BECOMING A TRANDISCIPLINARY PRACTITIONER: PARADIGMS AND POTLATCHES

by

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Abstract

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The goal of the dissertation is to show how biomedically trained allied health professionals, nurses and a physician learned how to integrate psychological paradigms into their biomedical practice paradigms to become transdisciplinary practitioners. Semi-structured recorded interviews were held with 14 graduates of the Infant-Parent Study Center of the Jewish Board of Family and Children Services (IPSC). The interviews were conducted using a constructivist approach. The responses were organized into a narrative. A new definition of transdisciplinarity had to be created in order to describe the learning process. Prior to enrolling in the IPSC, the respondents had conscious and unconscious drives to practice clinical psychology which led to professional isolation, some training in psychology, mentors and peak experiences about integrating mind and body. Respondents first felt alienated by the specialized psychological knowledge and discourse of the teachers and the majority of students. They kept silent until they discovered that they possessed specialized knowledge needed by the mental health workers. Peak experiences related to training occurred. After graduating, the respondents felt part of a practice community. They acquired the ability to think in two epistemological, physical and psychological, to understand and treat complex clinical problems. Graduates also became organizational change agents in line practice, universities and social service systems. Peak experiences appear to have ceased upon realization of psychologized practice. The learning

process entails creating a dual paradigm mindset that concurrently accommodates biomedical and psychological epistemologies rather than a single transdisciplinary viewpoint as anticipated by the IPSC. The learning process at the IPSC can be compared to a First Nation Haida potlatch exchange ritual. Biomedical practitioners being trained in clinical psychology need support in crossing the epistemological divide that separates biomedical from psychological practice. The transition will be faster if; 1: trainers encourage biomedically trained to students to value their own professional experience before taking on the new information thought process; and, 2) tell students from biomedical professions that mental health professionals use a contrasting practice paradigm .

Acknowledgements

As a prelude to the following narrative thesis I will go back in time to the possible origins of my interest in my topic of work: striving towards excellence. I would like to offer gratitude, first, to the craftspeople in my family who planted the deep roots of my thinking. The story starts with my maternal great grandfather, the boot maker to the local, czarist nobleman; his son, my grandfather, also a leatherworker, who used custom made brushes as a housepainter in America; and my mother, an expert milliner. On the paternal side, I recall my grandfather, the baker whose wrinkled hand effortlessly turned the flour, water, salt and yeast into silky dough. My father for unceasingly discussing the details of classical music and the details of workmanship when he worked in a factory that made wings for experimental aircraft and the specially designed electrical control panels for skyscrapers.

Next are the Fannins, expert weavers, hand spinners and all around craftspeople. Alan taught me how to use antique, hand manipulated machines that wrap wire under high tension around broom corn onto thin, lathed wood to make brooms. With this task, I began to appreciate the difficulty of how even common tasks take attention, skill and time to complete. Dorothy gets appreciation for listening and balancing out her husband's loquacity. Their ideas and practice of appropriate technology paved the way for my interest with the craft production of food and work as dietetic clinician.

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I. Introduction

This dissertation is a narrative case study that tells the story of how a small group of professionals became transdisciplinary practitioners. The professionals are transdisciplinary because they have gone from being based exclusively in their original discipline which is based in therapeutic applications biology which focus on working with the body and have acquired a second discipline based in psychology and is rooted in the mind requiring interpretation. The case consists of allied health practitioners, nurses and one physician who become trained and grounded in a branch of clinical psychology called infant mental health. Data for the study of the process came from interviews.

The ability to work across disciplines is a skill and skills takes time and persistence to acquire. Sociologist Richard Sennet says in his book, *The Craftsman* (2010) that the acquisition of skills is not mysterious. He declares this because

> Every good craftsman conducts a dialogue between the concrete practices and thinking; this dialogue evolves into sustaining habits, and these habits establish a rhythm between problem solving and problem finding. The relation between hand and head appears in domains seemingly different as bricklaying, cooking, designing a playground, or playing the cello—but all these practices can misfire or fail to ripen. There is nothing inevitable about becoming skilled, just as there is nothing mindlessly mechanical about technique itself (9- 10).

The inner dialogue of the respondents in this study was accessed in the form of interviews and the responses to the questions make up the data of this study. Newer dialogues arose in the course of the research and these, too, are included.

Sennet goes on to say that in our society, there is no special impetus towards craftsmanship (p.9). Schools do not prepare us for it. In *Capitalism and the Corrosion of Character* (1998) Sennet discusses how modern industrial processed can erode craft. He details how a modern baking factory erased the need for skilled work. That theme was initiated earlier by Braverman (1974) in *Labor and Monopoly Capital*. A personal feature of Braverman's book comes in the Introduction. There he talks about how he began his work life as a coppersmith and, as he matured, his trade literally emptied from his hands. The coppersmith who was a feature of the human landscape for thousands of years was, in the course of Braverman's life, no longer needed.

When Sennet (2008) turned his attention to the creation of craftsmanship, he looked at trades such as glassmaking and computer programming to examine how the impulse to do a good job asserts itself modern and traditional guises. The impulse, he believes, begins in the hands and extends to the mind (p. 10). The Linux programmers he presents work on a code, adapting the Linux coding system as if it was any other material you or I might be familiar with, such as leather, but do not know how to use (24-27). On the other hand David Levi Strauss 2010 in his collection of essays, *From Head to Hand,* sees the creative process starting in the other direction. His essay on the art of sculptor Raoul Hague is an example (Levi Strauss, 2010b, pp. 24- 30). Hague would drive around New York's Catskill mountain groves looking for tree trunks that fit his imagination and small studio. Similarly, Reg Davidson, a native Canadian and Haida carver who befriended Levi Strauss, also needed to find a log to fix his thoughts (p. 50).

When considering what makes a craftsman, it is well within reason to consider the allied health professionals, nurses and physician who are the respondents as craftspeople. Their

professional life began with working with the body. To become transdisciplinary practitioners they extended their work to include psychology to span the mind-body divide. The site of the transition was at the Infant-Parent Study Center (IPSC) at the Jewish Board of Family and Children's Services in New York City. It is a two year program of seminars, reading and clinical supervision leading to a certificate of a newly acquired skill. One noteworthy feature of the program was that the respondents were minority of the students. The majority of the students were psychologists and social workers. They had to learn the basics of clinical psychology in terms of ideas and practice in a room of seasoned psychodynamic practitioners.

To explore the process of becoming a transdisciplinary practitioner, the Introductory and Literature Review sections provide the background. The background includes a novel definition of transdisciplinarity suitable for this study and the nature of the kind of work the respondent performs in terms of epistemology and the philosophy of science. After the Introductory section, the data will be presented in a chronological narrative as best as possible. The respondents' transition is told in narrative form because they have made a change in their work over time (Chase, 2005). In addition, the narrative approach is especially useful in capturing biographical details. The respondents change is described by examining their experiences before, during and after the training experience.

The Discussion section summarizes the findings and results in a metaphor based on the contemporary Haida potlatch. Contemporary Haida potlatches are a ritual gift exchange ceremony. To give the ending away, the respondents acquired a gift. The gift they received was the skills to manage the complex relationship between mind and body in pediatric rehabilitative care. The narrative is about how they acquired the gift of working psychologically by giving their knowledge of the body away to others.

II. Literature Review

The literature review has three main topics. First is the creation of a definition of the word transdisciplinary suitable for this study. No simple definition exists for the word and three sources had to be used to describe this intriguing work. The second topic is the historical and workaday contexts that led to the type of transdisciplinary work being examined. The third topic is the program of study that the respondents attended in order to become certified and forged as transdisciplinary practitioners.

Overview of Transdisciplinary Work

Transdisciplinary work is based on the idea that the boundaries that define professional disciplines can be merged to produce a novel or transcendent product or treatment (Choi & Pak, 2006). The reason for merging boundaries is to find solutions to complex problems that have technical and social components. While much discovery is made by analyzing parts, transdisciplinary work is based on fusion of parts in order to find something new. Innovation is a goal for transdisciplinary projects because transdisciplinary teams are created to solve problems that have resisted solution due to their complex nature. Examples of complex problems suitable for transdisciplinary teams come from agricultural economics as described by Batie (2008) and water conservation as described by Griffith, Mitchell, Walkerden, Brown and Walker (2010). Transdisciplinarity is a popular term but a look at the literature finds that transdisciplinarity is hard to define in a succinct way. One problem is that transdisciplinarity is often described in many ways but not defined in a standard way. Choi and Pak (2006), for example, say that when technical disciplines are subsumed under a social science heading, then a project can be called transdisciplinary. That definition, it will be shown, is not specific enough and too limiting in scope. In at least one case, the word is used incorrectly. Little (2010) calls typical conversations

between professionals helping one patient in their different, role-based capacities as transdisciplinary. No interdisciplinary mingling in this description of a clinic occurs at all nor are there any interdisciplinary combinations.

More studied definitions of transdisciplinary work first contrast transdisciplinarity with two other forms interdisciplinary work*:* the multi- and interdisciplinary team as was done recently by Gehlert, Murray, Sohmer, McClintock, Conzen, and Olopade (2010). Multidisciplinary work occurs when people from different disciplines work separately on single problem. The information is then collated and a decision is made by one person. It is a like being sent to a number of specialists for a health problem and the personal physician makes the final determination. The other health care providers do not meet to discuss the case and, therefore, there is little integration or merging of disciplines. The next higher degree of integration is called interdisciplinary. In the interdisciplinary setting, people have meetings to discuss the case but remain in their professional discipline. These two team approaches are distinguished from transdisciplinary work by the nature of the functioning in relation to the result. Rather than operating in disciplinary silos. Transdisciplinary teams operate as a mutually informative unit above and beyond disciplines.

A solid example of transdisciplinary research was recently published by Gehlert et al (2010). The team addressed an epidemiological paradox. African-American and Hispanic women are more likely to die of breast cancer than their white counterparts even though they are less likely to have breast cancer when compared to their white counterparts. To unravel the puzzle that included late diagnosed and consequent late treatment of advanced breast cancer, genetic and hormonal mechanisms were explored in relation to individual psychological and sociological factors. Ultimately, it was determined that neighborhood stressors such as poor housing, crime

and lack of social support lead to high levels of stress and isolation. The linkage between biology and social inequality was found in the stress that increased the expression of hormones that promoted the expression of genetic mechanisms that promote tumor growth. Along with better screening, part of the final recommendation included increasing opportunities for social interaction in the low-income neighborhoods. In contrast to complexity of their research, Gehlert et al still resorted to a simple descriptive account but side-stepped using a definition of transdisciplinary work.

Defining Transdisciplinarity

There is no simple definition of transdisciplinary research, according to Stokols (2008). The lack of a definition creates problems because is hard to assess something with no standard (Boix Mansilla, 2006). Klein (2009, pp. 15-30) in the *Oxford Handbook of Interdisciplinarity* took on the task of defining the word and her solution was to present transdisciplinarity in a taxonomical way so that the varieties of transdisciplinarity can be distinguished from one another. In order to arrive at the exact kind of transdisciplinary work that this dissertation examines, it is necessary to follow her taxonomic paths where, first, three main categories of transdisciplinary work are established: *transgressive, transforming* and *transcendent*. Transgressive transdisciplinarity is about undermining grand narratives and is often the province of feminism and other fields attempting to find voices for the oppressed or underrepresented. *Transforming* transdisciplinarity has to do with research into change. The third kind of transdisciplinarity is called *transcendent* transdisciplinary and is about transcending disciplinary boundaries. At this point, it can be said that this dissertation is a study of transcendent transdisciplinarity because the kind of transdisciplinarity we are examining has to do with

erasing the epistemological boundaries between physical disciplines based in biology, a physical science, and clinical psychology, a social science discipline.

Transcendent transdisciplinarity contains an epistemological feature that is subdivided into two types: *narrow* and *broad* to define the way the work address the epistemological differences. In the narrow form, the disciplines have similar paradigms and methods such as mathematics and physics. In the broad variety, the disciplines are disparate with vastly different paradigms and methods. For example, mixing genetics, a hard science, and clinical psychology, an interpretive science, represents the broad variety of transcendent transdisciplinarity.

The idea of merging the epistemological methods, the theme of fusion, is founded on the idea that disciplinary differences can be overcome. One way to understand the merge is presented by Gehlert et al (2010). They imagine that the various disciplines working together create a place where the disciplines enter and can transcend their methodological differences. That space is outside the individuals who might normally function in the space of their own discipline. The distance between disciplinary epistemologies is what determines the use of the terms narrow and broad. A transdisciplinary team spanning physical and social science domains suggests a bigger space than a transdisciplinary space than the one that might be present in a project proposed by Derry (2005). She created a narrow transdisciplinary space for mathematicians, engineers, computer scientists and other technicians. Without demeaning important differences between those disciplines, that intellectual space created by Derry is smaller than a broad one that might have included a psychologist specializing in cognition. In Gehlert's team the geneticists and endocrinologists share knowledge of biology but they have to confront and integrate psychological and social knowledge and the ways those last two disciplines define knowing. The behavioral scientists have to do the same integration but in mirror form. The space, then,

created by Gehlert's team is greater than the space in Derry's team because it created a place to link genes, hormones, to, ultimately, neighborhoods with individuals. Now, the term transcendent is qualified by the term broad.

The practical difficulty of transcendent and broad transdisciplinary work is that scientific disciplines engage in two epistemologically different kinds of knowing contrasted by philosophers of science as outlined by Hacking (1997, pp. 21). Hard scientists, such as biologists, are trained to appreciate theory that correspond directly to observable reality. This view is called scientific realism. For example, a physical therapist (PT), who is an applied biologist specializing in treating muscles, finds a muscle weakness by palpation and observation of motion. The PT applies a theory that says exercise makes for a stronger muscle and more fluid movement. Manipulation by the therapist and the patient's exercising strengthens the muscle. Improved mobility and strength are easily observed by the PT.

The contrasting view of scientific knowing is called *anti-realism* (Hacking, 1997, p. 21-22). Anti-realists are mostly concerned with organizing thinking in order to achieve a practical goal or creating working models rather than finding the actual explanation in situations where direct observation is impossible. Anti-realistic thinking is at work when we hear about postulated but unobserved subatomic particles or psychological mechanisms that are neither expected to be visible nor palpable. In fact, proposed particles and psychological complexes may only exist as functions or descriptions, according to anti-realists, not actual entities. The actual operation of the surmised events may be totally different from our current understanding. To anti-realists, the proof is in the final outcome, not actual existence. The true divide between realistic and antirealistic science is not, then, between physical science and social science, rather, it is in the

fundamental type of thinking used in that sub-discipline, observational or interpretive (Boix Mansilla, 2006).

Once someone has switched from the exclusive use of scientific realism of muscles to work with the anti-realism of clinical psychology to explain muscle activity, different conceptual knowledge and perceptual organs come into play. When the anti-realistic perceptions get applied to physical phenomena, a foundational aspect of role restructuring called complete overlap occurs (Lynch, 2007). Complete overlap is a condition where multiple roles are managed and centered in the individual. An example of complete overlap offered by Lynch is the female lawyer who is a professional at work and a homemaker at home. This woman is combining modern and traditional ideas of social roles for women. It engenders its own kind of stress that was called role strain by Pearlin (1989). The way individuals affect roles is studied by social cognitivists who are interested in how apparently defined social roles get altered by the individuals filling those roles. Lynch, a member of this group, followed on work done by Callero and Morgan (Callero, 1994; D. L. Morgan & Schwalbe, 1990).

Transdisciplinary Work Based in the Individual

The idea of the transdisciplinary individual is rarely considered in the transdisciplinary literature. Teams, it appears, are the dominant form of transdisciplinarity because, almost always, transdisciplinarity is discussed in terms of teams. From the little that was discovered, there is little known about the work of transdisciplinary individuals. In the related literature on the study of complex or "*wicked*" problems, Andharia (2007) suggests that individuals use a technique that social workers would recognize as force field analysis. Pfirman and Martin (2009) call interdisciplinarity in the individual, *intrapersonal*. In intrapersonal transdisciplinary practice, what would has been described as occurring in a team goes on in the mind of one person.

Now, the word intrapersonal can be added to the taxonomic description of transdisciplinarity used in the study. The individuals who are being interviewed are transcendent, broad, intrapersonal transdisciplinary practitioners. An example of intrapersonal and broad transdisciplinary practice comes from Humphry (1995), an occupational therapist, who became interested in pediatric0 feeding problems. Her original training led her to work with fine motor problems related to swallowing but she eventually began to see the feeding problems in her young patients in terms of relationships, anti-realistically, through a psychological lens.

In the reverse epistemological direction, Altilio and Shirley (2005) propose that social workers in palliative care go beyond their psychodynamic toolkit by developing competencies in pain management pharmacology, a realistic science discipline, and nursing in order to administer pain management medications with hypodermic needles, an applied discipline. The professional discussion for the social worker becomes internalized and occurs in the transdisciplinary space of the mind.

The problem of managing distinct domains was earlier explored in myths. The Bible tells the story of the Tower of Babel to show us how linguistic unity was destroyed by God in order prevent humankind's attempt to unite the disparate realms of heaven and earth with a skyscraper. By creating linguistic diversity, people could not continue to work together as group. A mythical cycle from the Fon, a West African tribe describes the problem from the individual perspective Hyde, 1998, pp. 259-260) The Fon believe that their gods cannot speak to each other because their specialized divine tasks demanded an equally specialized language. Only one Fon god, Legba, knows all the separate tongues and acts as a transdisciplinary god.

The problem of languages and domains arose in our civilization around the early 1900s and the difficulty of united two different domains was explored by Greenberg (1993, chapter 2) in

Transgressive Readings: The Texts of Franz Kafka and Max Planck. At that time physicists, such as Planck, were concerned with the problem of managing two modes of thinking when atoms and subatomic particles came into theoretical view. One contradictory discovery was that light behaved as a particle, in the form of a free electron called a photon; light simultaneously behaved as a wave. The problem for physicists was that the laws of particles and the laws of waves contradict each other. Soon, it also came to be known that electrons behaved differently when '"excited" or, more technically, when extra energy was added to the electron. The excited electrons are called "quanta" and a new discovery in the early part of the 20th Century. These excited electrons forced physicists to realize that there was instability in the subatomic realm instead of sublime constancy. Our view of the universe was further complicated at the macro level after Einstein discovered that even the speed of light was not a constant under conditions of very high gravity. In some cases, measurements had to be interpreted and a new kind of thinking had to be developed to manage the new facts. Atomic physicists, who started out as the original scientific realists, also had to become anti-realistic scientists at the same time. The formerly hardnosed physical scientists were in the same position as the respondents in this study. Physicists' formerly confirmable world could only be understood by the interpretation. Planck himself said that measurements are always interpretations. Greenberg quotes from one of Planck's essays:

> The physicist's ideal goal is knowledge of the real outside world; but his only research tool, his measurements, never tell him anything directly about the real world, but are always only a more or less uncertain message or [...] a sign that the real world transmits to him and from which he then tries to draw conclusions, similar to linguist who must decode a document which comes from a culture completely unknown to him (p. 64).

