now”.
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Table of Contents
Appendix A: Ethics Application Form

University of Edinburgh, School of Health in Social Science
Research Ethics, Integrity and Governance

The forms required when seeking ethical approval in the School of Health and Social Sciences have now been merged into this single electronic document. The sections you are required to complete will depend on the nature of your application. Please start to complete the form from the beginning and proceed as guided. On completion the entire document should be submitted electronically to your section’s ethics administrator using the email addresses detailed on the final page.

Applications submitted without appropriate documentation will be returned.

Please work your way through this form, reading the questions and accompanying information carefully. Sections highlighted in yellow are mandatory, so you must answer all the questions in these sections.

Aside from the mandatory questions you won’t always need to answer all of the questions in the form. Section 1 “Your project details” includes a set of filter questions that determine the rest of the questions you need to answer. Please read the notes carefully to make sure you answer the right questions. The notes contain hyperlinks so you can jump directly to the relevant section.

Sections highlighted in yellow are mandatory. These must be completed for every application.

Section 1: Introduction
Section 2: Your project details
Section 3: Description of the research
Section 4: Potential risks to participants and researchers
Section 5: Participants and data subjects
Section 6: Participants or data subject information and consent
Section 7: Confidentiality and handling of data
Section 8: Security sensitive material
Section 9: Copyright
Section 10: Good conduct in collaborative research
Section 11: Good conduct in publication research
SECTION 1: Introduction

This is a:

New application for ethical approval – first submission □
A resubmission following reviewer comments  □
A resubmission with requested amendments □

Please select your School:

☒ School of Health in Social Science
☐ CPASS
☐ Clinical Psychology
☐ Nursing Studies

It is each researcher’s responsibility to check whether their project requires Sponsorship, Caldicott Approval, R&D approval, and/or IRAS. [https://www.ed.ac.uk/health/research/ethics/sponsorship-and-governance]

If the project requires any of these, these need to be secured prior to submitting this application.

Please tick the relevant box before proceeding:

I have checked and this project does not require Sponsorship, Caldicott, R&D and/or IRAS approval  □

My project requires Sponsorship □ Sponsorship letter attached □
My project requires Caldicott approval □ Caldicott approval letter/e-mail attached □
My project requires R&D approval □ R&D approval letter/e-mail attached □
My project requires IRAS approval □ IRAS approval letter/e-mail attached □

External Research Ethics Approval

Does your research project require the approval of any other institution and/or ethics committee, nationally or internationally?

Please state the name of the review body and the current status of your application [for example, submitted, approved, deferred, or rejected]? Please include any known submission/approval timelines.

Not applicable
SECTION 2: Your project details

2.1 Project details

Your name: Keith Evans

Please enter your project title: Coming into Being: An autoethnographic and narrative exploration of the importance of womb life and birth

Proposed Project Start Date: 23rd November 2020

Proposed Project End Date: August 2022

Q1. Are you a member of staff or a student?

☐ Staff member

Supplementary questions for staff members only:

List the names and institutions of any Co-Investigators working with you on the project.

☐ Student

Supplementary questions for students only:

What type of student are you?

PhD candidate

Please provide your course title or programme name

Doctorate (PhD) in Counselling Studies

Who is your supervisor?

Seamus Prior (primary) / Fiona Murray (second)

Q2. Please indicate any external ethical guidance your project has to adhere to. For example, the British Psychological Society (BPS), the British Academy, the British Association of Sport and Exercise Sciences (BASES)

None
2.2 Participants

Q3. Will you be collecting or generating any new data (including autoethnographic writings)?

☐ Yes
☐ No

Q4. Will you be extracting, re-coding or using existing data that contains sensitive information (i.e., identifiable information)?

☐ Yes
☒ No

If the answers to both Q3 and Q4 are ‘no’ you are not required to complete:

Section 4: Potential risks to participants and researchers
Section 5: Participants and data subjects
Section 6: Participant or data subject information and consent
2.3 Security-Sensitive Material

Q5. Does your research project fit into any of the following security-sensitive categories?
☐ Your research project is commissioned by the military.
☐ Your research project is commissioned under an EU security cell.
☐ Your research project involves the acquisition of security clearances.
☐ Your research project concerns groups which may be construed as terrorist or extremist

If you answer ‘yes’ to any of the questions above you must complete Section 8 Security Sensitive Material. You must answer all questions in the section.

2.4 Good Conduct in Collaborative Research

Q6. Will your research project involve collaborative work?
☐ Yes
☒ No

Selecting "Yes" to this question means you must complete Section 10 "Good conduct in collaborative research" later in the form. You must answer all questions in the section.

2.5 Project Funding

Q7. Is funding required for your research project? (To be completed by staff only)

*Please indicate how the project will be financially supported.*

2.6 Knowledge Exchange and Impact

Q8. Will there be any knowledge exchange and impact activities associated with this project? (To be completed by staff only)

2.7 Consultancy Potential

Q9. Could your research project lead to potential consultancy activities in the future? (To be completed by staff only)
SECTION 3: Description of the research

Q10: Please use the box below to describe your research; including a background summary, rationale, research questions and hypotheses, methodology, procedures. If you have identified ethical considerations that are not addressed in other parts of the form, please outline and discuss them here.

**Introduction**

I am an accredited and registered psychotherapist, when I was in training for my master’s degree, more than a decade ago, in Core Process psychotherapy (a blend of Western psychodynamics and objects relations theones with Buddhist psychology around the process nature of being), I was introduced to pre- and perinatal psychology. This was initially through an experiential piece of work called ‘umbilical affect’ with the course director, where a psychological correlate of being in the womb is generated in the form of a regression via an energetic connection between a therapist and client (in the umbilical area), pre- and perinatal psychology as a field of inquiry was developed further on the course through other exercises and theoretical learning. The possibility that womb-life and birth can, in some cases, start to inform our object relations and ways-of-being-in-relationship was, for me, what Bochner and Ellis (2016, 50) might call an “emotional epiphanies”. I subsequently learnt things about my womb-life and birth from my mother that fundamentally changed my self-understanding and the related psychotherapeutic journey I was (and am) undertaking, significantly starting a process of creating narrative-based sense-making understandings and meaning around some of my being-in-relationship modalities. Specifically, I was able to bring womb-life and birth stories into my frame of reference for self-understanding, healing and change.

**My area of study**

In my research I wish to draw on an ontological position that combines a sense of how we come to construct our social relational worlds through the narratives and stories that support our self-understanding and meaning-making, especially in how that construction is formed when we come into relationship, connection and contact with others - in other words our inter-subjective relationalities. I would define inter-subjective relationalities as our experience of ourselves and other objects, including non-human ones, in any connection we have with each other. This describes an area of study that is:

*An exploration of how womb-life and birth stories contribute to and augment our processes of self-understanding and meaning-making of our being-in-relationship to the world.*

This is a working articulation of my intellectual puzzle (Mason 2018), therefore, about how womb life and birth stories, once revealed to us through different methods, can inform, augment and be incorporated into the multiple realities we occupy throughout our everyday relational existences.

An aim of my project is that using narrative explorations, both autoethnographic and through data generated in reflexive narrative interviews with others, I will bring to the fore the importance of this field to psychotherapists and counsellors, contributing to a wider understanding of the art of being human from our earliest experiences in life. As Polkinghorne (1998) noted, we construct narrative meaning through our cognitive processes and it is an
activity, not something that is available as an object to be directly observed, however the narratives we create from
our individual stories and histories – and I would add all the life experiences we engage in – are available for study
and examination when elucidated. Posing my area of study and aim as a broad, over-arching and main research
question:

How are womb-life and birth stories incorporated into meaning-making as part of self-understanding,
psychotherapeutic journeys?

Methodologically, I see a narrative-based approach for investigating womb life and birth. Simple put, my position
is we are story-telling beings that construct our selves and our realities, and make sense of these two things,
through the use of narrative. I therefore see narratives in the same way as Frank (2010), who states narratives can
be understood as resources that are used to construct the stories we tell ourselves and others, and used to make
sense of the stories we hear. It is by working through my thought processes over the last year in relation to which of
the many possible areas of womb life and birth I want my project to be located in that I have come to see how
working with narratives as a methodological choice fits with the ontological and epistemological choices I have
made. Polkinghorne, as one of the leading figures of the ‘narrative turn’ in the human sciences, believed that
narrative was ‘the primary form by which human experience is made meaningful’ (1988, 1, my emphasis); many in
the social sciences see narrative as a principal means of human knowing, a ‘portal’ to human capabilities and
reasoning (Hiles, cramped and Churz 2017), used to influence the lives we live (Speedy, 2008). I have started to truly
appreciate how the training and experiential activities I have undertaken in pre- and perinatal psychology have
helped me reconstruct a ‘narrative knowing’ (Polkinghorne 1988) of myself, where creating a narrative of the
embodied experience (Sills 2009), felt senses (Gendlin 1996) and potted histories of womb life and birth have
helped to shine a light on how I have been in the world, how they have shaped my relational processes, how they
have given meaning of these processes to me.