The problem arose again in mathematics during the mid-20th century when mathematicians began with what is now called *chaos theory*, a way to discover underlying order in apparent disorder (p. 71-72). The mathematicians' problem was that each new, radical discovery required its own language and intuitions. Mandelbrot, a pioneer of a new kind of geometry based on grasping a pattern in apparently incomprehensible shapes, said the following:

> When I came into this game, there was a total absence of intuition. One had to create an intuition from scratch. I've trained my intuition to accept as obvious shapes which were initially rejected as absurd and I find everyone else can do the same (p. 71)

What appeared to be incomprehensible simply needed a new but challenging way of thinking to make it comprehensible. In mythology, characters that develop new ways out of impossibilities are called tricksters (Hyde, 1998, p.74). Tricksters, like Legba, the Fon god of transdisciplinarity, create new ways of seeing out of old contradictions because their ability to see things in a new way make us regular folks think they have tricks. The trick that helped physicists understand light was offered by physicist Neils Bohr. His solution is called the *Principle of Complementarity* (Greenberg, p.72). The principle is easy to understand but calls into question the dominance of single category thinking (Pattee, 1978). Bohr says that, in some situations, such as sub-atomic physics, we need two ways to read a situation to understand it fully. That thought remains controversial because, according to Lakatos writing in 1965, the interpretive aspect is just a fancy way to cover up ignorance (Lakatos, 2004, p. 91-180) . However, calling the Principle into question may really have to do with ways of managing incomplete knowledge. The apparent contradiction between particle and wave aspects were later resolved by creating a unified view of light as a separate category of phenomenon that undid the dichotomous categorization of particles and waves (Kuhn, 1993, p. 114) . Yet, the Principle of

Complementarity remains a tool to link concepts or disciplines that may appear to be disparate such as the biological and social systems as in the case of the our respondents who have to manage the interaction biological world of the body and the social science aspect of the mind according to Pattee (1978) whose view post-dated Lakatos' later attack on complementarity. Despite disagreements, the complementarity principle enables us to understand transdisciplinarity in a way that enriches the understanding of transcendent and broad transdisciplinarity, the type of transdisciplinarity that transcends epistemological boundaries and which occurs within the individual. Complementarity links disparate epistemologies and provides a way to understand how the new theory and skill learned by the respondents' of the study. They, as we shall see, operate on the Principle of Complementarity in order to go back and forth reading a physical problem in a psychological framework and vice versa.

Complementarity can also be understood in terms of paradigms. Paradigms are, from Kuhn's (1993, pp. 10-11) perspective, general ways that scientists perceive their discipline and determine the way the discipline carries out its work. New scientific paradigms, Kuhn says in the *Structure of Scientific Revolutions*, in science attract adherents from older and competing views of scientific activity within a discipline and, then, create new kinds of problems to be solved. Depending on the intellectual problems created by the old and new ways of understanding phenomena and pursuing research, the old and new paradigms compete for dominance. During this period, scientists often work under the two, competing paradigms until the discipline settles the dispute (p. 91). Masterman (2004) , one of Kuhn's colleagues and interpreters, called the condition of competing paradigms "dual-paradigm" science (p.74). Kuhn (1993, p. 98) says that one of the competing paradigms will overtake the other over time. In our case, the respondents remain in dual paradigm science because the need for two disciplines remains and will remain

until a unified view of mind-body works comes into view the way a unified view of light came to be understood.

In the meantime, using complementarity or dual-paradigms, provides the respondents with an advantage. Managing mind-body practice with complementary viewpoints inhibits the practitioner from what Fuller (2009) calls *deviant transdisciplinarity*. Examples of deviant transdisciplinarity are Marxism, Freudian psychoanalysis and other modes of thinking that strive to contain all phenomena under one heading. In deviant transdisciplinarity, the interpretation is predetermined by the outlook of the interpretative theory. When a person has two or more ways to understand an event, theoretical blindness is less likely to occur. In the transdisciplinary team setting, corrections and disagreements naturally occur but individuals need the protection that complementary thinking provides.

In the past, physicians were trained to manage the mind-body relationship but currently they are not. Some currents of medical practice are trying address the imbalance that focuses on the body only. McWhinney and colleagues showed one way out of the body only kind of medicine in a program designed to train family practitioners to work in rural Canada (McWhinney, 1995). The book that describes the program, *Patient-Centered Medicine*, gives a brief history of medical care that described the shift from mind-body care to body-only care and a way back to unified care. Physicians, like the respondents, have a background in hard science. Hard science is based on certainty and control, features of modernity that began in the 17th century (Toulmin, 1992, Chapter 2) . At that moment in Western intellectual history, interest in universals began to dominate thinking. In terms of medicine, care that once addressed individual and universal factors leaned increasingly to the idea of universals in health thinking that lead to standardized treatment (p. 5) (McWhinney, 1995). Treatment by universal theory is called the ontological

approach and, until modern times, it was paired with the physiological approach, which saw disease as an imbalance between the person and the environment. Until the success of modern medicines and sanitation, physicians worked between the two models of care. In the language of this study, physicians could work between the epistemological poles of medical knowledge, scientific realism, and anti-realism which included their personal knowledge of the individual and other interpretable concepts such as personality, family and physical environment.

McWhinney and her colleagues are not alone in looking for a way back to unified care. Unifying body and mind practice in the allied health professions also come through applications of narrative theory. Occupational and speech therapists' use of narrative is explored, respectively by Mattingly and colleagues (C. Mattingly, 1994; Cheryl Mattingly & Lawlor, 2001) and Hinckley (2008).

Managing contradictory or uncertain factors assumes the ability to work with different theories or applying a theory of a different order to a problem. Like the narratively aware allied health professionals described by Mattingly et al (1994, 2001) and Hinckley (2008), physicists working at the sub-atomic scale understand that higher levels of abstraction can bring us closer to reality rather than further from it (Greenberg, 1993, p. 80). For the respondents in the study, adding the adequately but not absolutely knowable psychological element to physical care aids the child and the family. They apply a theory to theory, one view to another view and, thereby, apply the lessons learned by mathematicians and physicists: that thinking based on only on laboratory models is not always suited to capture the world. The idea of working across domains is the point of transdisciplinarity but the taxonomic definitions present by Klein (2009) benefit from complementary thinking, because the definitions she proposes are pictures but not actions. To say that we are looking at a broad intrapersonal experience is not enough. A way to

understand the action of a broad, intrapersonal, transcendent transdisciplinarity is also needed. Complementarity provides part of the story. Later on, the Findings chapter will show how the respondents practice dual readings.

Transdisciplinary Work and Role Theory

Role theory provides additional insight into how people become transdisciplinary workers. Roles refer to the socially defined categories of behavior in organizational settings by Lofland (1984).Lofland, following on Gouldner and Merton, saw two basic categories of the way people work into two and called them local and cosmopolitan roles. Workers who function in a local capacity stay within prescribed roles. A local speech therapist, to take an example that will appear in the findings, would remain within scope of practice guidelines work with the child's speech problem exclusively. Cosmopolitan workers step outside their strictly defined roles and try to bring a wider, rather than specialist, view. A cosmopolitan speech therapist would see a lack of family and social expectations for early childhood speech, and would then be interested in addressing the family's behavior. If the therapist can apply a relationship therapy, she is practicing in a cosmopolitan, transdisciplinary way because a physical problem is treated in a physical and psychological way. The shift from using local skills associated with physical care, to applying psychological skills within physical care can be examined under the heading of *role restructuring* established by Pearlin (1989). He specifically describes the professional restructuring with the example of the apprentice growing increasingly skilled but chafing under the master's unchanging rule. In our case, the "master" is the basic, local structure of a profession.

Role restructuring in a formal, training setting is called *role release*. The formal process leading to lets us see how physical care practitioners acquire a psychological orientation as they

shift from realistic to anti-realistic science. The first description of the process of becoming transdisciplinary was described in terms of roles and role release by the founder of transdisciplinary care in pediatric rehabilitation, Hutchison (1978). The process was recently elaborated. by Woodruff (2006), as shown in Table 1.

Table 1- Levels of Role Release*

Level	Purpose
Role extension	Increase of general and current knowledge in one's field, experience and types of programs within one's field, supervision within one's field of practice role
Role enrichment	Learning about other disciplines and their terminology through sharing cases, study, team conferences.
Role expansion	Increase in breadth from intentional pooling of information, knowledge, and skills among team members outside of one's discipline through reading, decisions, observation, and role play.
Implementation	Purpose
Role exchange	To implement theoretical skills from other disciplines in the therapeutic setting
Role release	To carry out interventions in another discipline with authorization from someone that discipline.
Role support	To give or receive continued supervision from another discipline.

* Woodruff (2006)

The internal processes linked to role restructuring are not well described according to sociologists Morgan and Schwalbe (1990). That concern was echoed in 2007 by Lynch, another sociologist interested in linking role theory to personal experience (Lynch, 2007).These sociologists and others such as Callero (1994) see role theory enriched by learning exactly how people fill and change roles because all roles are negotiated. Such sociologists critique role

theory for considering roles as static categories because they claim roles are filled with people who alter the environment when they alter their roles as is the case in role release carried out under the heading of role release as suggested by Howard (1994b) and later by Lynch (2007) . The sociologists who think along these lines are called social cognitivists. Howard (1994), for example, is concerned that micro level, or personal, experiences get examined.

Lipsky examined the dynamic relationship between the person and the role in *Street Level Bureaucracy* (Lipsky, 1980). Lipsky sees some workers expanding beyond their job descriptions when they have high degrees of discretion and relative autonomy from organizational authority and because their superiors support irregular practices as they are necessary for carrying out the job in daily life (Chap 2). The therapists under study in this dissertation tend to work on their own authority and often in the client's home or as executives, which provides them with considerable professional discretion as noted by Rapport, McWilliam and Smith (2004). They are free to use standard and non-standard treatments as they see fit.

History of Transdisciplinary Practice

In this section, the history of the need to unite physical and psychosocial care is presented. The specific context of creating appropriate psychosocial care is in the realm of developmental disabilities in infants and children under three years of age. The people who need to be involved with the uniting of mental health and physical care, at this stage of the discussion, are allied health professionals, nurses and a physician.

The transdisciplinary practice that blends physical and mental health care was first developed by leaders of United Cerebral Palsy in 1976 as a team approach to remedial services for

neurological disabled and mentally challenged children as reported by Haynes (1976).The term and the practice model came originally, however, from Hutcheson, a nurse, whose practice with atypical children led to the elaboration of role theory and the original coining of the word by Hutchison (1978). The evolution of practice that led to the need for transdisciplinary care is best seen in the light of models of healthcare that have developed since the 19th century which had implicit feathers of roles. Foley (1990) describes how practice in physical rehabilitation shifted from unidisciplinary care where all care is conducted by the physician, to multidisciplinary care directed by the physician, to interdisciplinary care where teams provide integrated assessment. The culminating step in this process was the creation of transdisciplinary work in pediatric care in the 1970s.

By the late 1960s, increased knowledge of infants and young children demonstrated the role of stimulation from the parents and the active role the children play in their own development (Gilbert M. Foley, 1990). During this period, child development researchers learned that the child activated the attention of the parents and could no longer be seen only as results of environments. The new discoveries showed that infants and children existed in dynamic relationship to their world.

A related development was the concept of holistic care in which the person is more than the sum of her parts, as discussed by Lusky (1999). One feature of holism was the interest in the home life of children. Interest grew in the role of the body in child development and one sign of this interest was the popular revival in breast feeding. A related interest was the invention of *kangaroo care* for premature infants. Kangaroo care uses the warmth of the parents' body as a substitute for the incubator because the skin-to-skin and intimate emotional contact with parents improves physical development and emotional attachment. The lesson our society learned was

that parents should be the primary caregivers, even when children were prematurely born or in some way disabled. In the Anglo-American world, this idea persists in the present day model of home visits for pediatric rehabilitation and the idealization of the parent as primary therapist as presented by Leiter (2004). As clinicians and researchers saw the needs of children based on the behavior of the parents, two models of care developed. One reflected physical care and that was developed by UCP. The other addressed mental health needs and was developed by Selma Fraiberg. Both appeared in the mid-1970s.

The physical care model will be discussed first with information derived from Conner, Williamson, Gordon and Siepp (1978) *Program Guide for Infants and Toddlers with Neuromotor and other Developmental Disabilities*. The model of care designed by UCP is to increase the abilities of children born with cerebral palsy, a general term for brain damage that occurs in utero or during birth. The effects range from mild to profound disability the cognitive and physical domains. Between 1967 and 1968 (UCP) held hearings around the US to determine the needs of disabled children (p. 17) . One result was the discovery of the need for comprehensive service to children and families. The other discovery was that UCP by itself could not provide the funding to attempt a new service model. In 1971, funding from the Bureau of Education of the Handicapped of the US Office of Education supported the establishment of the National Collaborative Infant Project (NCIP), a second, 6 year study involving 49 local agencies and over 4,000 children burdened with emotional or physical delays. The practitioners in the study worked across physical disciplines, most often occupational, physical and speech therapies (Haynes, 1976, p. 1). At the end of the study period the effort was summarized in two reports. One is a short curriculum for training professionals in a transdisciplinary model entitled *Staff Development Handbook: A Resource for the Transdisciplinary Process* (Haynes, 1976).

The second is a final report, *Program Guide for Infants and Toddlers with Neuromotor and other Developmental Disabilities,* that gave more explicit instructions for practitioners (Connor et al., 1978.) . The curriculum and the final report emphasized the need to understand the developmental and family context of the child's disability because the child's age and emotional environment could determine the success of physical care.

Transdisciplinary care in the UCP program model met two service goals (Connor, 1976). The organizational goal of transdisciplinary care was to free up a limited staff to work with more children. To meet this goal, the physical care providers would have to learn enough about other disciplines to provide all the care. UCP hoped to operationalize the theoretical goals of role release established by Hutchison (1978). A physical therapist, for example, would have to act in some degree as an occupational or speech therapist. To accomplish this, the practitioner would have to get periodic trainings in other disciplines.

The psychological goal in UCP was to minimize the disruption that home services caused by providing a lead therapist who provided all the therapeutic instruction and service coordination. Too many therapists visiting the home is believed to disrupt the child's natural attachment to the family. Having the family serviced by one therapist allowed an active service provider to act as case manager for the parents instead of adding yet another person for the family to work with. The decrease in services was also based on the idea that parents could provide the therapy; this was part of the movement that promoted the family as an indirect care provider. The global nature of routine activities, such as walking with the family, is preferable to more therapy sessions that limited the progress because little children cannot always generalize therapeutic activity to daily life (Woodruff & Shelton, 2006).

Under the UCP model of service provision, a lead practitioner was supposed to consider social and emotional factors in relation to physical disabilities (Connor et al, Chap 10). However, it is clear from a reading of proposed strategies of the UCP program (Connor et al, Chap 11) that intentional psychological work was minimal even though the cumulative effect of numerous stressors on the families and practitioners could be high. Lack of resources made it impossible to incorporate social-emotional training for the allied health practitioners according to Gilbert Foley in a personal communication (Gilbert M. Foley, 2008). He was part of the project team. The inability to add the psychosocial support led to the creation of a model of transdisciplinary care addressing the body that we will call the UCP model, a narrow type of transdisciplinarity. In that model, the spread of disciplines to be linked focused on allied health professionals.

The second model of care addressed mental health and is based on the work of Selma Fraiberg. In 1972, she established the Child Development Project at the University of Michigan where she trained community mental health social workers and nurses to provide psychotherapeutic help for troubled infant-parent relationships during home visits as described by Adelson, Shapiro and Bennet (1982) her colleagues. It was at this time Fraiberg wrote her significant works on failure-to-thrive, such as *Ghosts in the Nursery*, with her colleagues (Fraiberg, Adelson, & Shapiro, 1975; Shapiro, Fraiberg, & Adelson, 1976). At this point, professionals from the biomedical field of nursing began to work in a transdisciplinary capacity.

Fraiberg's students soon formed the nucleus of the Michigan Association for Infant Mental Health which became, in 1979, the International Association for Infant Mental Health and initiated publication of the Infant Mental Health Journal as recounted by Fitzgerald and Barton (1999) . Soon after, in the 1980s, psychiatrists interested in early childhood mental health formed the World Association of Infant Psychiatry and Allied Discipline and soon after renamed

World Association for Infant Psychiatry. The psychiatric association is indirectly linked to René Spitz, another FTT researcher. The shared interests in the two professional organizations led to their unification in 1992 as the World Association for Infant Mental Health. The merger finalized the creation of infant mental health as a clinical specialty working in areas where relational problems between parents and their young children need professional attention. In brief, infant mental health practitioners see the relationship, not individual people, as the patient according to Sameroff (2004, p. 5).

The Federal Early Intervention Program

As interest in treating developmental disabilities grew, the federal government began to increasingly mandate care for developmentally delayed infants and children less than three years of age in history of disability programs in the US by Romano (2006). The late 1980s saw the passing and signing of the Individuals with Disabilities Education Act (IDEA) which expanded the government's role in mandating services. Rehabilitative services for atypically developing children under three years of age have been mandated since 1986 under the Education for the Handicapped Act (PL99-457) which has been continually reauthorized since 1990 under the Individuals with Disabilities Education Act (IDEA) (PL101476) as reported by Malone, McKinsey, Thyer and Straka (2000). IDEA greatly expanded the availability of services for delayed children but IDEA maintained the minimal provision of mental health services that existed in the prior federal programs that lead up to the passage of the 1986 bill (Romano, 2006). Despite the shortfall in provision for mental health services, IDEA created the largest increase in physical services for developmentally delayed infants and children under three years of age. The program is now known as the Early Intervention Program (EIP).

The primacy of physical care is seen in the percentage of therapists coming from the allied health professions who, at 87% of the EI workforce, as Hebbeler, Spiker and Bailey (2007) reported. These professions dominate the care offered by EIPs nationally . State-run EIP agencies can provide mental health services but in practice, psychologists and social workers generally perform other functions such as evaluation or service coordination, respectively. As noted before, mental health training is needed for many physical delays because emotional and physical factors are not differentiated fully in young children (Rosenblum, 2004).

The interrelatedness of body and mind in feeding problems, to take the best known example of mind-body interactions in young children, was established in the 1970s most notably by Selma Fraiberg (1975) famous paper, *Ghosts in the Nursery* using psychoanalytic methods and equally by the less known Dennis Drotar (1975) who applied attachment theory . Transdisciplinary care for feeding problems remains a mainstay of care in specialty feedings clinics (Nyambose & Cunningham, 2004). However, observers of EIP find that few practitioners in the system such as Ben-Sasson, Cermak, Orsmond, Carter and Fogg (2007) or outside the system such as Kessler (1999) can manage the interdependent relationship between body and mind in young children with delays.

The current federal regulation governing early intervention practice, Part C of Individuals with Disabilities Act (IDEA), PL 101-476, does not actively support transdisciplinary care that spans psychological and physical needs. Program leaders and Congress included the term transdisciplinary along with interdisciplinary care, as described by Rapport et al (2004), without setting a mandate for transdisciplinary care. Despite the good intentions of the legislation, the split between mind and body remained in place in the program.

Along with a shortage of trained transdisciplinary practitioners, another reason for the lack of impetus is that transdisciplinary care in early intervention has expert but little evidentiary support. The first report of therapeutic work in the early intervention literature comes from Shanok, Welton and Lapidus (1989). They described the role of mental health services played in a successful outcome of a speech delay related to trauma. Another exception is an IMH intervention to manage depression and increase attachment in 67 mother-infant dyads as attempted by Cohen, Muir, Lojkasek, Parker, Barwick and Brown (Cohen et al., 1999). While successful, this was a non-randomized trial and not the kind of support needed to create a federal mandate.

Managing parent-therapist relations and managing families remains a persistent problem in early intervention practice that could be improved by applying IMH in EI. Steel (1998) Parents associated with Steele's agency were said to report that failure to thrive, regulatory disorders such as sleeping, self-calming, being fussy and difficult temperament, multisystem developmental disorders, infant depression, severe disruptive behavior, and difficulties with separation and attachment were better managed with psychosocially trained practitioners; no data were given to support this statement.

There was one attempt to realize transdisciplinary care. In England, visiting nurses are trained in applied developmental psychology, nutrition, and family guidance to manage, with some success, the common causes of pediatric underweight or failure-to-thrive by Wright (1998) . In New Jersey, the Optimus Project began training existing practitioners in transdisciplinary care during the 1980s (Woodruff & Shelton, 2006).Optimus provided training and a supportive atmosphere to support the physical and mental health needs of children and families in a

comprehensive style but funding cuts made it unable to continue providing the complete care envisioned by the program's founders.

In Massachusetts, state run growth clinics treat underweight children with a transdisciplinary team and a lead practitioner as reported by Nyambose and Cunningham in 1994. That clinic accepts children who did not benefit from early intervention or child protection and those with unexplained medical problems that have resisted treatment. The existence of the specialty clinics suggests that transdisciplinary practice with an infant mental health component has not permeated among practitioners. One prominent observer, Kessler, (1999) says that this knowledge remains poorly disseminated. One reason for poor disseminations is that transdisciplinary work is that research suggests that outcomes are uncertain and uncertainty inhibits dissemination as explored by Rogers (2003, p.6) in *Diffusion of Innovation* In addition, as will be shown, transdisciplinary work is complicated and complexity further inhibits adoption (p. 16).

Infant Mental Health in Early Intervention

Infant mental health remains at the periphery of early intervention due to the physical orientation of the program (Romano, 2006, p. 48.). Mental health care remains on the fringe, in part, due to the association of infant mental health with psychiatry that was reflected in a split between those who favored medical models of care that included emotional support and those who favored the parent educational model when the program was first developed (p. 50). While the latter approach aimed to train the mother or family in supporting the child's physical needs, it also relaxed the focus on the mother and child's mental health needs.

Transdisciplinary care exists in the early intervention authorization language but the revised mandate did not translate into program changes to support the practice besides lack of evidence. There are reasons for the lack of change at the level of service delivery based on the findings of Ryan-Vincek, Tuesday-Heathfield and Lamorey (1995). The reimbursement structure did not change to support the extra work involved transdisciplinary care. Practitioners have also resisted it for ethical reasons related to scope of practice as well as concerns with billable hours (Rapport et al., 2004). Some lead practitioners, feeling underpaid and overworked, sometimes resent providing advanced care. Administrators do not always understand or support the transdisciplinary model. Sometimes, biomedical professions such as medicine and nutrition resist sharing their skills with allied health professionals as discovered by Polmanteer (1998) in her doctoral .

Most importantly, few workers are actually trained to offer such care since training programs are few in number (Romano, 2006). Not only are they few, but the teaching is resisted by the students. Surbeck (1998) reported that students in a pre-professional training program that emphasized transdisciplinary approaches felt capable of absorbing the intellectual aspects of transdisciplinary training but were unsure of taking the approach into practice. A second study of pre-professional students by Smith-Russell and Christie (2004) found that students overtly resist transdisciplinary preparation that is offered in professional programs . On a more ambitious scale, the Jewish Board of Family and Children's Services runs two affiliate programs to train willing professionals in transdisciplinary, mind-body care. One is in Boston, entitled the Infant-Parent Training Institute. In New York City, a comparable program is located at the Jewish Board of Family and Children's Services in New York City at their Institute for Infants, Children

and Parents (2008)). Both programs teach the broad, intrapersonal from of transdisciplinary practice based on principles of IMH.

Repairing the Mind-Body Divide

The Infant-Parent Study Center at the Jewish Board of Children's and Family Services represents the fully realized attempt to introduce transdisciplinary practice into EI. Their transdisciplinary model meets the epistemological definition of a transcendent, broad and intrapersonal transdisciplinarity and introduces infant mental health with an outlook that includes physical and psychological care for mental and physical health care providers (Institute for Infants Children and Families, 2008). The Institute aims at adding the mental health modalities and orientation of IMH to the children by training therapists and administrators who already work in the system. New York City started its own EI service program in 1994. The Jewish Board in New York conducted a needs assessment that revealed that most providers had no formal training in mental health; a program to meet that need was opened in 1995 as reported by Dr. R. Shahmoon-Shanok (2006), the program's director.. The program was also a response to the practitioners who had already begun to release themselves into mental health work with no official sanction and who were committed to working with infants and children under three years old.

The model of care promoted at the Institute is explicitly oriented toward practices that should have been included in the original UCP plan. The model places psychology in the form of IMH as the overarching form of knowledge and practice. This model meets one important benchmark of transdisciplinary care as described by Klein (2009). The overarching social science theory is the mixed theoretical model including under the umbrella of developmental psychology and attachment theory (Institute for Infants Children and Families, 2008). In

addition, other psychological theories, such as psychoanalytic and family systems, are also presented in the context of relationships. The goal of the curriculum is to create practitioners who understand the relationship between the parent and child affect the body and the mind of the child within larger social systems such as family and society. This approach to early intervention is fully elaborated in *Mental Health in Early Intervention*: *Achieving Unity in Principles and Practice* (2006), a book written by people associated with the program at the Jewish Board and edited by Foley and Hochman (G. M. Foley, & Hochman, Jane. D., 2006).

The important feature of infant-parent psychotherapy is that the relationship, not a person, is the patient. Despite the term infant-parent psychotherapy, no actual psychotherapy, in terms of individual psychological inquiry, is authorized by the certificate of completion offered by the program. It is a practice orientation that allows practitioners to place physical care within a psychological framework that supports and improves the parents' relations with the disabled child. By receiving training in the main frameworks of parental and child psychology, practitioners are able to help maneuver the parents past obvious and hidden obstacles without recourse to individual psychotherapy that lies beyond the scope of the graduates unless they are licensed psychotherapists. For example, a graduate might offer developmental guidance in the form of parenting advice to decrease tension when a parent sees a behavior as "bad" when it is actually a developmental stage or need the child is presenting. If the parent changes their view and can be more loving through understanding, the relationship has improved.

Part of the problem is that parents live with chronic stresses associated with delays. These are anger and a cycle of guilt and denial according to Foley (2006), a psychotherapist. Parents may also be suffering from the loss of the child they hoped to have and be struggling with the needs of the actual child a state of mind called "ambiguous loss" by Boss (2004). The stress

shows up in the statistics. Children with physical delays are 3.4 times more likely to be abused than children without delays and children with emotional delays are 5.5 times more likely to be abused as reported by Kendall-Tackett, Lyon, Tagliaferro and Little (2005). . Bagnato, Blair, Slater, McNally, Matthews and Minzenberg (2004) report that developmental or mental health services are needed in all early childhood settings but that they are provided rarely as part of a fragmented system. Fifteen to 18% of children under five years of age, or 10-13 million, have some chronic medical condition that requires routine maintenance such as ongoing consultative or technological support. Another 15 to 30% have some behavioral problem that present barriers to adjustment and inclusion in ordinary school settings. Early Head Start, EI, Head Start and other programs for infants, toddlers and preschoolers include mental health care but the number of programs carrying out this integrated approach when it was studied fell short of the need when studied by Bailey (1996).

Role Release at the Institute

Authorization for transdisciplinary care requires role release. Role release is a formal process that takes place when an expert authorizes a student to work in a new capacity. UCP envisioned in-service classes (Haynes, 1976) but researchers find that professionals release people into new roles informally (Polmanteer, 1998; Ryan-Vincek et al., 1995). At the Institue, roles are released completely within the formal organization. The program is authorized by the New York State Board of Regents to provide accredited, post-graduate training in psychological education for therapists who work with atypically developing children and their families (Institute for Infants Children and Families, 2008).

In contrast to the involuntary features of transdisciplinary care in the UCP model (Taskforce on Staff Development of the United Cerebral Palsy of America, 1976), the Institute model is

completely voluntary. Only the willing professional registers for the $5,000 per year training. The UCP model follows principles of quality improvement that addresses the needs of the institution but the practitioners may not want to learn what is taught and often resist quality improvement. Brophy-Herb, Schafman, McKelvey, Cunningham-DeLuca and Hawver (2001) (Brophy-Herb, 2001) found that workers in an Early Head Start program resisted infant mental health training and work. The workers did not want it for their own reasons so buy-in was difficult to obtain. The reasons included extra work, little feedback about the success of their work and uncertainty about working more with families and children. The Institute model follows principles of adult education that stress the importance individual desires for skill improvement as described by Davis (2006). Adult education favors the individual need for self-directed learning that is the mark of the cosmopolitan worker.

Using the terms of the guild system, the respondent graduate is a journeyman but not a master who can approve another's mastery. Costa (2006) describes four levels of mastery lead up to transdisciplinary care using principles of infant mental health. In order, they rise in degree of complexity: building an alliance, providing concrete services, providing developmental parenting guidance and supportive counseling and, finally, providing infant-parent psychotherapy. The provision of infant-parent psychotherapy is contingent on completing certificate program whereas training or supervising people in infant-parent psychotherapy is contingent on completing a doctoral program in mental health along with the appropriate certification or license. That last qualification excludes all respondents none of which had any doctoral level psychology training.

Limits on practice can be seen in terms of transference and countertransference. The non-psychologist but psychologically aware therapist is aware of transference and

countertransference. This awareness leads practitioners to be primarily concerned with managing their own feelings. They are usually only aware of the parent's transference experiences as they pertain to the work with the child (Gilbert M. Foley, 1994; Hirschberg, 1997-1998). Infant-parent psychotherapists are not allowed to manage the transference and countertransference of the parent-child dyad nor work with past trauma because it beyond the scope of the training. Treating trauma is left to licensed social workers and psychologists such as Leiberman and Van Horn. They present case histories in Chapter 6 of *Psychotherapy with Infants and Young Children* by Leiberman (2006).

On the positive side, the Institute graduate knows how to work with child development and attachment theories (Costa, 2006), use the helping relationship self consciously, manage his own reactions, maintain awareness that unconscious forces govern parent behavior, and, finally, use the idea that parenting is a relationship, first, and a skill, second. The job of the Institute graduate includes *remediating* the disability, *redefinition of the parents' perceptions of the child*, and *reeducating* the parent in relation to the child, as laid out in Table 2 (Sameroff, 2004).

Table 2-Goals and Definitions of Infant-Parent Psychotherapy*

Goal	Description
Remediation	a. Change a child's relation to the parent
	b. Increase the child's ability to interact
	c. Improve the physical problem
Redefinition	a. Change parents' thinking about the child to create optimal parenting.
	b. Minimize overwhelming aspects of disability to capture essential parenting strengths.

Reeducation	a. Change how parent behaves towards the child for parents who do not have knowledge or experience of positive child development.

*(Sameroff, 2004)

III Research Design and Methodology

The purpose of the research is to discover how the respondents became transdisciplinary practitioners during the course of study at the Infant-Parent Study Center at the Selig Institute of the Jewish Board of Family and Children's Services in New York City. The findings will also shed some light on transdisciplinary training and work centered in the individual as opposed to the team. The research was approved by the Institutional Review Board of Hunter College and the Selig Institute, the division of the Jewish Board of Family and Children's Services that oversees the Infant-Parent Study Center, the program that trained the respondents.

To accomplish the discovery of how healthcare providers become transcendent, broad and intrapersonal practitioners, 14 graduates who were trained in physical care disciplines were interviewed to create narratives of their careers that led to their enrolling in the program at the JBFCS and what they did with that training after completion. Narrative theory emphasizes that narratives, or story-telling, are a way of making sense of the world and use the tales people tell as the primary unit of data because, in this theoretical view, stories are among the most fundamental units that account for human experience (Pinnegar & Daynes, 2007). Narrative interviewing styles have been categorized by Hollingsworth and Dybdahl (2007). The categories of interview style are post-positivist, constructivist, and critical. In the post-positivist approach, the researcher is expected to be distant from the respondent and the interview is structured, as is the case with Wengraf's (2008) British-Narrative Interview Method (BNIM). BNIM interviewers maximize distance and attends to surfacing memories. The interviewer is focused on the content and the

wording of answers to primary questions. Interviewers will then ask follow-up questions using the same language as the respondent. An additional technique used to ensure objectivity from unstable human memory, the BNIM asks questions three times with deepening degree of detail. The same three pass method is used in the quantitative Nutritional Data Survey for Research, a prominent computer assisted diet history program designed to maximize accuracy of recall as described by Thompson and Subar (2008). In the BNIM approach, analysis is limited to the level of the word so the use of metaphor is discouraged. This method will not be used in the current study

The critical method moves to far in the opposite direction. Critical theory's sense of relationship between the researcher and respondent is fluid and shifting. Data collection is based on frequent encounters which will not occur in this study where one encounter is expected. More importantly, the researcher's intentions are not paramount in the critical approach. Questions are entirely open-ended. Finally, the analytic work is shared by the researcher and the respondent. In the present study, the narrators were not invited to share in the analysis due to the use of the constructivist approach which gives primacy to the researcher.

The constructivist approach provides a middle ground in narrative interview methodology (Hollingsworth & Dybdahl, 2007). In the constructivist view, the researcher and respondent co-create the 'truth.' In this outlook, the expectation of reliability of the respondents report is not as high as in the post-positivist approach where numerous questions drive to get as accurate a recollection as possible nor is it a secondary consideration as it is in the critical view. What does lend veracity to the accounts of the respondents is that their accounts are grounded in a technology and social networks technology and social networks constrain activity and limit invention. For example, Pentland (1999) finds that organizational narratives have a strong

relationship to actual experience. The researcher's identity and time constraints are considered within the constructivist method. There is a sense of equality between narrators and researchers. The sense of equality was heightened because the interviews were conducted by an interviewer who also works in the early intervention system as a clinician and has worked in a transdisciplinary way prior to the interviews. In addition, he is taking clinical supervision with one of the program instructors and this undertaking increased the emic aspects of the interviewing because the respondents had to undertake clinical supervision and some continue with the process.

Interviews are conducted based on the idea of the semi-structured interview as presented by McCracken (1988) in *The Long Interview*. Semi-structured interviews are the preferred interview form for constructivists because the structured interviews, in the form or standard questions, make sure the goals of research are met within the time constraints of the researcher and respondent and also permit the interview in a new direction if desired . The semi-structured interview guide is in Appendix 1. The guide's questions are ordered in narrative sequence moving from the period prior to enrolling in the training program, the two year learning period, and, the time after completing the program. Using this schema, the research guide oriented the respondents to experiences before, during and after their time in the IPSC to capture the element of change over time.

Holstein and Gubrium (1995) discuss the features of qualitative interviewing that suit the constructivist view in their book, *The Active Interview* . Holstein and Gubrium demonstrate from prior studies by others and themselves that much quantitative interviewing is actually dependent on incidental conversational techniques to move the interview process along and that these

conversations are part of the process (Chap 2). For this reason, Holstein and Gubrium find that the interviewer's co-constructing conversation is an important part of the research process.

Once this premise is accepted, the insider knowledge that the study's interviewer brings is useful rather than contaminating. Insider knowledge displayed during conversation spurred deeper investigation, trust and disclosure. One of the respondents enjoyed the interview process and reported it positively to another, not yet interviewed, respondent. This process occurred in more cases. The social aspect of the interviewing process is further suggested by the places in which the interviews were held. These were bookstores, homes, phone calls, professional settings and restaurants. The sites were negotiated with preference given to the respondent. In one case, an interview that was done in person had to be redone by phone when the original interview was found not to be recorded.

Data Analysis

All the interviews are examined using a structuralist view of narrative as suggested by Pentland (1995, 1999) , an organizational theorist interested in narrative approaches. He is concerned with activities that enable and constrain action in organizational settings. In other words, work life contains its own narrative based on experiences that support realistic reporting. In addition, Herman and Vervaeck (2001, p. 41) state that structural approach allows interpretation of the data to go beneath the surface and look for meaning. This faith in the reports and collective story is something post-structuralists do not entirely share (p. 112). The structuralist framework for constructing the narrative has three levels as described by Bal (1997, p.5) . First there are the words of the respondents. This is called the *text*. Next level up is the *story*. The story is a person's version of the event. The last step in Bal's schema is the *fabula*. The fabula is the researcher's version of events and their relationships. In Pentland's (1999) view

the problem lies in the creation of the fabula because the researcher has decided what was included and excluded in the fabula.