The situation with COVID-19 has helped shaped my rationale for my method, as it limits movement and activities
at the present time. My intent is therefore to draw mainly on activities that I and others have already personally
undertaken to generate new, fresh data that I can respond to autoethnographically and as a narrative-based inquiry.
There may also be some on-going CPD training and activities that I am able to participate in over the next
academic year but these will only augment and complement my autoethnographic work, if they are to take place,
and I am not reliant on them as part of my method. The actual procedural steps I will take are given separately in
the ‘Specific Actions’ and ‘Analysis’ sections below.

Self-as-subject as methodology
My reason for making personal explorations of my life central to the thesis by using a self-as-subject approach,
drawing on my experience pre- and perinatal education and experiential work, is that this field has been, and is,
such a transformative experience for me. Throne notes how “it is this unique and undifferentiated inner self that can
serve as the subject of research and holds an available wealth of unknown waiting to be explored within doctoral
education by means of systematic, empirical research methods designed specific to explorations of self-as-subject” (2019, 2). She goes onto note how the systematic collection and analysis of empirical data can be used as a “vehicle to uncover previously unknown findings… to better understand the dynamic whole self, society, culture, world” (ibid).

Autoethnography as method

I feel I can best represent the transformation that as a person exploration and explication of the pre- and perinatal field has given me by developing these impact, insights and reflections from a personal perspective. Like Stahle Wall, within existing literature I feel there is “...no representation of my experience and perspectives in it”. Like her, my intent is to “…contribute to the discourse on [pre- and perinatal psychology, and specifically womb-life and birth] through a personal but thematically organized and analytical narrative” Stahle Wall (2016, 6). I believe autoethnography would continue to allow a reinterpretation again and again of these life experiences (Jackson and Mazzet 2008) and to thereby “produce aesthetic and evocative thick descriptions of personal and interpersonal experience” (Ellis, Adams and Bochner 2011, 277).

I believe I wish to develop something I might call a “self-narrative inquiry”; a moderate autoethnography would allow me to “show not tell” about my experience of pre- and perinatal explorations and how they have shifted, affected, disrupted, explicated, enhanced, illuminated and fundamentally changed how I see myself, how I experience the different parts of me, both positive and what I perceive to be negative, what it means to be in relationship with the world. And in a moderate autoethnography, I can bring cultural relevance to this self-narrative through a broader social context. Throne (2019, 10) notes how the significant human experience that the researcher has gone through – the ‘epiphany’ of Bochner and Ellis (2016), the ‘kernel’ of Alexander (2013), as it were – is used by the heuristic researcher to identify the ‘problem’ which he or she wishes to seek “deeper meaning, illumination, or in short, an answer or new knowledge through the use of inquiry”. I feel I certainly fit Moustakas’ heuristic approach of having fully focused on my research area with unwavering attention and interest (Throne 2019): even before joining the doctoral program, I was on a self-as-subject research quest around womb-life and birth: the PhD is being focused time and a specific objective to this process. The actual procedural steps I will take are given separately in the ‘Specific Actions’ and ‘Analysis’ sections below.

Narrative explorations as method

Part of this widening out of the narrative, this abstraction to bring contextual critiques, would be to include the voices of others, which I am proposing to do through interviews. These interviews would inform my own autoethnography as well as be analysed as narratives from which themes that contrast, agree with or offer new perspectives to my self-narratives and indeed to the existing theoretical perspectives. I therefore also intend to undertake interviews with other participants to contribute to and complement my self-as-subject inquiry.

Interviewing is a very common method in qualitative research (Mason 2018) and is an appropriate method for my research. As Kvale (2007) notes, an interview is literally an inter-view – the views of (at least) two people being
shared and explored. There are different types of interviews and I am drawn to using what Anderson and Glass-Coffin (2016, 70) call “reflective dyadic interviews” and Chirban (1996) called an Interactive-Relational Approach to interviewing. In both these cases, which also reflect Frank’s (2010) Dialogical Narrative Analysis as a method of questioning, there is more scope for conversation, for the interviewer (i.e. me) to share personal experience in response to what the interviewee brings. The intent, after Josselson, is to understand the participant holistically “as an experiencing, meaning-making person… [to produce] a rich, nuanced, storied sample of subjectivity” (2013, viii-x). In particular, much of what Chirban (1996) advocates for the interviewer also corresponds with an ethical approach to qualitative research, for example exhorting the use of self-awareness, attunement to the interviewee and integration as interviewer in the process, as well as engagement of relational dynamics and appropriate positioning of the self in the interview. Interview material, fully transcribed, will function in two ways: as a contribution to the generation of new autoethnographic and self-as-subject reflections and as a complementary, additional strand to my own autoethnographic work. The actual procedural steps I will take are given separately in the ‘Specific Actions’ and ‘Analysis’ sections below.

Specific actions

I see an integrated approach that could be labelled autoethnography, heuristic inquiry or (as previously discussed) might be writing-as-a-method-of-inquiry. I am therefore remaining open to what emerges in the field of research, whilst setting an overall direction at this point that has autoethnographic elements combined with a narrative-based inquiry with others. This is what is right ‘for now’ in how I see my research unfolding over the next 2 years. I believe the ethical issues will be the same across an autoethnography that involves others and a heuristic inquiry that stays true to the self-as-subject but also involves others. Here is what I am proposing to do:

Part 1: Autoethnographic explorations of previous work

I plan to immerse myself in the various pieces of ‘pre-existing information/data’ in a systematic and organised way. This information/data comes from a variety of completed activities related to my professional and personal development in the field of pre- and perinatal psychology. These are detailed in Table 1. Additionally, as the table shows, whilst most of these activities have been completed fully some, at least at the time of writing, are continuing over the course of my PhD, both 2nd and 3rd year. I recognise that although I am taking these activities as CPD, the nature of them, being in the field of pre- and perinatal experiences, with inevitably inform and contribute to my research and therefore there will inevitably be some new information that can be used as data. This will continue to ‘thicken’ and enrich the narrative descriptions in the work.

I see the following process for the systematic and organised immersion:

Part 1 Stage 1: Producing typed-up copies of field notes and hand-written reflections from the time of the activity, re-reading written work produced at the time (e.g. essays), re-watching presentations and other video work (including recordings of my womb process workshops). At this stage, I will engage with things ‘as they are’, without too much interpretation or thinking through or with the content, but I know in performing this activity,
elements of Stage 2, I believe, will naturally arise.

**Part 1 Stage 2:** Reflecting on the Stage 1 data and responding to it. This would involve re-reading the written work I’ve produced, noticing (and noting) thoughts, memories, somatic reactions, contradictions or leads to other explorations in the literature. For example, this might generate new insights (including contradictions, confirmations or ‘thickening’ of understandings) based on all the data set, specific instances of it or on things I have learnt, developed and understood as part of my life narrative. It might also, I have already found, trigger a variety of memories, dreams or somatisations that can be viewed through the reflexive researcher’s lens to consider with curiosity in the context of my thesis.

**Part 1 Stage 3:** Produce new written reflections in the form of autoethnographic / heuristic writing based on Stage 1 and Stage 2. These would form both explorations of the other work and the basis for chapters of my dissertation. I would be sharing these writings with my supervisory team on a regular basis to develop, shape, otherwise use or indeed reject as part of my inquiry.

**Commentary:**
Although I have presented some of the actions as ‘stages’, it seems to me that there are the beginnings of an analysis in many of the ‘stages’. I have noted before that my methodology and method are iterative and this is reinforced as I write down the specific flow of my proposed method; it does not appear as a ‘stage’ model that is followed step by step like a laboratory experiment, but loops back, around, between and at tangents to the material being worked with. I believe this fits well into the University of Edinburgh’s resistance to the use of prescriptive methods in qualitative approaches, especially in the School of Health in Social Science, that have the potential to recreate or reframe qualitative research as pseudo-positivist. At the same time, the set of activities that I am proposing to use to generate data give the framework and containment necessary to ensure there is some grounding and direction, this is important within the doctoral research criteria, as suggested by Throne (2019).