To constrain the researcher, Pentland (1999) presents 5 aspects of fabula construction used in the creation of the study fabula. First, ordinary chronology is the organizing device. Events should be presented with a clear beginning, middle, and end. Some allowance is made for the researcher altering the sequence some events for dramatic effect. Second, there are actors about whom the story is told. Actors tie events together because they add a thematic detail. They may remain nameless as they do in this study to prevent identification. Actors are the respondents but they may introduce other actors that include the teachers, parents and their children that moved the story along. Third, there is a narrative voice which is the researcher's, Objectivity was attempted by using the actual words of a person and by using quotes from more than one person when possible or using longer narratives to explore a particular situation in detail. At other times, the experiences were framed in relation to current thinking about transdisciplinarity and to training programs as a form of criterion validity. For the fourth feature to be met, narratives have an evaluative or moral frame of reference. The stories encode cultural values and meaning, explicitly and implicitly, which offer a way the characters can be judged. For example, the respondents present their own practice, professional dilemmas and experiences from which our views towards their experience can be informed. Fifth, narratives contain information in the form of textual devices; these may appear as color only but in fact add to the description of the story. They do not advance the plot but provide clues to interpretation. Sometimes, such information is called an index (Herman & Vervaeck, 2001).

The quotes of the respondents were edited in the following ways. One respondent is from a foreign country. Her grammar and words were edited to further minimize identification. Some

of the respondents had particularly bad, spoken grammar. The lack of conformity to standard grammatical rules was kept to keep dramatic color and humanity in their responses to the questions. The transcriptions were analyzed with MaxQDA, a qualitative software program (VERBI Software, 1989-2010).

Sample and Study Sites

The sample consists of 14 of the 20 allied health professionals, nurse or physician students who completed the program at the Infant Parent Study Center as of the fall of 2009 when research began. Qualitative studies use purposeful but often small samples to find research participants who are rich sources of information as stated by Patton (1990, p. 169). An exception was made in two cases. One respondent (Movement 4) did not complete the final project but completed the two year coursework. The second exception was made for someone who did not complete the second year (Movement 2). She was included because she was able to carry out the mission of the IPSC program in her work as a state director for early childhood services. These two were included to keep the sample size at a maximum.

The 14 member sample represents about 17% of all the graduates of the Center; who were primarily mental health workers. On the other hand, it also represents 74% of the entire universe of possible informants which was 20 in total of the people who met the inclusion criteria.

Being an allied health professional or and nurse who completed the program was the original inclusion criteria. The idea was to create an intensity sample of people who had to make an epistemological jump from physical to mental health practice. Intensity sampling involves looking for participants who manifest the topic of interest but not in an extreme way (Patton, p. 171.) However, as refusals to participate in the study began to mount, the decision was made to include a physician. Physicians in the program have to span the same epistemological divide as the others in the sample. Medical doctors were originally excluded from the study because there was a concern that the power differential that physicians have in the medical field might somehow skew the findings. It was expected that clinical power struggles would play a large part

in the narrative but this concern turned out to be unfounded. Accepting the potential problems was a trade-off for a larger sample that turned out well.

Between the program's founding in 1995 and the year of research, 2009, 20 people qualified for inclusion. Three people were unwilling to be interviewed. One did not return the initial contact. No contact information existed for a therapist who lived in another country. The final pool available for interviewing was 14. The respondents are enumerated by profession in Table 4. In the Findings, the respondents are listed by profession and number to maximize anonymity and to maintain continuity. For example, the first nurse to speak is referred to as Nurse 1. When it is not necessary to list a profession, no profession is listed. This is done to maximize anonymity for the single physician in the study whose remarks often clue us in to her profession. To maintain anonymity, all respondents are referred to as she in order to mask the lone male respondent. To restate for clarity, the respondents were only a small part of the student body. The majority of the students were originally trained in psychology or social work.

Table **3-Distribution of Professions in the Study**

Profession	**Number**
Nurse or Nurse Practitioner	**4**
Dance Therapist	**1**
Occupational Therapist	**1**
Physical Therapist	**3**
Speech and Language Pathologist	**4**
Developmental Pediatrician	**1**
Total number of Respondents	**14**

IV Findings

The Antecedents to Enrollment

This section presents the beginning of the narrative describing how respondents came to be transdisciplinary practitioners. The first thin roots of transdisciplinarity appear in childhood and jumps to the college years. In hindsight, these roots become less vague. Family life, psychotherapy and work adumbrate the desire to work in a transdisciplinary manner. In the passage of time, respondents had marked a path towards unification of the physical with the psychological. This theme was emergent. It is as if there was a deep need to merge the physical with psychological based in the early phases of life. For many, the need to establish a way to understand the body and the mind as one unit appeared in conscious and intentional ways and in unconscious, unintentional ways.

Childhood

Four of the respondents took the story back into childhood. The uniting factor in these stories is *caretaking* in the context of family. Three stories of caretaking are presented and one story of being cared for. The caretaking stories refer in two cases to disability and show that some of the respondents had early experiences as care givers. Embedded in the stories is journeying. Each vignette will be identified by current professional status of the person to show the link between the story from their childhood and their current work life. The first journey, albeit a short one, was a visit to a relative and an early introduction to the role of families in caring for those who need help. Perhaps, it set the stage for the respondent’s current work as a visiting nurse. The event was far in the personal past and it will be placed in the unconscious category of experience.

> I had a cousin that had developmental disabilities when she was small. And as a child I was involved in taking care of her. I was probably about ten or eleven. She was a baby. (Nurse 1)

The idea of modeling and journeying to help is explicit in this anecdote. The respondent recalls her mother, a visiting nurse who worked with disabled people in rural Pennsylvania, was a model for her. Beyond the care that was offered, a social element associated with care was included. Today, this person works as an early childhood advocate and trains agency directors whose agencies provide daycare and homecare daycare across New York City. The modeling aspect is very strong here. She cites her mother's advanced age. She herself is working well past retirement age. This event will also be placed in the unconscious category.

> My mother was the head of the Visiting Nurse Service and was an old time nurse. My mother was old you know. She graduated in 1927, in Pennsylvania, in the hills. She had a state car, a model T, and would go around to every kind of place you could imagine and work with people and she was a model for me. So that, and when I was a teenager, sometimes, you know, I would go on a visit with her. That […] would have (been) somebody with someone with, like, MS (multiple sclerosis) that she worked with for many years where. I'd go the supermarket (with her). "Oh, Mrs. O'Brien, I can't believe it's you." I'm very comfortable with that. […] Early. So I liked it. (Nurse 2)

The third report presents an early awareness of the needs of families and an innocently accurate view of what parents really need to spend time with their children. There, this event can be placed in the conscious activity. This person is now a physical therapist and runs a state's early intervention program. Her goal in that capacity is to minimize useless home visits in order to maximize family time.

> Yes, oh yes! I use to baby-sit. [A]nd I would you know engage the kids and when they went to bed I would think, "You know what, if I do the dishes and sweep the floor then the mom will have more time to spend with the children the next day." So I started thinking in terms of what it would take for families to be more connected to their children

> because when I was 10 or 11 years old I always tried to think in terms of what can bring parents and children closer together. So I always thought about what it was like to support families. (Movement 1)

The next childhood story is about receiving the same kind of care the speaker currently offers. She returns us back to childhood's need for getting necessary attention and care. For her, the care she received represents a kind of break between herself and her mother. She quickly sketches a portrait of her busy mother running a big household and the 'nanna' who provided the more intimate care. The person is a master movement therapist. Much later on, she will tell the story of how she was able to connect a mother with her daughter. There is no journey in the narration but her early experience, like the experiences of the first three speakers, set her on a path that will become apparent as the study continues.

> Maybe, because I'm one of nine. I'm very ...…..How do say it. I always, I love children. I don't have children. I connect with children a lot and they connect with me. I had a natural ear before I studied. I connected with children, from a playful place. So I guess, I think it is to focus on the, how to really make the small things count, to make the little things count for children. I'm one of nine. I'm aware of that. Parents try to be good and everything but the little things kind of get lost in the shuffle. […] From the fact that I told you, that I grew being one of nine. And I had a wonderful nanna, that caretaker, who was focused on little things. But my mother was focused on the function of bigger things. So maybe she didn't pay attention to the little things. So I'm aware of the value of how some kids are more sensitive than others, I am a sensitive person, so I'm, it might seem like a little something, like the little details are important for the child. I think that's the origin of it. So, maybe, I'm trying correct, you know, I'm trying to correct, give children maybe what I didn't get, the little things, the importance of the little things. How valuable they are. I think that is part of it. I'm aware of that. (Movement 2)

In this last remembrance, the little things can be herself and her siblings, if we make a psychoanalytic reading of her narrative. Despite the obvious actions of the mother to organize and provide care, a need and some kind of trauma were created. From this story we see some themes that will be expanded on as the narrative continues. The themes are *reparative work*

between parents and children and *trauma* unrelated to abuse. The roles of giving and getting care begin to be established. Her experience can be placed in the unconscious realm. She is aware that she is correcting her own childhood trauma.

Prior Training in Psychology

Psychology represents one pole of the transdisciplinary spectrum for the respondents and it was of interest to the respondents by the time they attended college. Courses of study show consciousness of the interest in psychology. Two people received undergraduate degrees in psychology that they did not pursue. “I went to, I got bachelors in psychology around that time, […] then I took some courses and I went to this certificate program. It was sort of psychoanalytic. You’ll see in the resume. It’s sort of psychoanalytic.” (Nurse 2)

In the next quote, the respondent who was one of nine children saw undergoing therapy itself as part of her undergraduate training in psychology. She continued with her internalized view of the mind that she presented earlier based on the way she was cared for in childhood. “I couldn’t study psychology if I didn’t go through the process of discovering, I went into therapy, psychoanalysis, like exploring. I started exploring.”

For Nurse 1, psychology was part of the training but held no particular interest for her at that time. “Although I did a BSN program in [a foreign country] which also focused on social-psychological development [...].”

Despite the early moves in one direction, a kind of muddling indirection also appeared because all the respondents first became primarily physical care professionals. For example, the respondent who wanted to help families as a child, (Movement 1) described her academic

interest in psychology in relation to medicine and her own family responsibilities. The tension between physical and emotional care appeared early in her career.

> Well because I didn't know what else I wanted to do when I got my undergraduate degree in psychology. I applied and went to medical school because I also had a pre-med background and went to med school for three months and was the only female in my class. And my mother got very ill and I was very far away from home so I came back to Massachusetts at the time and decided that the only thing I really could do to get into school in the Boston area was to get a master's in psych. […] And, then, as I did one of my internships […] with the spinal cord injured males. I decided you know what I really want to work with the physical more than I like psychological so I can always (be) psychological so why don't I get a masters in PT because I seem to love it and knowing, full well, I could always use psychological training. (Movement 2)

Unfortunately, no line of questions emerged in the interviews regarding why the respondents embarked on a career in the allied health professions, nursing or medicine in the first place. What did arise on their part was an unaided attempt to construct a version of the Principle of Complementarity in the form of a psychologically inclusive view of physical practice. Respondents came to this problem with no training or systematic information concerning the two sides of the problem.

Planck and Bohr, for example, talk about the theories they had to unite in physics. They already understood that light behaved in particle and wave form. Their job was to reconcile observation. Once Mandelbrot perceived that apparent geometric disorder was, ultimately,

undergirded with a difficult to discern but still discernable order, he could proceed. The physicians who practiced pre-modern medicine were given a framework to manage the objective and interpretive. The respondents in the present study were neither handed a framework nor could they be. No one had such for members of the health professions. The theme of attraction to psychology is the unguided attempt to unify the interpretive or relational aspect of their practice. A second respondent was also already thinking along two lines in college. "[E]ven when I was in PT school, I enjoyed the psyche part. I've always been bent in that direction." (Movement 3)

Parallel thinking also emerged for an occupational therapist. She felt her initial exposure to psychology in college was inadequate. The aspect of psychology taught to her had more to do with working with the mentally ill rather than understanding and adapting care to the mentally ill. In other words, the theories of psychology were not the keynote of the course. While occupational therapists (OTs) get some exposure to psychology, it is directed towards physical care in mental health settings. (Hardaker, 2007; Wikeby, Lundgren Pierre, & Archenholtz, 2006). That was unsatisfying to at least one OT.

> How does an OT work with someone who has schizophrenia? So it's really very specific to mental illness. It's not in general how do you look at the dynamics of the family. Though, now that I say that, I remember we had a class like that, but it wasn't very good. So maybe they attempt to, but [...] there's not a real learning experience for us to begin to understand what's happening with families. (Movement 4)

Her initiation into applied psychological knowledge came when she took a series of classes with Arietta Slade, an Institute affiliate, at the City College of New York during her training.

> She is I think one of the main players in infant/parent research and I've developed a relationship with her. She was a wonderful teacher and I think I always had it in my mind that this was an interesting field of study. So maybe that was in the back of my mind and I was always drawn to it, to psych kinds of things.

The theme of attraction of psychological work became apparent in childhood, college and in early care experiences Despite the experiences of coursework, the interviews still suggested individuals struggling on their own to bridge an epistemological and practice chasm.

The next two speakers took advantage of advanced study at the doctoral level. Two students encountered the relational aspects of their profession at the doctoral level. The first person to speak currently trains graduate-level speech language pathologists. Here, she explains her initial interest in the relational aspects of speech therapy, in relation to her dissertation topic. The idea of an ever widening circle of interest continues as people developed professionally.

> I guess I had a long-time interest in the importance of relationships in speech and language pathology and I really believe that the clinical work I did was good because of the relationships I encountered with clients and families. So I had an interest in this for many years. […] I was in my 20s. […] I was very interested in autism. I did my dissertation on autism, so I was very interested in relationship and social/emotional development. […] Thirty years ago, I was young. I've always been interested in communication and the non-verbal aspects of communication. I wanted a deeper understanding of that. I was always very curious about kids who could develop language but were not communicative. I've always had an interest in that. (Speech 1)

The single physician in the study population who, like the nurse started out as a psychology major, also oscillated between the mind and the body during her early career.. Her narrative began with experiences that shuttled between “hard” science and social science due to coercion on the part of her family. On the other hand, they set up an educational pattern of science and the liberal arts. She is like Movement 1, who started as a psychology major, attempted medical school and then became a movement therapist.

> It goes way back. I wanted to be a chemist. My mother wanted to be a chemist. Her mother wanted to be a chemist. My daughters were chemists. But my parents wouldn't let me take a chemistry major in college, so I got into chemistry pre-med. [...] I went to college when I was 16. It was a special program, and I really loved chemistry. It was the first I'd been exposed to chemistry in my freshman year. I wanted to be a chemistry major, so I would have had to take chemistry, physics, and calculus the next year. And that was when my parents said “You're only 15 years old; you have to take some liberal arts courses.” I was at a liberal arts college. And that's how I didn't end up in chemistry. My mother never was a chemist. Both of my daughters started out in chemistry and now are doing something else. But chemistry is probably in our gene pool somewhere. (MD1)

She began her training in pediatrics, noting “I love babies,” in one response. To explore that love, we hear how the draw to transdisciplinarity began in medical school which happened 5 decades ago. She studied under some of the founders of developmental pediatrics in the 1960s. The theme of family which began in the first telling repeats the next.

> Then I went to medical school. I went to Case Western Reserve in Cleveland, which had a new curriculum, a much more humane curriculum than most medical schools. Dr. Spock was there at the time [...]. There was a program called the Family Clinic where I was first introduced to a pregnant woman and then followed her child through my years in medical school. That was run by Dr. Kennel, of Claus and Kennel. I wanted to be an obstetrician because I liked babies. By the time I was applying for residency, I had two children of my own. That was back in the late 60s, and there weren't many women in obstetrics. That's kind of how I got into pediatrics and how I liked babies and I was going to go on, maybe, neo-natology. But I ended up in the children's rehabilitation center.

For the physician respondent, many moments of apparent chance and/or social forces are described.. Genders in professions, family, chance encounters in classes with inspiring professors initiating a more humane medical curriculum appear in her history. We already saw some of those themes appearing in the prior narratives and will hear about other themes later. At this point, we can consider what kinds of forces are driving the respondents who, after taking degrees in physical care, wound up with an interest in psychology. It may be that the back and forth drives between psychological and physical orientation is a kind of wise confusion that has not yet found a path. Hyde, a mythologist, citing Jung and Yoruba mythology, says that chance

opportunities are a reflection of an inner unresolved state (Hyde, 1998, pp. 108-109). The presence of hidden drives can never be fully ascertained with the data that was collected but the next set of narratives provides suggestive support that the drive towards psychological knowledge also had unconscious features as manifested in settings more intimate than the classroom.

Psychology and Family Life

After tertiary school graduation, family life and work form the next big chapters for many people. Erikson (1994, pp. 66-72) considered this stage of life characterized by caring for others, intimacy, and productivity as opposed to isolation. He summarized this stage in two words, *love* and *care*. The presence of family already appeared in the childhood narratives. Now we can take a more detailed look at the respondents' interest in psychology in terms of their family life. Nurse 2 found that her natural curiosity about herself expressed in her therapy for herself and in relation to her son when I asked her why she enrolled. Having a child and a son with developmental delays provided some background for the later education in transdisciplinary care at the Institute.

> I know that I learned a lot about sensory issues from the OTs and PTs there [the IPSC]. And [...] 'cause I have a son with ADHD and I intuitively kind of knew what to do with not having read anything or him being diagnosed. But you know about the whole firm touch and you know where that they (give) those kids hooded vests. Like (to help in) getting them grounded. And so, like, I knew that holding him very tightly. So this kind of affirmed what I did instinctively. (Nurse 2)

The next set of reports, suggest deeper roots that led up to enrolling in EIP and betokens greater support for the idea that some kind of inner wish to become a psychotherapist existed. Three of the respondents had married psychotherapists. One was a speech therapist whose

spouse, with a kindred spirit, started out as an OT and became a psychoanalyst. The two other respondents report their marital status and provide more evidence for some underlying drive towards a psychological sensibility. The first response comes from Nurse 2 whose family life is suffused with developmental problems along with her marriage to a psychologist who may have his own delays.

> My son, my daughter, my husband, myself we all have learning disabilities. [...] My husband has a Ph.D. He's a psychologist, the slowest reader I know. [...] So, [I] just know how it feels. [...] I'm married to a psychologist. What can I say? […] I'm surrounded.

Another respondent married a psychoanalyst and was already sufficiently immersed in current ideas about child development that she was surprised to be among psychological practitioners who weren't.. Their dinner conversations must have been interesting.

> My second husband, who I married when I came to NJ, was a psychoanalyst, and I went to a psychoanalytic meeting. And they were talking about babies, and really going back to (Rene) Spitz going back to the 1930s. I couldn't believe they weren't talking about Brazelton, and they were years behind what I knew and understood. So I've been interested in psychosocial, emotional aspects of what goes on with children for a long time. (MD1)

She continued about what happened to her when she had some free time, a theme that will be discussed later. Some regrets appeared as she reflected back on her own shortcomings as a mother and translated her regrets into positive actions of reading about maternal psychology and spreading the word about it to pregnant acquaintances. The second book she mentions is by Selma Fraiberg, another pioneer in IMH.