It strikes me that some of this process has resonance with Kvale’s (2007) guide for interview analysis, the format almost being a ‘self interview’ with the material. I think this is helpful, as it frames the idea of how I can integrate the autoethnographic work with data generated through interviews with other participants. I appreciate this leads to a complex and ambitious project but I strongly believe it is achievable and will contribute to the rich qualitative research conducted by the University of Edinburgh.
Table 1: List of Completed Activities for Generating Data.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>When completed</th>
<th>Data generation sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Womb Process Workshop</td>
<td>3 days</td>
<td>October 2020</td>
<td>Written reflections of experiential work; specific memories of the experiences; video of my womb process &amp; feedback session</td>
</tr>
<tr>
<td>Integrative Baby Therapy training</td>
<td>Modules of 3 days</td>
<td>2 modules completed in Oct 2019 and Jan 2020; another planned Oct 2020</td>
<td>Field notes, written reflections; conversations with other participants</td>
</tr>
<tr>
<td>APPPAH conference</td>
<td>3 days</td>
<td>November 2019</td>
<td>Field notes</td>
</tr>
<tr>
<td>Prenatal Educator certificate</td>
<td>11 modules over 12 months</td>
<td>August 2019</td>
<td>10 essays; multiple (approx. 50) video presentations by the course team</td>
</tr>
<tr>
<td>Human Baby conference</td>
<td>3 days</td>
<td>May 2019</td>
<td>Field notes</td>
</tr>
<tr>
<td>Womb Process Workshop</td>
<td>4 days</td>
<td>January 2019</td>
<td>Written reflections of experiential work; specific memories of the experiences; video of my womb process &amp; feedback session</td>
</tr>
<tr>
<td>Womb Process Workshop</td>
<td>5 days</td>
<td>August 2018</td>
<td>Written reflections of experiential work; specific memories of the experiences</td>
</tr>
<tr>
<td>Prenatal Person Course</td>
<td>6 modules over 18 months</td>
<td>July 2018</td>
<td>Written reflections of experiential work; specific memories of the experiences</td>
</tr>
<tr>
<td>Psychotherapy training</td>
<td>Various dates</td>
<td>July 2012</td>
<td>Essays, field notes, other course material relevant to my thesis.</td>
</tr>
</tbody>
</table>

Part 2: Interviews to generate data for autoethnography and narrative inquiry

Here I plan to interview previous participants of pre- and perinatal explorative activities. Again, constructing this as a staged approach.

Part 2 Stage 1: Contact potential research participants from a variety of contacts. I would plan to do this in a structured way to select between a minimum of 5 and a maximum 10 participants total from across three main ‘pools’. For example, participants could be drawn from the following:

a. Previous colleagues from the Prenatal Person and from womb process/surround workshops – I have an agreement-in-principle from one to be a research participant and could approach 2 or 3 others.
b. Previous participants in Charisse Basquin / Mary Jackson's womb-process workshops*

c. Previous participants in Matthew Appleton's activities – specifically the personal exploration ones such as the Birth Journey, rather than the professional training elements**

** Commentary: I think that 5 to 10 participants (minimum 5, maximum 10 people) is a sufficient number to contribute to my research in two distinct but overlapping ways: firstly, as explained more below, the interviews will contribute to my own self-as-subject reflections; secondly, and importantly, I wish to give voice to others who have also used pre- and perinatal exploratory work in the development of narratives around womb-life and birth that form a structure for self-development. The number of participants I propose is a manageable number within the timing of a full-time PhD, assuming that interviews will be conducted and transcribed within the next academic year.

* I have spoken to Charisse on two occasions and she has willing and ready to support. We agreed an ethical framework that would mean her sending an invite to her list of previous participants in work with her, asking them to contact me directly if interested in participating in my research. To avoid any dual-relationship, she would not send this list to people she is currently working with in any capacity and I would not collect data on any critical comment of her trainings. She needs to ok the idea with Mary but felt this should not be an issue.

** I have been in e-mail contact with Matthew. He is committed to support my research and expressed trust in my ability to hold boundaries from an ethical perspective. I would propose a similar approach to that described above.

Part 2 Stage 2: Conduct a narrative-based interview with participants in the form of loosely structured interviews over 1 to 2 hours, conversational in nature yet steered towards my main research question. Ideally these would be face-to-face but in the current situation with COVID-19 and depending on the location of interested participants, these may be on-line via a video-conferencing platform. I am hesitant to call the interviews 'semi-structured' as this gives the sense of a list of questions to be asked: I want to be open to respond to answers to my main question, but will have a set of questions as 'back up', in case some participants need more interactive. Josselson (2013) recommends 'little q' questions which should be framed in language that participants are more likely to recognise than formalised academic language often seen in research questions. So, as examples of questions I may ask:

- [Introductory question] What brought you to undertake [the activity] and/or what is your interest in exploring pre- and perinatal areas?
- Can you describe how the learnings that have informed, changed or made you otherwise reflect on the understanding you have of your self (for example, your personality), and how you have been in relationship with others over the course of your life?
- What insights into the way you understand and make sense of the world has your exploration of womb-life and/or birth given you?
- Has anything changed in your life as a result of these insights?
Part 2 Stage 3: Produce a full transcript of the interviews for ‘analysis’. Where possible/practicable, I will share the transcripts with participants to verify the contents. I will ask this of them when consent is given for the interview to take place (i.e. to ask if they would be open to reading the transcript when it is produced to validate it, noting this may be several months after the interview).

Part 2 Stage 4: Analyse and integrate data from the interview transcripts. I explain below a little more around the analysis and integration work of the autoethnographic and interviews.

Analysis
My stated intent is to blend the output from my autoethnographic explorations with material that is generated in the interview process. As noted above, I feel my proposed method is an iterative process, with three complementary parts: my autoethnographic work itself generating new insights, interviews with others also generating new autoethnographic insights and lines of inquiry; and other material from the interviews both contributing to existing narrative themes and providing additional narratives that are not a part of my autoethnographic experience.

The steps below set out how I envision my analysis at this stage.

a) I will conduct new written reflections in the form of autoethnographic/heuristic writing based on the materials generated from my writing up, reflecting on and conducting targeted literature reviews. These would form both explorations of the other work and the basis for chapters of my dissertation. I would be sharing these writings with my supervisory team on a regular basis to develop, shape, otherwise use or indeed reject as part of my inquiry.

b) The interviews will be fully transcribed and used in 2 ways:
   a. To generate new meaning-making for myself as an autoethnographer/heuristic inquirer as Kvale (2007) and Thorne (2019) both note, this can happen during the interviews as well as afterwards in the transcribing and reflection/analysis phase. Such meaning-making generation may also happen for the interviewee through ‘spontaneous relating’ (Kvale, 2007) and reflects Adams, Holman Jones and Ellis’ (2015) use of autoethnographic interviews.
   b. To form both a contribution and a complementary, additional strand to my own autoethnographic work. Any new narratives that are complementary to the self-as-subject ones will be identified through my analysis of the transcripts. These different ‘narrative/themes’ may also reflect agreement or contradiction to existing theoretical perspectives.

In analysing the transcripts, I will actively look for ‘narratives/themes’ I have already identified in the AEG/HI phases, including other participants’ contradictions or contrary experiences to mine as well as be open to the narratives of others which I have not identified in my own self-analysis. The exact size and shape of the contribution from self-as-subject alongside other voices are still to be determined.
Timing
My research will be self-as-subject led, and come first in my activities – not least of which because, once approved, I am ‘ready to go’ and also because my intent has always been to broaden the literature and knowledge-base to include self-as-subject research [which I contend is a key and currently missing contribution to the field].

However, I propose, once ethically approved, to set up and conduct the interviews between October and February / March and thus these will be overlapping with my self-as-subject explorations and provide what I have described above as the two streams of data – that which generates more autoethnographic reflections and that which is from participants. In addition, again as noted above, there are modules of relevant CPD training that are planned to happen over the next academic year which will have the potential to generate more self-as-subject data.