> I moved to New Jersey in '75, [...] and I used to do my housekeeping. If I cleaned the house, then read another chapter. I've been integrating it in my life for a long time. I

> welcomed the opportunity to be with people who had the same interest and a chance to really study some of the basic articles and the work that had been done about infants. [...]I don't know how I got introduced to Berry Brazelton, but I used to go to his meetings and talks every year, and I loved his book, *Differences in Mothers; Differences in Development* and I thought with my own children I had completely missed their social emotional development. So I thought I should either have another baby so I could enjoy that, or that I should give that book to everybody that I knew was pregnant. It wasn't in the cards for me to have another baby, so I've given that book to many people. I [also] had the [...] book, *Clinical Studies in [Infant] Mental Health*.

Seeking Psychotherapy

It is no surprise that the application to the IPSC form asks the applicants to describe their experience in therapy whereas it does not ask them to detail their experience as allied health professionals, nurses or physicians. It is predictable as well because the Institute is primarily a training institution for the mental health professionals. The purpose of the IPSC is to teach applied psychology to the non-mental health workers. Most of the respondents appeared to have been in psychotherapy at one point in their lives. Only one respondent never had the experience being a patient in mental health care. "You did (have to write about your experience in psychotherapy) when I went, but I just had never been in it so I didn't write anything." (Nurse 1)

Consequently, respondents spanned the gamut from one with no therapy at all to some with lifelong courses of therapy as well as being married to psychotherapists. One respondent started a life-long journey in psycho therapy in college as a psychology undergraduate. This is Movement 2 and her early experience can be considered in relation to the experience of her fellow students. For the most part, therapy plays a complex role in the experience of at least three other graduates who connected therapy with their current family life. The long-term aspects of therapy continued to set the stage for the kind of dual thinking that would take shape at the IPSC. While the actual therapy deals with the hidden inner world, undertaking psychotherapy is a conscious act that acknowledges the unconscious.

> I've had so much therapy in my life. I see it as a positive thing. I wasn't put off by it. I think it's really important as a human to understand yourself. I don't remember my reaction. I've had a lot of group therapy in recent years, a lot of years of group. [...] In addition to my own interest in psychotherapy, my own therapy, understanding myself, my son. (Speech 1)

Having been in therapy prepared the respondents for the program. The next comment came from Nurse 2 who took a psychoanalytic course of training after graduating from college. It did not dim her sense of humor. “I had years of therapy, you kidding me! So it was not like some unknown thing.”

Dissatisfaction with primary training

As the respondents’ careers progressed, the tendency towards psychological or relational work grew more and more pronounced. The tendency appeared in the wish to be free of their current professional role as it is normally understood. They were like a creative apprentices chafing under the role of the traditionally-minded master (Pearlin, 1989). In our case study, the “master” is the role as presented in traditional physical training, scope of practice, licensing and reimbursement. Respondents’ desire for role expansion is expressed in this vignette as an unwillingness to simply check of the boxes on a checklist. It may be a cliché but this visiting nurse was already thinking “outside of the box” of conventional pediatric nursing practice.

> It’s kind of a negative in a way. I wanted to get out of traditional nursing, and it was more interesting to me to work with the parent-infant relationship than do assessments. […] Um, well I think the kind of work I was doing, it would have been really easy to just fill out a checklist and just let them go. But, and I probably still did that with certain people on certain days because you just can’t be a hundred percent all the time, but I think maybe I persisted more often and tried not to just do a checklist. (Nurse 1)

She presented the kinds of things that happen outside of the limits she is required to check off and then leave. Like other respondents, the desire to bring something essential to the family as well as the child with whom she is working is part of the drive. Her work has to bring together a suitable explanation of a premature infant's inability to self-regulate with the learning needs of the uneducated and low literate, often teenage, mothers. In this example, we hear how she began to work uniting the body with the mind before being trained.

> There's no prescribed way of doing it. But I'll talk to them, I try to talk to them about what you expect from a premature infant and regulatory issues. Some of them like them [explanatory pamphlets] but a lot of the parents that we see are, well a lot of them are first-time, teenage moms. I don't know how literate they are a lot of the time, [...] sometimes things like that are intimidating if it's a lot of text to look at. [...] I give them resources to look at. A lot of them have computers or access to one, and I will—we have some materials in the office which we get from different places, but I honestly don't know how much they read them. I actually was thinking of trying to institute the ASQ [Ages and Stages] questionnaires in the visits [...] a developmental screening which is what I use in the foster care program. But there's all sorts of things that get in the way, like time, and how many visits you're going to make.

Another respondent embraced a more limited scope of practice for herself. She specialized. Her view of herself is as a speech therapist who is highly skilled in the technical aspects of her profession. Her list of specialty trainings in speech is long and focuses on speech rather than psychology. By way of contrast with the others in the study, she kept within the strict scope of practice guidelines of her profession. She was willing to guess at an underlying psychological reason but shied clear of taking a stab at a modified writing instrument, talking with the child about their feelings about writing or even setting up a play therapy for writing. She could have tried a fat pencil or keyboard if she wanted to try right then and there to make a more firm substantiation of her intimation about the writing problem. The interview with her was characterized throughout by the response: "I don't remember." As she describes her clinical

work, she responded to being challenged about of working across disciplines.

> If I notice they really can't move the pencil well, I'm gonna speculate that part of the reason he hates writing so much is because it's hard for him to use, I have to get to his underlying analysis. So, he's not writing just because he can't think of ideas; he's not just not writing because [...] there's actually a motor issue going on that's making it more challenging for him. Then I need an occupational therapist or somebody to identify the grip for him to teach what he's doing in terms of holding. That's what I mean, like I wouldn't take the lead in that, I'll follow up and recommend to the parent to go [to] the OT and I'll watch for that, that he's using the proper grip, but I'm not going to make the determination. I can identify it and suggest they explore it. [W]hen I said, "I don't remember", it seemed like you thought everyone does it. I mean, it informs me, but I do draw a line as to what I'm clinically and ethically able to make recommendations on. (Speech 4)

The same speech therapist developed a broader perspective about work when she started in pediatric rehabilitation. She worked under the UCP model of transdisciplinary care and stated her dislike on the way New York's EI program operated.

> My very first job, I lived in Boston and the Zero to Three model was very different up there, where I started my career. [...] It was a very extensive transdisciplinary model. I was case manager. There wasn't splitting the child up and (their being) seen by an OT, PT. There was a consultation model. I was case manager as well as a therapist. [...] I was the primary therapist for the child, yeah but I knew about transdisciplinary models. It was in my first job. It was how I learned. It was my very first career, my very first place of work, that's how I was [trained]. It just didn't make sense to me [the way EI was in NYC]. And when I started to do early intervention in New York, I just hated it.

Other respondents were more like the visiting nurse who felt no such limitations. They took on other professional roles whether they have been trained or not. As the other respondents began to answer the questions with specific memories and feelings about work, the expressions of wanting to be free of their original training appeared. In fact, some of the physician's patients said that they thought she was a social worker.

> The patients used to think I was a social worker because I would talk to families and talk to the children but talk to the family also and not talk at them. I actually listened. You wouldn't believe it, listening to me go on today. I've always been, thought that I was a little different than my colleagues.

Another speaker, a physical therapist (PT), presents the problems she encountered with the foster care system in New York City. The upsetting foster family situations he encountered led her to think beyond bones and muscles. In her remarks, she is referring to the Pickler Institute, an orphanage in Austria. After watching a documentary on Pickler, she describes in another section what she felt was perfect care offered by the nurses and other staff members as well as the beneficial effects of that care in the very long run.

> I thought they had done incredible work beyond anything I had seen before and the data backed it up. In 1969, in 1970 they did a study and they found there was not a single of the sample there wasn't a single family, there wasn't a single child that was incarcerated from that had been in that institution, having graduated from that family, they always placed the child in adoptive homes, there only parents. Anyway, I was always trying to understand the NYC social welfare system. (Movement 3)

Her interest was unique in that it focused on a social service system. However, seen in a larger context, her interest in care beyond the body made her seek like-minded colleagues. She denied that she was like the other students but, in fact, she was interested in the merging psychological care in the form of cultivating attachment with physical care.

> There was on specific question I had that I wanted answered: What is the current status of the child welfare system in the city and elsewhere [...] I was particularly interested in this because I attended a seminar that Charlie Zeanah gave that was sponsored by the Institute. [H]e is child psychiatrist at Tulane. And he was talking about the social welfare system how we evolved from an orphanage system to a foster care system. And I had worked a lot in with foster families evaluating children for the VNS (Visiting Nurse Service) and other organizations and I found that to be quite poor in the whole system sometimes it worked really well and sometimes it was really bad. (Movement 3)

She gave an example of the poor foster parenting she encountered. The baby walkers discussed in the passage are not recommended by pediatricians or PTs. They hinder rather than promote walking. Walkers keep the back and abdominal muscles weak; they need to strong to support standing and walking. The deeper problem is that she is comparing skilled care with often underprepared foster parents who come with a good heart, some training and not much more. The therapist tries to paint a balanced view of the parents but her dissatisfaction cannot be disguised. Her disappointment eventually led her to think bigger thoughts about the entire system and her practice.

> In foster homes, I would often see the parents; first people would use these walker things for kids. [...] I felt often that the way they would smile at the kid was fake. The way that they would tend to the kid was very fake. [I]t was kind of like to showing to somebody else that they cared but they weren't really giving the care. Care for me is that you give them focused attention. Care isn't being smiley faced. And that's what I saw a lot of in foster care, a lot of smiley face. I don't mean to fault foster moms. It s not like I am trying to *dis* the system completely because I met a lot of foster moms who were great. Who were tremendous with their kids and their moms and they were *grandmoms*. They were able to connect with these children but I saw a great amount that really disturbed me.

> [W]hen [...] the biological parent [...] can no longer take care of the child, and the state is now responsible for doing that [...] that should be the best quality care. You are taking care of human beings that will later on grow up and be able to be integrated into society. And we know [...] [if] care is not the optimal, what will happen is a consequence of that: that those children can become delinquent. Those kids have kids of their own in a way that they can't support them. We know that their children will eventually end up again in foster care or in adoption. We know again that there are unwanted pregnancies. We know that those people can become problematic in society because they'll do abusive things to them.

She moved from sociology to her feelings based on what she knew about attachment in relation to her practice. Then she jumped back to social service systems.

> It is the powerlessness, powerlessness, is ...nothing, [...] nothing I could say or do. I do not think training for foster mothers is the crux. Everyone wants to dump training on foster mothers. [...] There has to be an alternative to this, so that this is not working now, this child can go someplace else.

Her emotional response to the situations she sees does not come with the realization that a well-funded, skilled care orphanage can only be a beacon to a child care system serviced by a corps of typically well-meaning, poor families that provide the foster care for children from the same socioeconomic background. She observes a parenting strategy of making a limited space even more limited for a child. The final coup is that the child is ignored emotionally from the perspective of someone who has seen ideal care and knows that a child who needs physical therapy cannot progress if kept penned in.

> I go into a project where the buildings are a disaster and they stink, and there is no room for the kid at all, and they are in the tiny little playpen the foster mother put them in. There is no room for the kid to move. There is no stimulation, [...]. There's no relationship.

In contrast with the dispiriting experiences, the ideal care given parentless children at the Pickler Institute is recalled by the physical therapist.

> Whenever a child is attended to, like in the changing the diapers, or their feeding or their bathing. They get one on one care. There is enormous amount of time given to that, those acts. So the child is talked to throughout the entire time. (I'm talking about) infants who might be one month, two months, three months old. The nurse, they call them nurses, are saying to them, "Okay, I am going to pick you up now. I am going to take your diaper off. I am unbuttoning the diaper." And they are always [...] looking for cues and reciprocal attention from the child. [...] The quality of that attention is what their staking will eventually enable the person to lead a functioning in life even though they've been abandoned, even though they're in an institution, even though they're going to be adopted by someone they met before.

This person reported no early childhood memories relevant to transdisciplinarity other than that she was steadfast in the eyes of her mother. 'She said, "I was very strong." She said, " I'm a pillar".'

Her strength and supportive nature did not prevent loneliness. Individual columns stand alone as they support roofs in supportive rows called colonnades. The word support appears in the she continues in the next narrative.

> I was looking for more like-minded community. To kind of support the approach I was using in my work. [...] I was looking for people who understood the complexity of the work. I was working at places that weren't very satisfying so I needed to just put a little life into what I was doing so I chose to do the Institute. (Speech 4)

Part of her dissatisfaction with work was about her sense of professional isolation. As was mentioned earlier by Carola d'Emery, a physical therapist who includes IMH in her work, there is no title for physical care providers who work with emotions (Hochman & d'Emery, 2006b). Therefore, they cannot refer to each other with the same title. People who work across disciplines tend to feel alone and seek support from distant sites or exemplars (Lynch, 2007) such as special places such as Pickler or famous people in the field. We already heard about one person's interest in Brazelton's work.

For one respondent, deteriorating working conditions led to feelings of professional isolation when working conditions led to a loss of collegiality in New York City's EI program, in the late 1990s. At first, EI in NYC had some sense of a larger mission beyond physical care. In those days, EI included a formal infant mental health practice by having mental health supervision or what the IMH people call reflective supervision where one gets a chance to reflect

on one’s inner state and one’s practice or have questions answered about the dynamic of the family.

> But I should say that before I did the Institute, the agency, the EI, it was like a different species back then. The service coordinators that were involved in my cases were social workers, so I would call them for help with some dynamics or for kind of checking in. So there was sort of like an informal supervision/supervisor process that was going on that sort of helped me to engage in that way.

The sole physician in our sample describes her solution to professional isolation. To offset her unhappiness with her colleagues she tells how she had already found her place in the world of child development and infant mental health:

> I also found going to the Zero to Three[1] meeting, I used to pretty much [go] every year when they were in Washington. The baby people were so welcoming and so interacting. You could sit down next to anyone and start a conversation and talk about what they did. I was much more comfortable with baby people than with doctors. I say now on occasion to a colleague “I'm more interested in the mental health,” and they just look at me. They don't have the foggiest idea of what I'm talking about. Not all of them, but most of them. (MD1)

Like the previous speaker, the next interviewee’s work moved her to the frontier of speech therapy and clinical psychology. She calls it a “gray area”.

> Well, you mean before the Institute? At the time I was one of the very few therapists that work[ed] with newborns. So when you work with a newborn, it’s like a six-week baby, you know, the baby is very sleepy, so its feeding but there’s a lot of time, and at that time you had hour sessions [in the NYC EI program]. So it was a nice amount of time to do both. So there’s always a dialogue back and forth with the parent, and with a newborn there’s certainly plenty of opportunity for that, and we had an hour in those days. So it felt like enough time. It felt natural, like that’s what you had to do when you’re working with a newborn. […] There is that gray area where you’re not going to get anywhere

[1] Zero to Three is the popular name for the National Center for Infants and Toddlers, a clearinghouse for research and practice in attachment and child development. NCIT organizes annual training institutes. The website is ZerotoThree.org.

> unless you can engage the parent. [...] But there has to be, there has to be a dialogue between myself and the parent in order for that to happen. I need feedback, I need to know how they're feeling: are they comfortable, what adjustment do they need, let's see what they're observing. It's a dialogue. And with that there's always the subtext of, you know, "I'm worried, I'm scared, this is uncomfortable, how do I know if it's working," that kind of thing. (Speech 2)

For several respondents negative work experiences led them to modify or disavow their original training. The respondents could not tolerate a narrow or local focus on the job but had nowhere to go with their problem. One reason, as noted earlier, is that no title or job definition exists for the kind of role the respondents wanted to perform. One way out of the dilemma was to volunteer. In the next narrative, the speaker was first assumed that she was in the wrong profession. Subsequently, she charted her move from a local speech pathologist working with children to a transdisciplinary practitioner rooted in uniting two professions. Her sense of speech and speech therapy grew to include the child's mind, parent-child relationships and family systems as part of the therapeutic picture but she could not find a place for her vision in her training when she first realized her professional predicament. The story is detailed because she became aware of her professional needs as her career proceeded.

In fact, her desire to separate from her narrow role as a speech therapist who worked solely on oral motor aspects of speech came up as the tape recorder was being readied for her interview. The tail end of that conversation and journey made it to the recording. "Because I'm not that interested in the aspect of speech therapy that would address itself (with the physical organs of speech)." (Speech 2)

Her detachment from the physical organs of speech and interest in child development began with an involvement with the emotional "inner lives" of children. Here again, the artificial separation between the fields has to do with lack of titles and vocabulary for

transdisciplinary practice. Lack of titles and professional vocabulary make it a challenge to discover the new way of working. Creation is a kind of burden due to the novelty on the practitioner's part. Paid local work led to volunteer work because it was less restrictive. That freedom gave her the opportunity to make an inner discovery on the job in a hospital. She made the following discovery of the mental health aspect on the next job.

> [F]irst of all, I never thought about treating a child who would be under two years old. […] I certainly didn't have any idea about treating in the context of the parent-child relationship; that I'm looking at the whole relationship that I'm dealing with the mother or the caretaker and the child together. [...] I didn't look at it that way. And I just didn't have the depth of understanding about what development is all about. […] It's a rehab institute (The Rusk Institute), part of NYU Medical Center. And I worked there. They had an adult division where I worked for 6 months. Then I rotated into the child division, and I never came back because I said, "Children, that's what I want. Children!" But I worked with the children, they were in the hospital and they would come in they were kids who had had rubella. They were kids in wheelchairs. They had all kinds of symptoms. But I never saw the parents. I never thought about the parents. It was, "Bring this child in and teach him how to speak." From that job, I went to a job with elementary school children at the Edelson Center for Child Research. This was already part of the Jewish Board. It was one of their divisions. And there were children who were considered schizophrenic at the time. So now there's a whole mental health component here. (Speech 2)

Although speech therapy became a distant interest she never completely abandoned her training. Nonetheless, she saw her initial training as hindrance. Alternatively, she had no problems relating to scope of practice. She found a way around scope of practice limitations by volunteering. Ultimately, her psychosocial education continued until speech and socioemotional development were combined.

> I volunteered at a nursery at Mt. Sinai. It was in the psychiatric department. […] But what I wanted was to be freed from speech and language. So now I was just interacting with little kids in a therapeutic nursery without any responsibility for their speech and language. No speech and language goals. […] It was a conscious decision. It was what I wanted to do. So then I really [...] didn't care about anything [related to speech]. I had my

> language background in my mind, but my focus was on [...] engaging the children. [...] And I would listen at the [...] staff meetings. […] And I felt like they missed the language piece, but I was attending to the psychological piece. […] And it was a pretty psychoanalytic place. They missed the language piece. They didn't know about language. But I was learning about the emotional […] And then [...] I went to visit the nursery at Montefiore which was a parent-child nursery. […] And it was Doris Allen [a]nd Lois Mendelson. […] Doris was a language person. Lois was a social worker. They were combining language and attention to the emotional life of the child. [...]. Every child received not only language therapy, but play therapy as well. So it was the first time I saw that model. And I spent some time there, and I liked it. (Speech 2)

Her desire to separate from speech therapy continued despite a seeing a vision of workplace holism where a transdisciplinary space was created. She continued volunteering in another therapeutic nursery and previewed a new role for herself. In referring to the birth of her last child, she talks about her own professional rebirth.