References:


Sills, Franklyn. 2009. Being and Becoming: Psychodynamics, Buddhism, and the Origins of Selfhood, Berkeley,
CA: North Atlantic Books


SECTION 4: Potential risks to participants and researchers

Q11. Is your research project likely or possible to induce any psychological stress or discomfort in the participants or others, indirectly associated with the research?

☐ Yes
☐ No

If “yes” state the types of risk and what measures will be taken to deal with such problems

Although the risk is low, reading, researching and talking about womb-life and birth has the possibility to ‘trigger’ stress and discomfort, especially if these processes were traumatic or impactful on the participant.

As an individual, I have undertaken extensive personal work in the fields of pre- and perinatal psychology, including academic work (around 600 hours in total plus my first academic year of the PhD). I have also, through my training, undertaken nearly 200 hours of personal therapy. I therefore am confident that as an autoethnographer I can manage any emerging impacts and take appropriate action to seek therapeutic help if and where needed.

When writing about my womb-life and birth, and the psychological impacts that has had on my ways of being, my work is not about other people, but primarily about my own experience. At the same time, there is a potential impact on the relational ethics with immediate members of my family – most notably my mother but also my father and siblings.

• The most obvious person that cannot be ignored is my mother, who is implicated throughout in my work I do. Even if I do not specifically write about her (which is probably impossible but nevertheless…), the fact I am exploring my womb-life and birth means she is ‘present’ in the writing and it is impossible to maintain confidentiality and anonymity in the sense that readers will know she is there and who she is, even if they don’t (and won’t) know her first name. She knows I am undertaking this research and has previously discussed her pregnancy and birth with me and I intend to honour and respect the relationship I have with her and be sensitive to what and how I write about my experience of womb-life and birth in relation to her. However, my position is that whilst there is a direct link between mothers and their children from conception on (through the umbilicus) and some of what she experiences when pregnant is felt physically by the prenate (for example, stress), this is not that different from life after birth and the attachment dynamics that exist between parents and children (Boyle 2005). The experience the prenate and infant has is influenced and impacted by those around it, including mum, but the response to those conditions is still an individual experience.

• The ‘wider holding field’ of my womb-life and birth is also implicated: this includes my father, my older sister and the health professionals that were present, as well as my younger siblings in later life. Again, with these individuals, I intend to be sensitive about what and how I write as my experience with regard to their involvement. I will maintain confidentiality and anonymity of all actors as best I can (for example, not using names of anyone or using pseudonyms if and where appropriate), whilst acknowledging that whoever reads my thesis could, in principle, research who my family is.
As my thesis is that womb-life and birth experiences set up my attachment styles and relational modalities (much as others see their early developmental life outside the womb as doing so (Bowlby 2005), I will be reflecting on the life impacts I have had. This will implicate friends, colleagues and former romantic partners as well as family. As with all actors, I will maintain confidentiality and anonymity/pseudonymity, and where necessary consider whether my writing could be used to easily identify individuals. If so, I will attempt to eliminate this identification by using composite characters or ensuring the details are vague enough not to lead back to an individual. However, as with family, this is an ethical dilemma that I acknowledge. For example, if I write about my experience of being abused in a relationship, I would anonymised the other(s) involved by avoiding giving details about specific people. My autoethnography will be about my experiences and my processes that come from those, not about the other people and I will endeavour (undoubtedly with the assistance of my supervisory team) to ensure my writing follows this ethical principle.

In terms of participants in interviews, I plan treat all participants with respect, sensitivity and tact and be ‘alert’ to participants being ‘triggered’ or overly affected by their sharing in the interviews. As an accredited psychotherapist, I am used to holding space for very difficult material. I am (and will be clear with participants) that this is not a therapeutic interview but I will be able to slow down, pause and end interviews if things seem to be too overwhelming and signpost participants, if necessary, to therapeutic support. When using any data that is generated through the engagement with other participants, I will also be mindful, maintaining confidentiality and pseudonymity/anonymity throughout the writing process. Moreover, in terms of data handling, I would – as I do with my clinical psychotherapy clients – assign code numbers for the individuals that will replace names on data and transcripts and ‘flatten’ any identifiable personal history provided (e.g. not use workplace names, specifies of others mentioned, specific dates and times that might be identifiers and so on). I will further provide pseudonyms to the participants for the written thesis.


Q12. Does your research project require any physically-invasive or potentially physically harmful procedures?

☐ Yes
☒ No

If “yes” give details and outline procedures to be put in place to deal with potential problems.

Q13. Does your research project require the use of privacy-invasive technology, such as CCTV, biometrics, facial recognition, vehicle tracking software?

☐ Yes
☒ No
If “yes” - Give details and outline procedures to be put in place to deal with potential problems.

Q14. Does your research project involve the investigation of any illegal behaviour or activities?

☐ Yes
☒ No

If “yes” - Give details of any illegal behavior or activities you may investigate

Q15. Is it possible that your research project will lead to awareness or the disclosure of information about child abuse or neglect?

☐ Yes
☒ No

If “yes” - Indicate the likelihood of disclosure and the procedures to be followed if you become aware that a child has been or may be at risk of harm

Q16. Is it likely that dissemination of research findings or data could adversely affect participants or others indirectly associated with the research?

☐ Yes
☒ No

If “yes” - Describe the potential risk for participants/data subjects of this use of the data. Outline any steps that will be taken to protect participants.

This is not likely but I have considered the following:

• I have considered the relational ethics with regards to writing about me in the context of my family life – as previously noted, it is impossible to research womb-life and birth without implicating mothers, fathers and the wider family field at some level. I would consider sharing my thesis / writings with my family as an ethical practice; however, I note 2 things in relation to this:
  o Relational ethics would also suggest considering what would be the least harmful route, under ‘malefice’ / primum non nocere: if sharing my experiences with my mother and wider family is likely – in my estimation – to cause distress, then it is better not to share it.
  o Related to the above, I have been in adult education since 1996. I have produced tens of papers, essays, presentations and other work of various forms, and ‘interviewed’ my mother in relation to womb-life and birth essays. Never once has any of them ever asked to read any of my work – so I feel the likelihood of them doing so this time is highly improbable. I cannot assume that will be the case, of course, but note it here in relation to malefice.

• In relation to clinical practice arising in the self-as-subject as well as interview research, I see that although these are parts of our lives, and may be informed by womb-life exploratory work, any individual clients can be fully protected using ethical principles of confidentiality and (where appropriate) pseudonymity/anonymity. If
any interviewee talk about their clinical work (if they are therapeutic practitioners – this is unknown at this stage as not everyone who participates in womb-life and birth explorations are) it can be brought into the data analysis, if appropriate: my aim is to research how the explorations have informed self-narratives and made meaning in relationships, so can appropriately guide interviewees to reflect on this element of any clinical work. I am well used to working in interview-like sessions (including most especially my own clinical practice) and know I am able to manage this appropriately.

I have already engaged, and will continue to engage, with 3 potential sources of participants (see Q. 33 for full details). These participants – as noted above – will have completed exploratory work, not be currently undertaking it (at least not with the providers I’m engaging with).

My ethical commitment to the providers who act as a source of potential participants is that I am NOT evaluating their trainings; if critical reflections / complaints or other elements of the training, traiiners or organizations involved, I will signpost interviewees back to them, and state (appropriately) that I am not able to discuss those elements of the training.

As a protocol in keeping with qualitative research, I will offer all participants confidentiality and pseudonymity/anonymity when representing them and their words in my thesis. In terms of data handling, I would – as I do with my clinical psychotherapy clients – assign code numbers for the individuals that will replace names on data and transcripts and 'flatten' any identifiable personal history provided (e.g. not use workplace names, specifics of others mentioned, specific dates and times that might be identifiers and so on). I will further provide pseudonyms to the participants for the written thesis. Interview recordings will be transferred to the University OneDrive as soon as practicable after the interview.

Q17. Could participation in this research adversely affect participants and others associated with the research in any other way?

☐ Yes
☒ No

If "yes" - Describe the possible adverse effects and the procedures to be put in place to protect against them.

Q18. Is this research expected to benefit the participants, directly or indirectly?

☒ Yes
☐ No

If "yes" - Give details of how this research is expected to benefit the participants.

This is not a specific expectation but as Josselson (2013) notes, often ethics in narrative research tend to focus on
the avoidance of harm and does not often acknowledge the potential benefits of having the opportunity to speak about a topic that is of great interest to the interviewee and derive value for them from being listened to by an acknowledging, attentive interviewer. Hutchinson, Wilson and Wilson (1994), for example, found that interviewees can experience an uplift in their self-awareness, feel more empowered and leave interviews with an improved sense of purpose when they take part in in-depth interviews whilst Campbell, Seif, Waseo and Ahrens (2004) reported that even when interviews were not intended to be therapeutic, some participants found them to be healing.

The ability to take part in research of this kind has been posited to produce benefits in terms of the participants being able to give voice to their life histories and tell their stories. The research itself does not directly aim to be of benefit, and is not necessarily expected to produce benefits, for participants but there is the possibility that taking part will be of benefit.

Personally, I have benefited greatly from my initial year in the PhD program, and believe that writing with and through my womb-life and birth, and deepening my research into pre- and perinatal experiences has had a strongly positive psychological effect on me. I am hopeful that continuing my research will also allow that positive effect to be maintained through my research. I also know I greatly enjoy hearing the stories of others in this field, and how their self-understandings have been generated or enhanced through engagement with pre- and perinatal fields.

Q19. Will the true purpose of the research be concealed from the participants/data subjects?

☐ Yes
☒ No

If “yes” - Explain what information will be concealed and why.

Q20. Will participants/data subjects be debriefed at the conclusion of the study?

☒ Yes
☐ No

If “no” – Why will participants / data subjects not be debriefed?

I will debrief participants in three ways:

1. There will be a debrief at the end of the interview, reviewing the participant’s experience and some (further) explanation of the steps I will be following in transcribing and analysing the interview material.

2. I will offer to send them information within 6 months of the interview that will give them key points of what I have learnt from the data we have generated in the interview. I will ask them at the end of the interview if they wish to receive this information and therefore have their permission to retain their contact information for this purpose. I will also, before sending it, contact the participant to ask if they still wished to receive it (and thereby also check if the contact details are still valid).

3. I will also offer participants to have an appropriate summary, of approximately 2 to 3 pages of A4, of my thesis after this has been accepted by the University and my degree awarded to me. I believe it ethical to
offer this after a degree has been awarded (and not before) as the content has been reviewed and approved to a relevant academic standard (and therefore has some validity). I would note this may be 18 months to 2 years after our interview and again ask permission to retain their contact details for this purpose. I would also send a ‘check-in’ email as point 2. above before sending any further information.

Q21. At any stage in this research could researchers’ safety be compromised, or could the research induce emotional distress in the researchers?

☐ Yes
☒ No

If “yes” - Give details and outline procedures to be put in place to deal with potential problems.

Please tick to confirm you agree with the following:

I will adhere to School guidance on risk assessment and health and safety and will seek advice on project and travel insurance prior to project commencement.

☐ I agree
☐ I do not agree
☐ Not applicable
SECTION 5: Participants and data subjects. For autoethnographic research also include those who may feature in your writings.

Q22. How many participants or data subjects are expected to be included in your research project?

There will be one subject in the autoethnography (myself) and a maximum of 10 interviewees.

Q23. What criteria will be used in deciding on the inclusion and exclusion of participants/data subjects in your research project?

For interviews, the relevant criteria for inclusion in the research is that the interested party has undertaken an experiential exploration of their womb-life and/or birth which has been helpful for them in their self-understanding and/or psychotherapeutic healing work. I will therefore actively select participants to interview based on their volunteering to take part and us jointly discussing the proposed research. Participants who have any dual relationship with any training provider that have acted as a source of participants will be excluded on the basis of my ethical agreement with those providers. I will also note to participants that I am not seeking reviews or critiques of the activities they undertook with the providers and that I am not affiliated in any way with them. Should such matters arise before or in the interviews, I would refer the participants back to the organisers.

Q24. Are any of the participants or data subjects likely to be under 16 years of age?

☑ Yes
☐ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q25. Are any of the participants or data subjects likely to be children in the care of a Local Authority?

☐ Yes
☑ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q26. Are any of the participants or data subjects likely to be known to have additional support needs?

☐ Yes
☑ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q27. In the case of participants with additional support needs, will arrangements be made to ensure
informed consent?

☐ Yes
☐ No

If “yes” – What arrangements will be made?

If “no” – Please explain why not

Q28. Are any of the participants or data subjects likely to be physically or mentally ill?

☐ Yes
☒ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q29. Are any of the participants or data subjects likely to be vulnerable or likely exposed to harm in other ways?

☐ Yes
☒ No

If “yes” - Explain and describe the nature of the vulnerability and the measures that will be used to protect and/or inform participants/data subjects.

Q30. Are any of the participants or data subjects likely to be unable to communicate in the language in which the research is conducted?

☐ Yes
☒ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q31. Are any of the participants or data subjects likely to be in a relationship (i.e., professional, student-teacher, other dependent relationship) with the researchers?

☐ Yes
☒ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q32. Are any of the participants or data subjects likely to have difficulty in reading and/or comprehending any printed material distributed as part of the study?
Q33. Describe how the sample will be recruited.

For interview participants, there are 3 potential ‘pools’ from which participants can be selected:

a) I will invite people that I am still in contact with who have participated in pre- and perinatal activities with me, to ask if they are interested in taking part in my research. For example, I am still in contact with several people who took part in the Prenatal Person training that concluded in July 2018 and one of them has already expressed a willingness to participate. I would formally ask these prospective participants and provide them with the same participants information sheet (PIS) and consent form (CF) as any other participant not known to me.

b) Former trainees or explorers in womb process workshops with Charisse Basquin / Mary Jackson will be e-mailed by Charisse to offer the potential to be a participant in my research. She will ask them, if they are interested, to contact me directly so that she does not have to know if they participated or not.

c) A similar set of people will be approached in the same way by Matthew Appleton, from the work he has undertaken with others.

When prospective participants have contacted me to say they are interested, I propose to set up a ‘conversation’ (phone, VC or e-mail) to further discuss the project and provide the Participant Information Sheet and Consent form. Participants will then be able to have ‘space’ (I would propose up to 5 days) to consider the information and before confirming participation or not. I would be open to clarify any points arising for them before they confirm. An interview date, time and place will be agreed. Prior to the interview taking place, participants will sign the informed consent form.

Q34. Will participants receive any financial or other material benefits as a result of participation?

☐ Yes
☒ No

If “yes” – What benefits will be offered to participants and why?
Section 6: Participant or data subject information and consent

Q35. Will written consent be obtained from all participants or data subjects?

☐ Yes
☐ No

If “yes” – attach participant information sheet and consent form
If “no” – explain why not and how consent is obtained (e.g. orally), and/or if consent cannot or should not be sought for some reason, please provide a clear case and rationale for this

Q36. Have you made arrangements to tell participants what information you will hold about them and for how long?

☐ Yes
☐ No

If “yes” – what arrangements have been made?

It is written in the information sheet and consent form that I will keep information for up to one year after my thesis has been submitted and then destroy it unless participants have opted to have a 2 – 3 page summary of my accepted thesis, where I will keep their contact details until such a time as I am able to offer them such a summary. Contact information will be limited to phone number and/or e-mail contact details as provided at the time of the agreement to be a participant in the research.

Q37. Have you made arrangements to tell participants whether you will disclose the information to other organisations?

☐ Yes
☐ No

If “yes” - What arrangements have been made?

There is no need to share any participant information with any other organisation. I have stated in the consent form that I will follow GDPR and the associated Data Protection Act in the management of data.

Q38. Have you made arrangements to tell participants whether you will combine that information with other data?

☐ Yes
☐ No

If “yes” - What arrangements have been made?

__________________________________________________________________

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Q39. In the case of children participating in the research, will the consent or assent of parents be obtained?

☐ Yes
☐ No

If “yes” - Explain how this consent or assent will be obtained

N/A

If “no” – Please explain why you won’t be obtaining consent

Q40. Will the consent or assent of children participating in the research be obtained?

☐ Yes
☐ No

If “yes” - Explain how this consent or assent will be obtained

N/A

If “no” – Please explain why not

Q41. In the case of participants who are not proficient in the language in which the research is conducted, will arrangements be made to ensure informed consent?

☐ Yes
☐ No

If “yes” – What arrangements will be made?

N/A

If “no” – Please explain why not

Q42. Does the activity involve using cookies or tracking individual’s activity on a website or the Internet in general?

☐ Yes
☒ No

If “yes” – Describe the arrangements, you have put in place to obtain informed consent for the use of these tools?
SECTION 7: Confidentiality and handling of data

Q43. What information about participants/data subjects will you collect and/or use?