> Rebecca (Shahmoon-Shanok, Director of the IPSC) called me into early childhood group therapy, […] I was not there as a language therapist. It's like the time that my youngest son was born. I took off from work and had the freedom to explore. I released myself from all of my speech and language responsibilities. (Speech 2)

Volunteering and Role Release

Volunteering is a special type of work that is less constrained than paid employment. New possibilities can open up when there is no job description to fill. That state of affairs makes it ideal for cosmopolitan workers and is a species of role release as was just shown. For similar reasons, another respondent volunteered at the Yale Child Study Center. To live, volunteers still need time and money. Although we did not explicitly explore how respondents who took the volunteer path supported themselves while they volunteered, the related issues of time and money emerged in other ways. Several respondents were financially well off, with comfortable homes where interviews took place. They could afford nannies to mind their children when they

volunteered or attended the IPSC. Alternatively, one respondent's employer paid the tuition to attend the Institute as well as continuing the day's pay for the weekly classes at the Institute. Another was fortunate enough to have a place of work that satisfied her need for transdisciplinarity.

> But I ended up in the children's rehabilitation center. It was there I got much more broad exposure to other aspects of children, besides just medical pediatrics: OT, PT, speech, education, social work. So, I've always been most interested in a very broad definition of what I do. [...] I ran a grant-funded program to try to coordinate care, get different doctors to talk to each other, and it was called the Tertiary Multi-Disciplinary Service. [S]o I was in pediatrics, but I also had a pretty good introduction to education and special education. I came out of pediatric rehab. [...] There weren't many specialists there, so I was not one to have exactly a body of information which was just developmental pediatrics, but I saw children with many kinds of medical problems. They would ask me to be involved with the most complicated children who required many different medical specialists, to try to set priorities and try to integrate and coordinate. I say I was a coordinator. (MD 1)

Felt Need for Mental Health Training

The next example of intentional interest in mental health practice was the respondents' acknowledgement that they needed training in mental health. The line practitioners could have skirted training. This freedom has to do with the nature of much early intervention work which takes place outside the hospital or other health organizations where supervision is more consistent. For the most part, therapists in the early intervention system work on their own in the home (Rapport et al., 2004). They are free to use standard and non-standard treatments as they see fit.

One speech therapist released herself into the role of a counselor and dropped her role as a speech therapist in this incident prior to any mental health training. Here she describes the event and the experience of wanting to be free of her role as a speech therapist. The psychological stream arose from underground despite her discomfort with it. She did not feel

limited going well beyond her scope of practice as speech therapist. She had the example of her husband, an occupational therapist, who went through a similar struggle

> Well, it was very uncomfortable, I mean, you know, I think I felt like I had to justify my time being there, so I would try to engage the baby, and it was very difficult to engage the baby, there was a lot of soothing involved in the sessions, and at the same time there was this parallel soothing of the mom. And so it always felt, like, I was having to justify my role as a speech therapist and then at the same time balance the needs of this mother. It just felt, I kind of felt a little fraudulent. I kind of felt a little uncomfortable but then at the other hand, it felt like how could it be fraudulent because this is what's needed in the situation? And it just, you know, it was a little hairy. I found myself wanting to associate with speech therapy less and less. […] My husband's an OT and a social worker, and kind of felt the same way that there are such constrictions to your obligations under those licenses. But we both wanted more freedom.

Other respondents shared what they saw as the perceived narrowness of their own profession but at the same time felt their own limitations. Thus, one OT talks about her difficulties in working the larger issues of the mother while she was conducting an OT session from a DIR[2] perspective. She was having trouble conducting sessions that kept both the physical and psychological goals in mind. Like the previous speaker, her discomfort did not dissuade her.

> She would come in, and I felt the focus of the therapy was more on her than on my working with the child. I was trying to use a DIR frame of reference. So I really invited this mother in, but the idea was that I was sort of a coach. [...]. You're a kind of a coach to the mother. So you bring the family in by helping the mother learn about what you're doing. But maybe the idea of being a support to the mother is beyond what DIR would necessarily suggest. […] So she would come in and she would always have a million things to tell me. So I would kind of get the child ready with some kind of obstacle course, and she would go through this thing. And then I would try to incorporate the mother into the play, so she could feel more comfortable playing with this little girl who she was just not comfortable playing with. And there were moments when it was kind of uncomfortable, because her focus was to unload and talk about the child with the child there, and that also was not great. And my focus was to try to engage this mom in play and teach her about what she could be doing at home with this sensory stuff. […]

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[2] DIR: Developmental, Individual-difference, Relationship-Based Therapy, popularly known as floortime (Greenspan, 2006). DIR uses developmental theory and interactive play to reach autistic children.

Ultimately, the mother did participate in the therapy and likely carried it out during the times between sessions. The therapist still felt uncomfortable in role despite her effectiveness in engaging the mother who made her uncomfortable. As the mother carried out the important indirect therapy when the therapist was away, the therapist could have given the mother more time but the respondent did not know how to manage two patients at one time. She could not put the body of the child and the mind of the mother together. “She did. [...] I helped her to understand her daughter more. But I think I needed to figure out a way to, on the one hand allow myself to be supportive to her and at the same time maybe move it outside of the session.”

One respondent’s experience shows both the desire to work with feelings but recognition that she did not know how to do it. Working as a community-based, mental-health nurse, she recognized her inadequate previous training.

> So, I was going into the community. I liked working in the community. I worked on in an inpatient clinic. So, I had a lot of experience with the inpatient unit. I was the only nurse on this crisis team and managed [...] the walk-in clinic. So, by the time I came to the Institute I had a lot of experience, you know, in terms of mental health, but I did not have a whole lot of training. (Nurse 2)

Another respondent, a professor of speech and language pathology, looked back at her early days of clinical practice. She had already moved into the relational sphere in her practice and she states the importance of relationships in her past work with families. That experience also raised legitimate concerns about working without training. Now, as a trainer of speech therapists, she thinks that the current, standardized speech and language curriculum does not include enough training in the relational features of speech therapy. She linked her desire to inform her students about the hidden dimension of the mind, available to psychologists, to her

experience in therapy and its relation to her family. Her reasons bring us back to the theme of mothering, family and family care introduced in the childhood section as well dissatisfaction with the primary profession.

> I had a long-time interest in the importance of relationships in speech and language pathology and I really believe that the clinical work I did was good because of the relationships I encountered with clients and families. So I had an interest in this for many years in addition to my own interest in psychotherapy, my own therapy, understanding myself, my son. [T]he discipline specific nature of the field left some things to be desired that students need to know about. [...] I had two reasons [to enroll]. [I] wanted to integrate reflective supervision into speech and language pathology. [...] I had read a lot about it, and I wanted more training. I wanted to get supervision and I wanted to get training with people that were experts in reflective supervision. (Speech 1)

Instead of seeking further specialization in their original fields, study respondents chose to go in the direction of mental health training. This theme appeared in the narratives about volunteering, but not everyone could afford unpaid work. Their desire took the form of role expansion at work and consequent struggles.

> I was going into the community. I liked working in the community. I worked [...] in an inpatient clinic. [I] had a lot of experience with the inpatient unit. I was the only nurse on this crisis team and managed [...] part of the walk-in clinic. So, by the time I came to the Institute I had a lot of experience in terms of mental health, but I did not have a whole lot of training. (Nurse 2)

As her career progressed, her direction became surer but others felt she needed more seasoning since she lacked mental health qualifications for clinical work. Her BA in psychology and experience on her job at Bellevue were not sufficient seasoning in the view of her employers. But she followed her employer’s advice and kept her eye on her goal.

> The thing is when I moved from Bellevue to St. Vincent's and I wanted to work in psychiatry. I had to work for a year in med/surg. 'Cause they didn't want to put a younger graduate in psychiatry. They said, "No, you need to broaden in yourself." So I did that for a year and transferred into psychiatry. (Nurse 2)

Sometimes, the need for more training arose because colleagues did not share the respondent's vision. As we have already seen, one speaker was unhappy with her colleagues but she had found a place for herself in the world of child development and infant mental health. "I say now on occasion to a colleague "I'm more interested in the mental health," and they just look at me. They don't have the foggiest idea of what I'm talking about. Not all of them, but most of them. (MD1). The next quote shows how another respondent saw her next step because she realized that her work already included much counseling and saw her next step. "Well I was doing a lot of EI and I found that I was doing a lot of talking and counseling in my sessions." (Nurse 1)

In the next narrative, we see an example of how a respondent went deeper into the relational realm without training. She grasped the internal or relational issue but others could find themselves over their heads when they tried to go into that dimension. Earlier, a speech therapist talked about being in a "gray area" between her training and her actual mental health practice. Now, we hear about the two poles of physical and mental health care and what happens when the therapist cannot merge them.

> I found myself at a loss, because I did have a very interesting case which would have been a perfect case to blend the two and I bombed. It was a mother who wasn't sure what was going on with her infant daughter, and she contacted me because it could have been sensory or it could have been physical. I felt, I saw right away. […] I saw right away was that this mother was very anxious and there was something going on with her. [...] She seemed like she was nervous to engage this child and understand this child and just be there. [...] But what did I do? I gave her a list of sensory ideas, you know, and while I felt like I kind of had a handle on [...] the fact that there was something going on between the relationship with the baby and the mother, I didn't really know how to address it other than reverting back to my OT self. […] I think I needed to feel confident in the fact that I could... that she was confiding in me, she was talking to me. [T]hat was ok and [...] that

> was important, and that I could be the person that she needed at that moment, which was really just a supportive ear most of all. In my mind I was the OT. I needed to do my OT things. I guess I wasn't comfortable taking as much time as we did. The mother would talk to me for sometimes half the session. I was working with the child and I thought I had to make sure I was meeting my OT kinds of goals. (Movement 4)

Journeying or Broadening

That all respondents had to travel to take additional trainings in mental health and traveling for trainings was another sign of how avidly program participants wanted to intentionally expand roles. In the narratives presented earlier, we heard about one respondent going with her mother, a visiting nurse, on her rounds in a Model T ford. People went out of their way to volunteer and to go to conferences. They also had to travel to trainings such as those offered at the Zero to Three called National Training Institutes.

The feeling of wanting to be free of one's role also represents a kind of departure. From this perspective, all trainings in another role are journeys. Journeys have a basic quality of going from here to there. The experience of the respondents can be considered from going from local to cosmopolitan practice. However, the drive to become transdisciplinary appeared so early in the process that it is fair to say respondents had this desire deep within them before coming to the IPSC. If the process is looked at in terms of expanding roles we might have more insight into their process. Expanding out is a centrifugal journey that expands scope in a way a spiral expands outward encompassing more and more space. The idea of a circular journey just came up in the preceding narrative that expanded the narrator's experience. She could only go so far on her own without additional training. Broadening, a related word in this kind of description of role expansion, is another kind of a centrifugal journey. It, too, starts from a center and moves outward as we hear in the next narrative. When someone broadens they can contain more space.

Transdisciplinary space gets created as experience broadens. “They said, ‘No, you need to broaden in yourself.’ So I did that for a year and transferred into psychiatry.” (Nurse 2)

In order to broaden themselves, the graduates undertook additional study and training. We heard from the respondent who traveled to study with Brazelton. The following respondent’s training in Developmental, Individual-Difference and Relational-Based Model therapy (DIR) developed by Greenspan and Weider (2006), a method of working with autistic children, led to her reexamine the underpinnings of her professional background. She had to travel to Maryland to the Interdisciplinary Council on Developmental and Learning Disorders, the DIR headquarters, to develop the skills she wanted. DIR training broadened her therapeutic perspective. Here she reflects on a case that occurred before she attended the IPSC. In this narrative, the word *sensory* refers to a neurological problem associated with atypical responses to touch that are managed with desensititizing exercises.

> I was feeling like my practice was not broad enough. I wanted to broaden the perspective of the way I deal with kids. Families, I knew, probably, starting from the DIR training, that there was more to working with kids than providing sensory diets and giving families suggestions on how to handle things. (Movement 4)

Expanding the circle of practice also meant expanding the circle of professional acquaintances. Apart from the need for continuing education credits that all professionals must obtain, the Institute graduates also needed to meet people who shared some biopsychosocial perspective to help them manage the loneliness we discussed earlier. Meeting others also involved traveling and volunteering together. The OT who just spoke found that even in the famous Yale Child Study Center, where much multi-disciplinary pioneering work had been done, professions could remain in silos. However, while volunteering there she began to see how mental health professionals work.

> I was on a team that looked at birth to five year old children that had different kinds of emotional issues. Sometimes they were on the spectrum. And it was a team. Supposedly it was a multidisciplinary team, but it really wasn't. It was mostly social work students and a psychiatrist. And I think they were interested in having some OT perspective so they invited me which was very interesting because I got to hear this whole other psych piece. […] I still wonder how it would have helped, because I feel like nobody's really thinking along this trans-disciplinary, in this trans-disciplinary way.

A nurse mentioned in-service trainings, attendance at conferences including those out of state. The speaker is referring to the Bank Street Infancy Institute, an annual event at the Bank Street College of Education in New York City. This Institute offers workshops and lectures across disciplines for professionals working with young children. The first trip took her from Mt. Vernon and the second to a seminar in Maryland for occupational therapists.

> Well, I attended a lot of conferences, and had some training of my job before that. […] Well, for example, we went to the 0-3 conference, and Bank Street Parent Institute, and off the top of my head we went to listen to Georgia D________ in Maryland. [S]he's an OT, does a lot of sensory integration stuff.

Trips that started in the town of Mt. Vernon in Westchester County, just north of New York City,and went as far as Manhattan and as far as Maryland are hardly voyages but they represent desire to expand knowledge. The speaker is married with children and taking the time is part of the trip. Like another respondent, she is probably busy but still makes time for what she feels is important. "Really it is time, I am booked out. I feel really booked out. I feel extra booked out." (Movement 3)

One popular destination for training is the National Training Institute (NTI) provided by National Center for Infants and Toddlers (NCIT), better known as Zero to Three (ZTT), the premier organization promoting the policies, research and practices that undergird the infant mental health perspective. Along with publishing a journal, books and a useful website, NCIT

provides policy, administrative and clinical workshops at their annual NTI. The meetings allowed the respondents to meet with people who shared the same developmental and psychological perspective regardless of original orientation. The developmental pediatrician was already introduced to an integrative perspective during her medical training well before she made her way to the IPSC; the NTI was part of her self-directed training. We presented some of her early training experiences and readings but she still needed living, breathing colleagues so she went to the NTIs as was shown a few paragraphs earlier. IN that quote, she mentioned what she felt was a lack of emotional understanding that was endemic among her physician colleagues but doctors' personalities were not the only impediments to the lone physician in the study. She observes the lack of room for emotionality is reinforced in conventional pediatric practice. First, she reflects on there being no legitimated room for physicians' emotions. Much earlier, we heard talk about the need for space from the PT who worked with many foster families where lack of physical space matched lack of emotional space. For the intrapersonal transdisciplinary practitioner, the interior space and the need for it to be matched externally can sometimes go hand in hand. We hear this from the next speaker—the need to go somewhere to grieve, both internally or externally.

> I have something else to say about medical training, particularly pediatrics. We're trained on, in institutions or mainly children's hospitals where children are very sick, and they die. There's no generally there's no acknowledgment of how the doctor feels. How they feel that they've failed. It's just: "Oh, that child died. Now we'll go on to the next child." There's no closure at all. I think that doctors, pediatricians, it's a self-protective mechanism to protect yourself from overwhelming feelings that you can have. There's no recognition of that.

It is commonly thought that physicians and emotions do not always go well together as she describes. Significantly, she discusses the problem in terms of architectural space in relation to grief. Neither the family of the deceased child nor the caregiver has a physical place of solace.

> There's very seldom even a memorial service. There's not even a place -- or there wasn't at the children's hospital in the whole building. Perhaps it's better now -- but there's no place for a family to grieve. They'd be out in the hallway, moaning and screaming.

She continued discussing the idea of space. One architect, probably following hospital industry standards, designed a new children's ward with a reductionist view of space. He probably focused on airflow and workflow. Someone willing to see what a spacious children's ward would like could go back to 1897 and see the photographs presented by Dr. Chapin (Chapin, 1897). There was plenty room for children and parents. The ward also included a dining table for recovering children and rooftop playground. Dr. Chapin had no other title than pediatrician but he was a pioneer in a relational therapy that led to the end of a failure to thrive epidemic that ravaged America's industrialized, east coast cities for decades. His reforms and observations can be read in the paper written in 1897 and expanded in 1915. The respondent continues with her exploration of the need for space. In her view, there is barely space for the patient and none for the patient's family.

> The university built a new [...] intensive care nursery, and each baby had like 3 sq feet of space. [I] went in and I [...] (she choked up here) said to the man who built this [and] was very proud of this. I asked, "Where's the space for the parents?" He just looked at me. It's like the parents don't exist.

Being Mentored

Mentors supported the respondents' desire for role expansion. Mentors saw the actions, heard the questions and complaints. The following example of recognition by a mentor happened at the Yale Child Study Center. For the respondent to take up the suggestion of going to the Institute in Manhattan, she would have to travel from Connecticut.

> She is I think one of the main players in infant/parent research and I've developed a relationship with her and she was a wonderful teacher and I think I always had it in my

> mind that this was an interesting field of study. So maybe that was in the back of my mind and I was always drawn to it, to psych kinds of things. And I participated as a volunteer on a team at Yale. And the leader of the team, Linda May, suggested that I look into the Institute.

More commonly, respondents came into contact with people affiliated with the IPSC. The next two speakers made direct connections to influential Institute leaders.

> I was working indirectly with a psychologist who runs a clinic in the Bronx, with infants and toddlers, and she introduced me to Dorothy Henderson (the assistant director) who was looking for somebody who was working in foster care at the time, and I was, and that's how I made the connection. (Nurse 1)

> I had a supervisor who wasn't a good manager. I'm a good operations person. She was not. But she was brilliant and had great ideas. I don't say that as a negative thing, just. So things kind of run amok on her. So she really understood child development. She was very big in 0-3. And she reflected. She was very big on reflective supervision. She tried to bring it to the VNS, to these nurses. I wasn't, my group wasn't nurses, they were early intervention people. The other group was nurses and trying to get them to reflective supervision. She really tried. And there were social workers in the early intervention who were part of the group who were helping with that. You could just see how impossible it was. These were just sort of died-in-the-wool, old time field nurses. They just weren't moving. So I had her as a role model, and [...] he's famous at the institute, David Jones. He worked with the VNS. He had taken the program. I needed to do something, like now, I feel. I need to do something for my brain and my development. (Nurse 3)

Another interviewee reported her that she had multiple mentors who responded to her awareness of her need for mentoring. She is the speech therapist who went through many volunteer positions. At her last stop, she volunteered on a project called Early Childhood Group Therapy (ECGT), run by Dr. Rebecca Shahmoon-Shanok who currently directs the IPSC, which did not exist then. At that time she became a therapist-in-training working with a psychologist for hands-on training.

> Because her [Dr. Shahmoon-Shanok] interest is always merging the fields. Bringing different people in from different disciplines and giving them this mental health piece. I think, as well as, as well as mental health, learning from other fields. [...] I had a co-therapist. I think I would have been really scared without the co-therapist, because she

> was a psychologist. [W]e complemented each other very well. I just felt that I was learning so much there. (Speech 2)

It was no surprise the Dr. Shahmoon-Shanok took interest this respondent. Two other professionals practicing transdisciplinary work spotted and trained her as she told us earlier. They showed her that speech and mental health work could be effectively combined. Her unique interest, ability and training must have been obvious to someone like Shahmoon-Shanok who was already on the lookout for people who could mix disciplines. However, the respondent felt it was necessary to take her training one step further and unite the transdisciplinary “team” within her. That inner unification, the creation of a transcendent, broad, intrapersonal transdisciplinary practitioner could only happen with training for the role.

Enrolling at the Institute

The themes of having discretionary time and making contact with transdisciplinary colleagues continue as the respondents began to decide to enroll. Two respondents were between jobs after long careers. They were both married and likely qualified to collect unemployment insurance. The theme of sufficient resources reappears here. “In 1996, when the Institute opened, and I had just been downsized from my job, it was good timing on both aspects. I had the time and interest to start at the Institute.” (MD1)

Personal contact with someone affiliated with the Institute was part of the enrolling experience for several. We heard already about the speech therapist who was already being eyed by Dr. Shahmoon-Shanok. Earlier we heard how contacts in the Yale Child Study Center facilitated enrollments. Two other stories of personal contact were heard. One concerns the IPSC Director, Dr. Shahmoon-Shanok and the other, the Assistant Director, Dorothy Henderson. For a second respondent, having time, in concert with a good impression of the program’s director, Dr.

Shahmoon-Shanok, made it possible to attend. Past experiences begin to impinge on present conditions and the world got smaller getting smaller. Psychology begins to get personified or identified with a person and access. Personified ideals are part of becoming a person with multiple roles according the Lynch (2007) In the next two recollections, the speakers refer to Dr. Shahmoon-Shanok, the program director and Dorothy Henderson, the assistant director and a clinical social worker.

> So then I got downsized from that hospital. And it was right at that point that I got information about the Jewish Board starting this program. I had been going to 0-3 and I had heard Rebecca speak at one of the 0-3 meetings. [...] I was very impressed with what she had to say, so I thought this would be the connection. (MD1)

> I was working indirectly with a psychologist who runs a clinic in the Bronx, with infants and toddlers, and she introduced me to Dorothy Henderson who was looking for somebody who was working in foster care at the time, and I was, and that's how I made the connection. (Nurse 1)

The next speaker saw enrolling in the program represented a natural progression in her career interests. It made conscious sense in the scheme of things for her. "I was looking for more theory; I was just looking to increase my knowledge to be a more transdisciplinary therapist." (Speech 4)

Some respondents reported, an instant decision got them to fill out the forms and enter the door of the IPSC. The previous speaker had wanted to go to the Institute, but her incorrect understanding of the requirements appears to be what, at first, kept her from signing up. Then, she made an instantaneous decision to enroll.. The following recollection that follows hers also is a snap decision. Nurse 1 recalled this experience: "[A]nd then the Institute sort of came across

my desk and I decided that it sort of made sense." (Nurse 1) Movement therapist 5 recalled her inner experience prior to a sudden decision to enroll.

> I called the Institute and got the packet and I was reading it. It just seemed to, again, look at all the different aspects of a child. [...] I've always had an interest in the total child. [S]o all of the sudden, I remembered that I did enjoy that a number of years ago as well.

Peak Experiences

Some respondents reported *peak experiences* or epiphanies that precipitated enrollment. This section will present and discuss three peak experiences related to transdisciplinary work described by the participants. These experiences are discussed apart from the chronology which is the primary organizing feature of the narrative because the intensity of the experience needs exploration that can occur only if they are grouped for analysis. Though the experiences are analyzed apart from the overall narrative they still fit in the narrative and simply represent intense versions what was already presented in the narrative context. In order of presentation, the experiences fit into college experience, work experience and volunteer experience.

The experiences add support to the contention that they shared an unconscious stream of desire to work psychologically in a physical context. Their reports reveal an element of intersubjectivity with very young children. Earlier manifestations of hidden drives to the practice of psychology took the form of early childhood experiences, marriage to psychologists, dissatisfaction with the limits of the physical care of their original training and the impulse to see the inner workings of the mind in relation to physical care, or in some cases, attempts to move away from physical care. The idea of inner and hidden drives supposes a kind of suppression (Hyde, 1998, p. 108-109). Hidden drives can lead to strong eruptions when a ripe fullness and meets with piercing spark. Seeing the peak experiences as part of the maturational or "ripening"

process is another reason to view enrollment as an expansion as well as a journey. The desire to work with the mind-body was already there but it had to grow in nurturant conditions and, professional experience, in order to express itself fully.

Three people reported peak experiences that we will call *illuminations* based on the terminology proposed by Moustakas (1990) . Moustakas consolidated ideas of some integrative thinkers including Polanyi, a philosopher of science and student of intuition, along with those of the psychologist Carl Rogers to create a template to explore the sudden apprehension of integrated knowledge. The process starts with a period of questioning and involvement with a problem. The respondents had long periods of questioning their training and work. This period is called *incubation*, a period of having the necessary information enter the cocoon of the mind. The illuminations, for the respondents, also are preceded by some release from ordinary work demands and were expressed as volunteering and free time. Referring to Rogers, Moustakas says moments of intense interaction are the basis for personality change. We can consider profound changes in professional outlook as personality change because such experiences drove the professional behavior of the respondents.

The experiences these respondents reported refer to these periods of incubation and interaction. We are considering hard work and hidden feelings and, in two cases, decades of practice and professional maturation leading to dissatisfaction. The dissatisfaction was based the dissonance with the way they were trained in professional school and their experience as practitioners. Seeing the dissonance in terms of fullness, the impulse to work in an unnamed style met lack of words for the style and ability to work in that style. The respondents who wanted to be free of their profession or regretted their professional choices simply were limited and they struggled to find that way out until people came along and helped them as family

members who were psychologists, mentors and teachers at the IPSC. Inner struggle needed outside help but sometimes there was no outside help and the help came from within.

The three peak experiences that occurred prior to enrollment will be presented. These experiences, and more that will be presented in the next section, came as complete surprises to the interviewer. The experiences arose in the interviews when respondents relaxed the conscious part of the mind that is engaged most of the time, a process which allows a deeper and more integrated view of a question or problem. This relaxed mode of thinking is part of the incubation experience. The interviews are placed last because, like the snap decisions, they represent a foundation of ordinary experience that lead to unconscious questions that needed to be resolved.

Attachment theorist Daniel Stern (1995, pp. 108-109) explored what happens with the relaxed mind in detail. He was interested in the mother's ability to suspend her normal mental activity and reach deep in her usually unavailable unconscious mind to come up with a parenting solution. Speaking phenomenologically, he calls it a *way-of-part-of-the-self's-being-with-another-part-of-the-self*. Stern goes on to say that this experience involves a brief withdrawal of the mother's attention from the baby in order to reconnect in a deeper way.

Illuminations, in our study, can thus be recognized as a personal transdisciplinary moment where technical and social science information connect in a moment of insight. The experience is associated with some period of withdrawal as were many of the learning experiences of the respondents. The idea of withdrawal from work already appeared in the context of learning, travel and volunteering. For simplicity of expression, we will use the word illumination rather than Stern's construction. The experiences are examples of intrapersonal transdisciplinary realization that Pfirman and Martin (2009) say exist. They say that

intrapersonal transdisciplinarity involves integrating disparate information. However, they provide no examples, only taxonomy.

They suggest two classes of peak experiences. The first of these are the snap decisions that led some respondents to enroll. These are relatively small illuminations. The people who, upon recollection, simply decided to sign up with IPSC saw the decision as part of their professional evolution in the moment. The realizations made sense in a logical way and the respondents gave themselves rational reasons for their decisions. For this group of respondents, past and present streamed together in a gentle way like a small mountain brooks merging here and there into a river. The moment did not determine any change in career. Snap decisions would not have held special interest that required the background on the topic but a more intense variety of peak experience emerged during the interviews. The small peak experiences provide additional context for the big experiences. The intense illuminations that are about to be described are part of a spectrum of intuitive decisions that led to enrollment and other intuitive practice insights that were presented throughout this section in the narratives.

For the following three respondents, something deeper coursed and another way of knowing appeared in the form of profound integrations of realistic and anti-realistic science in relation to early childhood. The first illumination occurred while the respondent was training to be a physical therapist and the experience falls under the heading of college experience. There, she was introduced to the Feldenkrais System as part of the curriculum. The Feldenkrais System is an alternative mind-body approach. Like other respondents, she already had some interest in psychology during college. She was already described herself as “bent” in this direction. This interest expressed itself in a four-year, post-graduate training in the mind-body Feldenkrais methods. This PT placed her insight during a moment during the training. The illumination is

about a link to a preverbal time in infancy. Here we see an intersection of training in an actively pursued interest and two years of attention to developmental training in infant postures and movements as she grasped a professional path and viewpoint that led her to pediatric specialization and, eventually, the Institute. The need to be able to expand is expressed in this narrative by phrases about not being interfered with.

> In the Feldenkrais training, it is a very developmental work. We spend the first two years […] on the floor in developmental movements we did as infants. And during that time, I had this sense. It wasn't a dream. It wasn't a memory. Maybe it was really an implicit memory, one of those memories that you have before you can explicitly describe it. It's a movement memory of that [...], being supported well. [W]hat I mean is, [being] given [...] the space and the room to be on my own and not to be interfered with, not to interfere with that process. Not to be overly held. Not to be overly supported, not to be overly led on. […]. I had never a deep interest in pediatrics. It was not my bent in PT school. [B]ut after this experience it was like a magnet to me. I thought I really needed to do this because I felt that our profession wasn't really supporting, honing in on how to be therapeutic with these kids without being interfering. That's what I saw as false, this tremendous amount of interference with the developmental process. That I felt was creating a serious problem. (Movement 3)

The second and more profound illumination occurred to a nurse during a cessation of the NICU's (neonatal intensive care unit) therapeutic rush. The nurse practitioner recalls her peak experience in relation to her usual mode of working in crises by contrasting it with a calm moment with a child previously on the cusp between life and death. As the child strengthened, the pace of work slowed and the infant became a person, not a patient. She retrospectively includes references to knowledge earned later on at the Institute such as intersubjectivity and refers to Stern to describe her sense of communion with her resilient little patient. At that time in her career, she did not have the words to describe her experience. The lack of vocabulary is part of the reason the respondents felt alone. They could not share their experience in a professional, only emotional, way.

> I was used to blood pressures, resuscitation; really hard core critical and now I started to have insight about developing relationship and what the experience would be. Not only the mother but for the baby. And this is what brought me to the Institute. I remember, having an experience. I never forgot this. It was with a baby that was very premature and she was on the respirator for a very long time and we thought she was not going to make it. And she [...] started to get better. I remember sitting by the warming table with her as she was just getting extubated and looking at her and we('re) having this interaction and it was this element of intersubjectivity. And that was my first revelation into this whole area. […] And that's what actually what brought me to the Jewish Board. They were totally into this intersubjective experience that I got involved with: Stern's work. And I realized, "Oh, my God! I was clinically experiencing what he was writing about." […] That's what drove me to the Jewish [Board]. I am getting goose bumps as we speak now. I was just so not mechanically or robotically [working in my usual way]. I had to learn to respond immediately to a falling blood pressure, to a baby whose heart rate was dropping. I didn't have the time to be in this same interpsychic space with the child but as the baby started to get better we were having this connection. And I knew that the baby, in a sense, was saying to me "Thank you." […] I would be sitting by the warming table and I would be, just be talking to the baby and the baby would just gaze toward me and we are talking about very premature babies who didn't have the motor skills. […] This baby was probably 26-27 weeks. Way back then the survival rate wasn't that high. Now she's 34-35 weeks. She's much bigger. She's extubated but she's still on the warming table. I am observing her that she wasn't going to have any respiratory stress. Talking to her and touching her and watching her [body] language, and [her] just leaning into me. It was communication [...] And I observed that as the babies would recover with the parents. But I had this experience with the baby first and that's what compelled me to learn more about it

This nurse was surprised and emotionally moved by the baby's physical movement towards her. A baby that age and condition is not conventionally thought to be able to move and make eye contact easily. Earlier, we heard from the visiting nurse who had to explain to a mother that her prematurely-born infant had trouble focusing due to the early birth. Premature babies, often, cannot make eye contact for some time after birth. Surprising things can happen that appear beyond the diagnostic scheme when the child is engaged with the parent or the therapist. It is worth pointing out, that the nurse had no word for this part the experience either.

That is one reason why Moustakas (1990), in describing illuminations, invokes Rogers who thought the entire therapeutic experience was based on relationship. This idea is carried

forth by the proponents of IMH who think that emotional connections can help correct problems in the physical realm. When physical problems interfere with typical human exchanges, physical care informed by emotional needs remains essential.

The technical aspects of relational aspect of work with premature babies was initiated by Als (1982), a colleague of Brazelton's . Her work focused on addressing the developmental needs of premature babies. In Als' research, the emotional/neurological development that failed to place *in utero* could be initiated by learning how to read the baby and responding appropriately. The nurse hit upon one technique with Als' training approach Newborn Individual Developmental Care Assessment Program) (NIDCAP). Kelberb, Westrup, Stienqvist, and Lagerkranz (2002) describe how NIDCAP is used in some NICUs by nurses or occupational therapists to address shortfalls in development due to early birth.

The NICU nurse had her illuminatory experience on the job, which she could not have had at home. She is one of the women in the program who had no children of her own. Childlessness is another undercurrent driving some of the practitioners. Her acknowledged grief over her own childlessness and her love for children got funneled into deeply caring for other people's infants and for promoting good parental care. Children's problems and her sense of loss were combined in a current that led to her illumination. At this point in the interview however, she did not mention her own inability to have her own children.

> What you need is ongoing education, ongoing training. I had the two year post-graduate training [at the IPSC]. I had the training in the Bailey [Scales of Infant and Toddler Development]. You have to keep growing. But if you build upon what really excites you and what you feel passionate about and for me it's the mother-child, parent-child experience.

She herself linked her passion for children to her grief over being childless in the next passage.

> I think because my husband and I didn't have children, we couldn't have children, we had some pregnancy losses. I think I had to find a place to channel this nurturing and this real desire to connect and to make a difference with the parents that I've worked with; to help them know their babies and to have them learn about their babies apart from being part of a medical entity. They are not a baby with CP, they are not preemies. They're their babies and it's like that's the path God or whatever-you-want-to-say has made for me.

The final illuminative experience comes from the speech therapist whose role expanded during her volunteer work as she began to understand the inner world of children. She wanted to be free of speech therapy but could never quite leave. She now works on communication delays with autistic children. Her illumination occurred during one of her withdrawals from speech therapy and sojourns into volunteering in a mental health nursery. In the moment of the experience she had even ceased from volunteering. Instead, she was having some fun with her one year-old, her second child. This experience reveals the role of free time and parenting. It is also about expansion because, as we are about to see, her conception of human speech expands. Her experience was long in coming. Thirteen years of practice and intentional questing for alternatives beyond her basic training in speech and language pathology.

> So I was practicing since I was 23. So, that's what, 13 years? Thirteen years of practice. And I'm beginning to shift. It was when I had my second son... he's six years younger than my older son. I guess when he was born, the year he was born, I took off from work and I began to do the ECGT stuff. [It] was after ECGT, I'm not sure. But it was sometime when I was not working. I volunteered at a nursery at Mt. Sinai. [I]t was in the psychiatric department. I can't remember if it was a parent/child nursery. But what I wanted was to be freed from speech and language. So now I was just interacting with little kids in a therapeutic nursery without any responsibility for their speech and language. No speech and language goals.[…] It was a conscious decision. It was what I

> wanted to do. So then I really began to, didn't care about anything. I had my language background in my mind, but my focus was on, you know, engaging the children. (Speech 2)

She was playing with her new son and momentarily free from work as a speech and language pathologist. Even the burden of volunteer work was dropped in favor of time spent with her infant. Nonetheless, her speech and language training remained in the background like a lock just waiting for the long lost key. The key was made up of conscious experience, years of questioning and motherhood. She could also appreciate the difference between her typically developing son and the atypical children she treated. Finally, she figured it all out. Even so, she was like the NICU nurse who did not have the words or job title with which to frame her experience. She could not put a name to what happened but she had some insight into the way emotions and the ability to produce words were tied together as children began to acquire the meaning that underlies communication with language. Still, her path was clear. She needed to unite the desire to communicate with the physical ability to communicate.

> And there I was working with little children, preschool children. [A]t team meetings there was the social worker, the psychologist. I was getting a much more integrated view. […] So now I felt like I was beginning to address something more, like, interpersonal between the children and [...] my mind was beginning to open up. I have to tell you that a dramatic change, just in the way I looked at speech and language, came when I became a mother. […] So when I became a mother and my own child was a year old, I saw that in the use of one word, let's say "*ball"*, how much interaction and conversation we were having about the ball. How much was happening just between he and I. That was not happening with the children that I worked with. And it sort of said to me that something about this is what I need to be focusing on. This is what I need to be. Now, I was still not anywhere near what we're talking about but there was a shift. There was a shift in there. […] Yeah! Just like that. All this child has is a few words. We're only talking about "ball." "There's a ball." [...] And all he had to do was say, "Ball." Means he has the ball and he's delighted. Or, "ball," he's going to go get the ball. Or "ball," meaning throw me the ball. It had so many meanings to it. It was so much fun and so much pleasure sustaining the interaction, etc. So that was a turning moment for language therapy for me. […] And then, I think ECGT was just being recruited in a sense. I mean Rebecca [] recruited me. "Would you

> like to work?" And it was interesting. So I said yes. And then that was a whole other world.