I have no need of any data about participants other than their name and (where necessary) contact details for arranging interviews or follow-up discussions (e.g. e-mail or phone number). Other demographics are not necessary for my study.

Q44. Will you collect or use NHS data?

☐ Yes  ☒ No

If “yes” – what NHS data will you collect or use?

Q45. What training will staff who have access to the data receive on their responsibilities for its safe handling? Have all staff who have access completed the mandatory data protection training on the self-enrolment page of Learn?

I am registered as a professional psychotherapist with the Information Commissioner’s Office [reference ZA129610] as well as through my management consulting company [reference A8630172] so am very used to handling and managing confidential data and the legal obligations around that.

I confirm I have completed the data protection training on Learn.

Q46. Will the information include special categories of personal data (health data, data relating to race or ethnicity, to political opinions or religious beliefs, trade union membership, criminal convictions, sexual orientations, genetic data and biometric data)

☐ Yes  ☒ No

If “yes” – Explain what safeguards e.g. technical or organisational you have in place; including any detailed protocols if this requires special and/or external processing, storage, and analysis.

If you answered “no” to this question, please skip Q56 and continue answering the rest of the questions.

Q47. Please indicate how your research is in the public interest:

☒ Your research is proportionate
☐ Your research is subject to a governance framework
☐ Research Ethics Committee (REC) review (does not have to be a European REC)
☐ Peer review from a funder
☐ Confidentiality Advisory Group (CAG) recommendation for support in England and Wales or support by the Public Benefit and Privacy Panel (PBPP) for Health and Social Care in Scotland
☐ Other
Q48. It is essential that you identify, and list all risks to the privacy of research participants. You will then need to consider the likelihood of the risks actually manifesting and the severity of harm if the risks actually manifest.

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<tr>
<th>Risk</th>
<th>Likelihood of risk manifesting</th>
<th>Severity of harm</th>
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<td>Remote</td>
<td>Possible</td>
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<tr>
<td>Identifiable due to data linkage</td>
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<tr>
<td>Identifiable due to low participant numbers</td>
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<td>Identifiable due to geographical location</td>
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Please use this text box to record any other risks and the likelihood of them occurring, along with the severity of harm.

No others foreseen

Please identify measures you could take to reduce or eliminate risks identified as possible/significant or probable/severe.

- All data will be managed in accordance with ICO / GDPR. Audio files will be temporarily stored on desktop or laptops that are password protected whilst ‘in transit’ (e.g. before the University OneDrive can be accessed) but otherwise transferred and stored on the OneDrive and removed from the external source at the earliest opportunity.
- The recording machine is kept in a locked safe in a locked cupboard when it is not being used but will be cleared of data (i.e. files moved to OneDrive) at the earliest opportunity.
- I will use identifiers for participants that are not their names – for example I can use a code number, as I do with my clinical clients.
- I will use a cross-reference file between name and contact details and code numbers in an Excel sheet, which will be password protected, and stored on OneDrive.
Q49. Will information containing personal, identifiable data be transferred to, shared with, supported by, or otherwise available to third parties outside the University?

☐ Yes
☒ No

If “yes” - Please explain why this necessary and how the transfer of the information will be made secure. If the third party is based outside the European Economic Area please obtain guidance from the Data Protection Officer.

Q50. Other than the use by third parties, will the data be used, accessed or stored away from University premises?

☒ Yes
☐ No

If “yes” - Describe the arrangements you have put in place to safeguard the data from accidental or deliberate access, amendment or deletion when it is not on University premises, including when it is in transit, and (where applicable) it is transferred outside the EEA.

As per Q. 48:

- All data will be managed in accordance with ICO / GDPR. Audio files will be stored on the University OneDrive.
- The recording machine is kept in a locked safe in a locked cupboard when it is not being used but will be cleared of data (i.e. files moved to OneDrive) at the earliest opportunity.
- I will use identifiers for participants that are not their names – for example I can use a code number, as I do with my clinical clients.
- I will use a cross-reference file between name and contact details and code numbers in an Excel sheet, which will be password protected, and stored on OneDrive.
- When attending interviews (if these are not on-line from home) the digital recorder will be kept with me at all times, or locked in a suitable place (e.g. motorcycle pannier) when in transit.
Q51. Will feedback of findings be given to your research project participants or data subjects?

☑ Yes
☐ No

If “yes” - How and when will this feedback be provided?

1. I will debrief participants at the end / soon after participation in the interview, to discuss their experience and give an overview of what I intend to do with the data generated (as outlined in the PIS).

2. I will offer two potential pieces of feedback to participants
   a. Within 6 months of the interview that will offer them key points of what I have learnt from the data we have generated in the interview. I will ask them at the end of the interview (in the debrief) if they wish to receive this information and therefore have their permission to retain their contact information for this purpose. I will also, before sending it, contact the participant to ask if they still wished to receive it (and thereby also check if the contact details are still valid).
   b. I will also offer participants to have an appropriate summary, of approximately 2 to 3 pages of A4, of my thesis after this has been accepted by the University and my degree awarded to me. I believe it ethical to offer this after a degree has been awarded (and not before) as the content has been reviewed and approved to a relevant academic standard (and therefore has some validity). As above, I will ask them at the end of the interview (in the debrief) if they wish to receive this information and therefore have their permission to retain their contact information for this purpose, noting this may be 18 months to 2 years after our interview and again ask permission to retain their contact details for this purpose. I would also send a ‘check-in’ email as noted in a) above before sending any further information.

If “no” - Please provide rationale for this.

Q52. How do you intend to use/disseminate the results of your research project?

The results will be used to develop and deliver a written thesis for a PhD application.
I will also be writing papers for publication, giving conference papers, seminars and workshops.
SECTION 8: Security-sensitive material

The Terrorism Act (2006) outlaws the dissemination of records, statements and other documents that can be interpreted as promoting or endorsing terrorist acts.

Q53. Does your research involve the storage on a computer of any such records, statements or other documents?

☐ Yes
☒ No

If “yes” - Please tick ‘Yes’ to indicate that you agree to store all documents on that file store

Q54. Might your research involve the electronic transmission (for example, as an email attachment) of such records or statements?

☐ Yes
☒ No

If “yes” - Please tick ‘Yes’ to indicate that you agree not to transmit electronically to any third party documents stored in the file store

Q55. Will your research involve visits to websites that might be associated with extreme, or terrorist, organisations?

☐ Yes
☒ No

If “yes” - You are advised that such sites may be subject to surveillance by the police. Accessing those sites from University IP addresses might lead to police enquiries. Please acknowledge that you understand this risk by ticking ‘Yes’

☐ Yes
☐ No

By submitting to the ethics process, you accept that your School Research Ethics Officer and the convenor of the University’s Compliance Group will have access to a list of titles of documents (but not the contents of documents) in your document store. Please acknowledge that you accept this by ticking ‘Yes’

Please confirm that you have contacted your School Research Ethics Officer to discuss security-sensitive material by ticking ‘Yes’

☐ Yes, I have contacted my School’s Research Ethics Officer
☐ No, I have not contacted my School’s Research Ethics Officer
Section 9: Copyright

Q56. Does your project require use of copyrighted material?

☐ Yes
☒ No

If “yes” please give further details

______________________________
Section 10: Good conduct in collaborative research

Q57. Does your project involve working collaboratively with other academic partners?

☐ Yes  ☒ No

If “yes” - Is there a formal agreement in place regarding a collaborative relationship with the academic partner(s)?

If “no” - Please explain why there is no formal agreement in place?

My research is not collaborative

Q58. Does your project involve working collaboratively with other non-academic partners?

☐ Yes  ☒ No

If “yes” - Is there a formal agreement in place regarding a collaborative relationship with the non-academic partner(s)?

If “no” - Please explain why there is no formal agreement in place.

My research is not collaborative

Q59. Does your project involve employing local field assistants (including guides/translations)?

☐ Yes  ☒ No

If “yes” - Is there a formal agreement in place regarding the employment of local field assistants (including guides and translators)?

If “no” - Please explain why there is no formal agreement in place

My research is not collaborative and does not involve employing anyone.
Q60. Will care be taken to ensure that all individuals involved in implementing the research adhere to the ethical and research integrity standards set by the University of Edinburgh?

☐ Yes
☐ No

If “no” - Please explain why care will not be taken

N/A

Q61. Have you reached agreement relating to intellectual property?

☐ Yes
☐ No

If “no” - Please explain why you have not reached agreement

N/A
Section 11: Good conduct in publication practice

In publication and authorship, as in all other aspects of research, researchers are expected to follow the University's guidance on integrity.

By ticking yes, you confirm that full consideration of the items described in this section will be addressed as applicable.

☑ Yes
☐ No
Subsequent to submission of this form, both the applicant and their supervisor should review any alterations in the proposed methodology of the project. If the change to methodology results in a change to any answer on the form, then a resubmission to the Ethics subgroup is required.

The principal investigator is responsible for ensuring compliance with any additional ethical requirements that might apply, and/or for compliance with any additional requirements for review by external bodies.

ALL forms should be submitted in electronic format. Digital signatures or scanned in originals are acceptable. The applicant should keep a copy of all forms for inclusion in their thesis.

Keith Evans
Applicant’s Name

Keith Evans
Applicant’s Signature

8 October 2020
Date signed

Seamus Prior (by email)

9th October 2020

*Supervisor Signature

Supervisor Name

Date

*NOTE to Supervisor: Ethical review will be based only on the information contained in this form. If countersigning this check-list as truly warranting all ‘No’ answers, you are taking responsibility, on behalf of the HSS and UoE, that the research proposed truly poses no ethical risks.

ISSUES ARISING FROM THE PROPOSAL

---

1 Not required for staff applications
Thank you for this very thorough application. There are a few points that the committee would like to check with you, or would like you to address.

- Start date of research – please change to a date later than receipt of ethical approval (as no research is permitted beforehand)
- What online platform will you use to conduct your interviews? Please note that the University strongly recommends use of a University supported platform, and requires several further steps if you wish to justify use of a different platform. Please see attached leaflet.
- You are intending to gain written consent. If you are working online, how will you manage this and record and store consent?

PIE

- Please explain the recording consent process so that an interested reader knows what to expect. If your interviews are online, please also tell them what will happen, which platform you will use, how they will be able to join – no need to download software etc.
- Please include that the results of your study will also be used for your thesis.

CF

- Bullet point 6. Typo – ‘My’ instead of ‘By’?

- Please link the PIE to the CF by including on both a Header in the format of: Brief project name/version number/date

- The points above assume that you will be collecting data online. If you wish to do in-person interviews, and also may travel to conduct these, then there is further work you will need to do to meet new College guidance before your application can be reviewed for in-person research.

- In your response to this review, please state clearly whether you will be working solely online for data collection or not.

Please note that all documents need to be submitted in word format.

The applicant should respond to these comments in section below.

Signature:  Marion Smith

Position:  CPASS REC Co-Chair

Date:  11th November 2020

| APPLICANT’S RESPONSE (if required) |
• Start date of research – please change to a date later than receipt of ethical approval (as no research is permitted beforehand). I can confirm that no research activities related to data generation have taken place before my application for ethics, and none will take place until ethical approval has been granted by the committee. I have changed the start date to November 23rd 2020 as I hope to get approval by end Nov latest.

• What online platform will you use to conduct your interviews? Please note that the University strongly recommends use of a University supported platform, and requires several further steps if you wish to justify use of a different platform. Please see attached leaflet. I plan to use Microsoft Teams, as recommended by the University. I am very familiar with Teams as I use it daily in other work. I am also lecturing using Collaborate at Heriot Watt so know this to be a possible back-up as another University approved system.

• You are intending to gain written consent. If you are working online, how will you manage this and record and store consent? Yes, I am planning to gain written consent. In my clinical practice, due to the COVID situation, I have done this in a number of ways:
  o I have asked clients to sign an agreement by printing and scanning if they can;
  o I have asked them to electronically sign the document (pdf) if they can – e.g. insert their name or signature;
  o when neither of these is possible, I have asked them to reply to the e-mail I have sent them with suitable words: for example, for my project, I would propose wording such as: “I accept the contents of the Consent Form for this research dated, and the associated project information Sheet dated XXXX. I hereby give consent to be a research participant as per these two documents”. I would also verbally check consent before we started the interview.

PIS

• Please explain the recording consent process so that an interested reader knows what to expect. If your interviews are online, please also tell them what will happen, which platform you will use, how they will be able to join – no need to download software etc. I confirm I’ve done this. In blue on the document.

• Please include that the results of your study will also be used for your thesis. I confirm I’ve done this. In blue on the document

CF

• Bullet point 6. Typo – ‘My’ instead of ‘By’? Thank you, yes, a typo and corrected.

• Please link the PIS to the CF by including on both a Header in the format of: Brief project name/version number/date I confirm I’ve done this

• The points above assume that you will be collecting data online. If you wish to do in-person interviews, and also may travel to conduct these, then there is further work you will need to do to meet new College guidance before your application can be reviewed for in-person research.

• In your response to this review, please state clearly whether you will be working solely online for data collection or not. I confirm I will only be working on-line for data collection.

Signature: Keith Evans (electronically)

Date: 12 November 2020

CONCLUSION TO ETHICAL REVIEW (if required)
The applicant’s response to our request for further clarification or amendments has now satisfied the requirements for ethical practice and the application has therefore been approved.

Signature: Marion Smith

Position: CPASS REC Co-Chair

Date: 19th November 2020
Appendix B: Participant Information Sheet

THE UNIVERSITY of EDINBURGH
School of Health in Social Science

Project: Experiences in Womb-life and Birth
Researcher: Keith Evans - k.evans-10@sms.ed.ac.uk

Information Sheet: Experiences in Womb-life and Birth

Who am I?
My name is Keith Evans and I am a PhD student in the School of Health in Social Sciences at the University of Edinburgh.

What am I doing?
I am conducting research, including interviews, as part of my dissertation requirements. Seamus Prior and Fiona Murray at the University of Edinburgh are supervising my project. I am particularly interested in how an awareness of our womb-life and birth helps us develop a different or deeper understanding of our personalities and our “ways-of-being”. This includes how we have been in our relationships with parent, siblings, partners, work colleagues and others throughout our lives. I am interested in how we use this understanding through the stories we tell ourselves and others, and how those stories might have changed through learning about womb-life and birth.

What do I need from you?
• Your participation will entail an in-depth interview which will last between 1 and 2 hours
• This will be a ‘formal’ research interview but is intended to be conducted in an informal way as a conversation with me as the researcher, rather than a list of questions to be answered.
• Due to the on-going uncertainty related to travel and physical distancing requirements during the COVID-19 pandemic, the University of Edinburgh recommends on-line interviews.
  o This project will use on-line interviews using Microsoft Teams.
  o You will not need to download any software to access the meeting via Teams: if you agree to participate, a date and time of the interview will be agreed and a link provided in an e-mail that will allow access into Teams. An electronic calendar reminder can also be provided.
  o Due to the relational nature of the research project, the interview will be a video ‘conference’ and recorded as a video. However, you can still participate using only voice recording (no video) and have the right to turn off your camera during the interview if required.
• The main questions I will ask are for you to share how you came to undertake/participate in/join the pre- and perinatal exploratory / experimental course(s), and for you to describe how this experience and the learning(s) from it have informed, changed or made you otherwise reflect on the understanding you have of your self, and how you have been in relationship with others over the course of your life.
• Other questions may arise as part of this discussion.
• If you choose to participate, you do not have to answer any question if you do not wish to. You are able to withdraw from the interview at any time.
• You can also withdraw from the project at any time before my data collection / generation is complete (i.e. January 2022).
• The results of my study will be included in my (written) dissertation.

At the time of the interview you will be asked to sign a consent form that outlines more about your rights during the project and guarantees confidentiality of your information as well as anonymity. The interview will be recorded, and physical and electronic transcriptions produced which will be anonymised. All the information I collect during the course of the research will be processed in accordance with Data Protection Law, stored in a secure place for twelve months after the confirmation of my thesis, then destroyed. You can ask not to have your interview recorded or ask to have the recording device stopped at any time during the interview. No information that could identify an individual will be used in the production of my thesis.
What are your data protection rights?

- Keith Evans is a Data Controller for the information you provide. All and any personal data will be handled sensitively and in keeping with the common law duty of confidentiality under the GDPR regulations.
- For general information about how we treat and your data go to: https://www.ed.ac.uk/data-protection/privacy-notice-research.
- You have the right to access information held about you. Your right of access can be exercised in accordance with Data Protection Law. You also have other rights including rights of correction, erasure and objection. Details about these rights can be found here: https://www.ed.ac.uk/data-protection/data-subject-rights.
- For more details, including the right to lodge a complaint with the Information Commissioner’s Office, please visit www.ico.org.uk.
- The legal basis under which the research is being conducted is "a task carried out in the public interest". ‘Public task’ as the legal basis assures you that the University is a reputable organisation that has a genuine reason to hold and use your personal data. For the University of Edinburgh, the public research purpose has been established by the Universities (Scotland) Act 1966.
- Questions, comments and requests about your personal data can also be sent to the University Data Protection Officer at dpo@ed.ac.uk

Who will it benefit?

- For participants (interviewees): The research will be of interest if you would like to share your experience of what learning about womb-life and birth has taught you about yourself and your life in terms of your personality, and how, and in what way, your understanding may have changed due to this learning.
- For academia and practitioners: it will enhance the importance of understanding how womb-life and / or birth can influence our personalities and how they can, in some instances, be a part of the ways we are in relationship with others.

What will happen with the results of this study?

The results of this study may be summarised in published articles, reports and presentations. Quotes or key findings will always be made anonymous in any formal outputs unless we have your prior and explicit written permission to attribute them to you by name. Information may also be kept for future research.

Finally, I am very grateful for your participation in this project and the giving of your time to help me in my research. Please find below my contact details if you have any further questions about the study:

Keith Evans
Email: K.Evans-10@sms.ed.ac.uk
Mobile: 07342 888646

The project has passed the ethical approval process of the University of Edinburgh’s School of Health in Social Science and is professionally supervised by members of University of Edinburgh staff: For this project, my supervisors are Mr. Seamus Prior - Seamus.Prior@ed.ac.uk – and Dr. Fiona Murray - Fiona.A.Murray@ed.ac.uk.

In terms of complaints or serious concerns about this research, you can in the first instance contact my supervisors. Alternatively, you can contact the Head of the School of Health in Social Sciences, Matthias Schwannauer, e-mail: headofschool.health@ed.ac.uk

November 18, 2020
Appendix C: Consent Form

Project: Experiences in Womb-life and Birth
Researcher: Keith Evans - K.Evans-10@sms.ed.ac.uk

Consent Form: Experiences in Womb-life and Birth

You have volunteered to take part in a research project by being interviewed on how your experiences of womb-life and birth have informed your self-understanding. If you choose to participate, you will be asked some questions, but do not have to answer any question if you do not wish to. You may also request further information at any time from the researcher or his supervisor.

- The interview will be recorded, and physical and electronic transcriptions produced which will be anonymised and stored in a secure place for twelve months from the confirmation of my degree and then destroyed.

- You are able to withdraw from the study at any time during the data collection and analysis phase, which for these interviews will be up to January 2022.

- You may do this by contacting the researcher (details below) and in which event, none of your data or information will be used in the project.

- You can ask not to have your interview recorded or ask to have the recording device stopped at any time during the interview.

- You understand that all data and information collected will be treated as highly confidential by the researcher and suitably handled in accordance with General Data Protection Regulation (GDPR) and the associated the Data Protection Law. The researcher is registered with the Information Commissioner’s Office. Any data or information used in the production of a research report will be anonymised such that no individual will be identified.

- Direct quotes from your interview may be used within the thesis. No information that could identify any individual will be used. By signing this consent form, you give the researcher permission to use statements you make during the interview.

Please carefully read the following consent form before signing and dating the form if you agree to continue with the interview:

- I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

- I understand I have the right to withdraw from the study at any time during the data collection phase up to January 2022 and to decline to answer any particular questions.

- I agree to provide information to the researcher(s) on the understanding that my name will be anonymised, and my confidentiality protected in any written work and not be used without my permission.

Version 1.1

November 18, 2020
Project: Experiences in Womb-life and Birth
Researcher: Keith Evans - K.Evans-10@sms.ed.ac.uk

- I agree / do not agree [please cross out as applicable] to the interview being recorded. I understand that I have the right to ask for the recording to be turned off at any time during the interview.

- I agree to participate in this study under the conditions set out above and in the Participant Information Sheet dated 18 November 2020

Name: ......................................

Signature: ..................................

Date: .......................................  

The researcher Keith Evans can be contacted on Email: K.Evans-10@sms.ed.ac.uk Mobile: 07342 888646
## Appendix D: Interview Schedule

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<th>Status</th>
<th>Teams invite sent</th>
<th>Consent form sent</th>
<th>Consent form received</th>
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<tr>
<td>Elizabeth</td>
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<tr>
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<td>18.1.21</td>
<td>18.1.21</td>
<td>9.2.21</td>
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Appendix E: Womb Process Workshop Advert

Charisse provides deeply intuitive presence and experience in the areas of contact, connection, creating boundaries and ways to develop meaningful connection with others without losing self.

‘Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness, that most frightens us. We ask ourselves, who am I to be brilliant, gorgeous, talented, and fabulous? Actually, who are you not to be?’

Marianne Williamson
(On the occasion of Nelson Mandela’s inaugural speech)

Charisse received her doctorate in chiropractic in 1986. She has over 35 years’ experience combining craniosacral therapy with manipulation therapy to facilitate the release of trauma held in the body. She worked with homebirth midwives in Alaska as a midwifery assistant, then trained and assisted Ray Castellino to integrate Pre and Perinatal Psychology into her body-centred practice. Whilst working with families during the peri-natal period, she realized how this vulnerable and empowering time is directly related to our sense of belonging and our ability to maintain healthy, loving relationships.

She has a private practice in Scotland working with individuals and families, facilitates Birth Process Workshops and teaches Pre and Perinatal Therapy for Professionals. She also worked with the Scottish Police Force supporting ex-offenders. All with a focus on enhancing bonding and transforming early traumatic imprints.

Integrating EARLY IMPRINTS
A Personal Process

An intimate group setting for a personal process - helping you to be who you really are.

5-9 December 2023
Anstruther, Scotland

Cost: £650 if paid before 1/11/23
£750 if paid after 1/11/23

Contact
Charisse Basquin
earlyimprintsuk@gmail.com
Integrating Early Imprints

These workshops offer you a personal process to boost wellbeing, self-empowerment and freedom.

Through a safely guided exploration of early experiences, you’ll deepen your self-understanding and discover new ways of engaging with yourself and others.

The experiential nature of the workshop and the emphasis on safety and spaciousness allow you to go at your own pace, and experience profound transformation.

What are early imprints?

Early experiences shape the development of the brain and nervous system. From conception to the age of 3, many neural pathways are formed, laying down patterns in the relational areas of the brain. This is the foundation for bonding and attachment.

Memories and styles of relationship are woven into your body. They are like ‘imprints’ in your nervous system and continue to affect your behaviour, relationships, self-esteem and expectations, as well as your physical and emotional wellbeing.

The ideal is for a child to feel nurtured, loved, accepted and affirmed. Where there has been stress, upset or poor bonding, resulting imprints may make it difficult for a person, in adulthood, to manage stress or to fully enter into relationship.

Creating new imprints

The nervous system, including the brain, is malleable, and can develop new pathways throughout life in response to new experiences.

It is possible to create new imprints that are conducive to relational wellbeing, health, and personal growth. The process tends to be deeply healing and empowering.

What happens in workshop?

Using a sensitive process that taps into the body-held memories of your early life, it is possible to access and alter patterns that inhibit full self-expression or cause you difficulties today. You can create new imprints.

Each workshop has 4-6 participants.

Each participant receives an individual session that varies in length and approximates 2.5 hours. The group structure offers the opportunity for exploration beyond what may be possible within the context of one-to-one work.

The group setting can mirror original family dynamics, which aids the exploration of early influences, and because the group is supportive, both exploration and healing can take place in a safe and therapeutic way.

Requirements

To support this level of exploration, each participant is required to have engaged in some of their own therapeutic work and have access to follow-up therapeutic support after the workshop.

To support clarity and safety, each participant is also required to refrain from the use of recreational and spiritual medications/drugs, including alcohol, for 24 hours prior to and during the course of the workshop.

Participants agree to attend the entire workshop and agree to keep evenings free from commitments.

Some reflections

“For the first time I feel like I belong.”

“I’ve found my voice and am more able to say what I truly mean.”

“I rediscovered my laugh.”

“After 25 years of being a psychotherapist, I have found the missing piece.”