Studying at the IPSC

This section describes the process of becoming a transcendent, broad, interpersonal transdisciplinary practitioner. The first narrative event in the process is a contemplative *silence* when confronted with clinical psychology and psychologists. Silence is followed by transformative experiences during the adult education process. It is as if the respondents were shocked into silence and transformed. The section ends with the presentation of more peak experiences. (By way of clarification, the respondents usually refer to the IPSC as the Institute and, sometimes, the Jewish Board.) With the tale come themes of *hierarchy* and *parity.*

Arriving at the Seligman Institute, the respondents enter the program with their dreams and experiences hoping to quench their covert and overt desires quenched. They arrive as state and senior administrators, medical service directors and senior practitioners in physical care but something happened once they entered a place of wish granting: a training program that gave them the chance to learn applied psychology. However, the presence of like-minded peers and the presence of mentors did not immediately offer comfort at first.

Potential mentors and colleagues could not overcome an initial obstacle. The respondents were, in fact, unprepared for the program. Despite all the prior orientations and fees, they had to pay something besides money to be initiated into becoming a transcendent, broad, interpersonal transdisciplinary worker. Before bridging any epistemological differences, they had an unsettling experience. Upon entering this place of expectations, they were first silenced.

Silence

Contemplative silence formed part of the initial transdisciplinary learning process. Many of the respondents quite literally kept still as the intensely psychological aspect of the program

became apparent. Despite all their prior readings, workshops, experience and attractions, they had never sat around a table full of mental health practitioners nor have they had the kind of training as the mental health practitioners. An interpersonal and professional chasm existed that first had to be crossed. The shock of seeing the gap was such that the respondents could not respond with words. Instead, they responded to the situation by withholding their opinions and what they knew. Recalling the prior narrative about the baby and the ball, respondents did not know how to accept what was being offered to them.

> First, I'm a very, very slow to warm up person, so I don't think I said anything in public in two years at the Jewish Board. I think they wondered if I could talk. So certainly in the 10 of us in group sessions occasionally I'd say something and it didn't resonate with anybody. I would make a comment and people just kind of looked at me. (MD)
>
> I didn’t feel…wasn't competent. I didn't feel like I would offer my insights if I had them. (Speech 1)
>
> That I’d never had anything much like that before because nurses traditionally don’t have that kind of supervision. In fact, I think we talked about that in supervision.[…] I guess talking about developing your own insights, is not something that we had a lot of back in a lot of supervision. […] I have to say, it wasn't completely uncomfortable. It wasn't. I think [...] having had a little bit of a background in attachment theory, and always being interested, I think I sort of hung back and took it in and enjoyed it. I don't think I felt, you know, I don't know, I don't think I felt in any way that it was negative, that I was outside of the field. (Nurse 1)

Only a few enrollees testified to having spoken during the first class sessions and names the program’s assistant director and director, respectively, as witnesses. One respondents recollection seems inconsistent with most of the rest of the comments that were collected.

> A lot of it came because we had - and I know every group feels they're unique- but I think we had a very special group, and I think if you asked Dorothy (Henderson) and Rebecca (Shahmoon-Shanok), they'll say that. From the very first night [...] people had various

> experiences in their life which you know they shared and that, you know, very easily it seemed. And that just grew and grew. (Nurse 3)

The comment from Nurse 3 contradicts the idea of silence at the beginning. A similar comment came from a physical therapist. She was not intimidated when she was first asked about her initial experiences. Her professional motivations got her past what others found to be difficult.

> I went into this experience saying to myself, "What can I take out of this experience that I can then share?" [...] I have 39 staff. [...] "What can take from this experience that's going to make me a better director, have our clinics and programs better meet the needs of children and families and better support staff?" So, no, I had zero trepidation. I had no inner angst. This was just wonderful but then again I had phenomenal supervisors [...]. (Movement 2)

Generalization from the last comment must be held back and its veracity taken with a grain of salt. The speaker, herself, provides the grain. The same respondent recalled her own feelings of intimidation early on as a member the allied health professions in a classroom full of mental health specialists. Like the person who "*hung back"* she claimed, at first, no fear or silence but the experience of her silence came out later in the interview. "And so that was the first time that I spoke up in this group that I felt highly intimidated in and I no longer felt intimidated by the group anymore." (Movement 2)

Breaking the Silence

Both silence and breaking the silence resonate with ideas about adult education traceable to the pragmatic educational philosopher John Dewey. His ideas influenced two highly influential disciples--Malcolm Knowles and Paolo Freire. Knowles, (1981) frequently cites Dewey directly. Knowles (Chap. 4) accepted Dewey's ideas about the inclusion of experience and dialogue in learning as an important feature of education and he describes how Dewey's

ideas were elaborated over time. Freire also makes a direct reference to Dewey's use of dialogue as his inspiration in *Education for Critical Consciousness* (1973, p. 51). Knowles, following on Dewey and others, also realized that adult learners have particular needs based, in part, on the developmental psychology of adults and adults' practical needs. Like Freire, Knowles summarized many current theories of adult education and combined theory with experience to create a distinctive approach to adult learning which Knowles called "andragogy," based on a theory about teaching adults as opposed to teaching children (Knowles, 1981). The etymology of pedagogy leads back to the ancient Greek words for child (paida) and leading (gogos). Andra, also from Greek, refers to adults. He developed this educational theory because adults differ from children in that children tolerate rote learning that is not immediately applicable to daily life. Adults, in contrast, need knowledge that is immediately applicable to current problems (p. 58). If adults suffer through preparatory knowledge that precedes application, such as introductory college courses, they get bored and impatient waiting for the "real thing." Knowles further incorporated such disparate psychological models such as Maslow's highly individualistic ideas on self-actualization, behaviorism (in terms of rewards and rigor), as well as applying practices based on environmental psychology such as , that included the way décor affects emotions.

Knowles supports his theory with his experience in a corporate education program model he developed in cooperation with senior management at Westinghouse (pp.180-197). This program was designed to decrease the dropout rate of new managers by meeting their desire to succeed by performing excellently. The program goal was intended to familiarize the new, junior managers with the complete operations of the company. The teachers were senior managers who were familiar with goals and the company's inner workings. Classes took the

form of dialogues. The project was a success. It increased the practical skills and communications within the company with minimal recourse to rote learning, Knowles thought, by maximizing dialogue between divisions and levels because the conversational teaching style encouraged relationships. Now, the junior managers, already a set of go-getters, could contextualize their work with a greater organizational knowledge and familiarity with the people who directed upper management. When the silence between levels of management was broken, the conversations led to a greater sense of cohesiveness.

Here is a typical comment from a junior manager who describes the value of the access he now had to the senior managers. "I find the biggest single factor to be ability to utilize the class as a resource for background, experience, personnel matters, problem solving-- in short, a reliable group of consultants on a full spectrum of business matters." (p. 188) At the opposite end of the economic ladder, Freire (1992), the left-wing Brazilian educator also talked about dialogue as a way of teaching adult illiterate peasants how to read. His educational goals were framed by his political values. Freire hoped to forge a unity between the educated revolutionary and the unlettered peasant, two other social roles. While Freire's political goals differed greatly from Knowles ideas of organizational transformation, they both felt the same way about dialogue. Freire describes how important it is for the revolutionary to get the peasants motivated and part of that process is the revolutionary's engaging in dialogic communication with the oppressed in order to elicit a revolutionary political consciousness from the peasants (168-176). Freire cites Ché Guevara's diary during the time Guevara spent in the mountains during the Cuban revolution: "Communion with the people ceased to be a mere theory, to become an integral part of ourselves."

Ironically, Guevara's role in the revolutionary struggle is similar to the role of the senior managers working with the juniors after Knowles' familiarizing training program was carried out. Freire points out that once Guevara and his cadre achieved trust and dialogic communion with the peasants, the peasants forged the site-specific ideology of the guerillas.

> In dialogical theory, at no stage can revolutionary activity forgo *communion* with the people. *Communion* in turn elicits cooperation, which brings leaders and people the *fusion* described by Guevara. This fusion can exist only if revolutionary action is really *human,* empathetic, loving, communicative, and humble, in order to be liberating (p. 171). [Italics all in the original.]

Freire calls Guevara's language "almost evangelical." Almost refers only to the religious associations attached to the word evangelical. The religious terminology probably came naturally to Freire. Alongside his well-known sympathy for Marxism, Gadotti (1994, p. 117) reported that Freire also had strong Catholic roots that were never fully abandoned. Christians and Marxists are both interested in transforming states of consciousness to improve the social order. So are organizational change agents. If Guevara wanted to erase deleterious distinctions associated with economic relations by increasing social relations, Knowles wanted to eliminate unproductive effects of organizational structure by transforming personal relations at Westinghouse.

One of Knowles' additions to adult learning is what he called *contract learning* (p. 127). Contract learning balances the individual's need for self-determination and mutual education, with an organization's need for measurable achievement. The need for balance between individual and organizational goals allowed Knowles to present his ideas to the human resource directors of large corporations. Learning contracts have a balance of direction and openness suited to adult needs in acquiring skills that maybe even the student remains unaware of at the time of signing the educational contract, according to Knowles. It would be unfair to ask the

Westinghouse junior and senior managers to anticipate exactly what new skills each one would acquire in an open curriculum with no exams. The program was designed to allow self-expression in the corporate setting. Knowles' students took on what they felt would actualize their own professional goals, which naturally differed from executive to executive. Furthermore, no one could know which juniors would connect with which seniors. Despite the open-ended nature of the process, everyone enters an in-house executive training course with some shared anticipation that the content or process is geared towards better management and, ultimately, profit. Based on the shared need to increase corporate gain, we could consider the program as one that encouraged a narrow type of transdisciplinarity because all the executives, whether accountants or creative types, shared the same goal based on the same theory and ideas of corporate life (Klein, 2009). It is likely, too, that the peasants who joined the revolutionaries in Cuba also had a fair idea of what to expect once they accepted the revolutionaries' educational program and goals but they had a different and broader transdisciplinary load to shoulder since the peasants had to go from passive to active participants in political life.

Returning from the mountains of Cuba to the towers of Manhattan, at the Institute, the physically trained workers had a number of challenges that make them similar to and different from the Knowles' executives and Freire's peasants. The enrollees under study were like the corporate managers in that they needed knowledge of a higher order of practice. At the same time, they were like the peasants because they had to learn that they possessed useful knowledge and had to acquire theory. However, as described earlier, the somatic workers had to move from one epistemological paradigm i.e., realistic physical science, to another, anti-realistic science, psychology, in the form of IMH, functioning as the overarching theory.

Likewise, they had to move from work where direct observation determined their responses to a model of work that involved interpretation of the life of the mind and relationships. In addition, the learning at the Institute was not dialogic in the sense that dialogue means two people speaking with each other or, in our case, two roles addressing each other. At the Center, the training is tri-lateral because along with the differences in outlook between mind and somatic workers, as we saw earlier in the story from the movement therapist who felt overwhelmed into silence by the mental health-trained students. Not only the psychological are there the students with mental health backgrounds but the psychologically trained teachers add more power to the anti-realistic perspective.

The mental-health-oriented students included psychologists, social workers and child protective service administrators whose primary orientation is trauma. The teachers, in addition, masters of one or more branches of child psychology, are second group the somatically trained students have to contend with. The somatic workers are double teamed by two types of early childhood professionals with psychological training. Speech 1, an academic, lumped them all together instead of making the distinctions one might expect of her. “[I]n our group of 9, there was [another allied health professional] and there was me, and then there were the social workers, psychologists, whatever, mental health people.”

The Odds are Against It

There was one important reason that many of the respondents were silent once they realized they were among the people they wished to be like. The reason is based on the way the IPSC addressed professional roles. The training program treats roles in two different ways because the IPSC is simultaneously a *local* and a *cosmopolitan* institution. The mental health workers come to be honed in early childhood work. For the students already grounded in mental

health, they sharpen their skills. For them, the Center is a local, mental health program. The teachers and the mental health workers already share concepts and methods. Whatever new knowledge they acquire fits in an established epistemological category based on role.

For the somatic workers, the school is the primary training ground in mental health knowledge, practice and theory; it is a cosmopolitan institution teaching an overarching psychological paradigm that is new to them. The respondents come to be forged into something new. In contrast to honing, forging is a crude process during which a piece of metal is hammered into another shape by repeated blows from above. In an educational context, hammering hurts and it is fair to use the cliché that students are beaten into silence and submission. The popular phrase "*head banging*" is another appropriate image. Ideas are seen as being pushed down from above into the minds of the students and it hurts. This section is about the challenges in acquiring an overarching theory.

From this angle, there is little wonder that the initial silence existed because the theoretical load is high and can generate long periods of silence as Freire says. While the respondents are like the junior managers in that they are educated, motivated and competent, they are also like the peasants who have no training in critical thinking within a psychological framework. In order to become revolutionaries, the peasants have to throw off old ways of thinking and ways acting to take up arms. The practical abilities of the somatic workers get challenged in a psychological way. The confrontation with the realities of overarching theory and its practice is a new experience that could not be expected nor contracted for. The students had no idea what would happen when they were confronted with real psychodynamic practice as soon as they started. If we use Knowles' concept of contract learning and consider it in terms of

the curriculum, they really have no idea about what will happen once the program begins. The otherwise very able respondents could not contract for lack of comprehension or skill.

> We only talked about cases if I really felt there was a case that was challenging me emotionally or challenging my skills that and, even when that was the case, it really wasn't about the case. It was really about my ability to handle and respond and act relative to that case. I mean that's a whole different ball game. [Nurse 4]

The reason underlying their shocked silence comes from the epistemological difference between the "hard" and "soft" sciences. The somatic students come from training in hard science. Hard science is based on certainty and control, features of modernity that began in the 17th century (Toulmin, 1992, Chapter 2). At that moment in Western intellectual history, interest in universals began to dominate thinking. In terms of medicine, care that once centered on the individual leaned increasingly to the idea of universals and a theory of practice that lead to standardized treatment (McWhinney, 1995, p. 5). Treatment by universal theory is called the ontological approach and, until modern times, it was paired with the physiological approach. The physiological approach sees disease as an imbalance between the person and the environment. Until the success of modern medicines and sanitation, physicians worked between the two models of care. In the language of this study, pre-modern physicians could work between the poles of medical knowledge, scientific realism, and anti-realism which included their personal knowledge of the individual and other interpretable concepts such as personality, family and physical environment. The medical training used to include the interplay of realistic and antirealistic science. This is the goal and it took time to reach it.

> [T]o just kind of play with the ideas, and, when I screwed up, I could come back and tell them, and it was okay. It was okay not to know. It was okay to struggle. That's a gift. [Speech 1]

To restore healthcare to a system of practice based on complementarity readings of body and mind, the respondents first had to meet the hierarchical aspect of that training's overarching theory. Although it runs contrary to the adult education theories of Knowles and Freire, the hierarchy of mental health professions apparently passed its ideas downward and this pedagogical approach created initial confusion and silence among the enrollees.

From the point of view of Schön (1968, p. 23), the allied health professionals and nursing are members of professions with roots in hard science based on predictability but their work spans the predictable world of bench science orderliness and the messy world of human interactions. The stable science that the respondents have at the core of their professional training becomes even more unstable in the practice realm once mental health enters the picture.

Psychology, unlike biology, is based less on control than constructing hypotheses that may only temporarily suit the situation until more information enters the therapists ken. This is the big shift that has to occur for the students. They are no longer in possession of the right way to proceed as the last speaker noted. Worse, the supervisors' interpretations can be wrong or differ from each other in solutions to the students. The following is a narrative of the receipt of bad advice and an illustration of the difficulties a transdisciplinary therapist faces when trying to manage the needs of the mother, the child and the supervisor at the same time.

> There was another case [...] that I discussed with my supervisor. And basically she said, [...] "That person needs to be in therapy, so refer them to therapy." And I did. But that was not the right thing to do, because this mother trusted me, she felt comfortable with me. She felt supported by what I was doing, so I was really in a position to support the mother in the way that she needed rather than say, "Go off to somebody else," which I

> think she found insulting. She was really put off, and it really disrupted our relationship. So [...] that way of thinking is a work in process. (Movement 4)

Perhaps, as the therapist reflected during the interview, the relationship between herself and the mother was more important than the mother's interpreted need for therapy. At that time, the therapist did not have enough confidence herself to manage the situation. The person supervising the therapist misjudged the mother's willingness and also misjudged the therapist's need to manage the complex situation. The therapist concludes the narrative with what would have been a more productive and training oriented approach. Looking back, it looks like the therapist thinks she needed a way to help the mother herself with her needs during the session. Referral was not the way. IMH's overarching theory did not yield the one to one correspondence between effort and result the respondents sought.

> I needed to feel confident in the fact [...] that she was confiding in me, she was talking to me. And […] that that was ok and that that was important, and that I could be the person that she needed at that moment, which was really just a supportive ear most of all. I felt the focus of the therapy was more on her than on my working with the child. I was trying to use a DIR frame of reference. So I really invited this mother in, but the idea was that I was sort of a coach. [...] You're a kind of a coach to the mother. So you bring the family in by helping the mother learn about what you're doing. But maybe the idea of being a support to the mother is beyond what DIR would necessarily suggest. [...] So she would come in, and she would always have a million things to tell me. So I would kind of get the child ready with some kind of obstacle course, and she would go through this thing. And then I would try to incorporate the mother into the play, so she could feel more comfortable playing with this little girl who she was just not comfortable playing with. And there were moments when it was kind of uncomfortable, because her focus was to unload and talk about the child with the child there, and that also was not great. And my focus was to try to engage this mom in play and teach her about what she could be doing at home with this sensory stuff. (Movement 4)

Under conditions of interpretation, different meanings to a single event emerge. The same problem acquired different solutions based on the interpreter's view. "Though [when] I tell

Barbara Greenstein, she said she would have done a whole other thing. So, whoever you do supervision with takes you in a whole other direction." (Nurse 4) Instead of finding answers, students begin to ask questions and raise new problems. The silence breaks. Hierarchy begins to yield to equality as new ways of thinking based on questions instead of answers begins to appear. Eventually enrollees began to accept the overarching educational theory of IMH.

In quite another context, Freire says this about the relation of theory to practice:

> As men, reflecting on themselves and on the world, increase the scope of their perception, they begin to direct their observations towards previously inconspicuous phenomena. […] That which had existed objectively but had not been perceived in its deeper implications (if indeed it was perceived at all) begins to "stand out," assuming the character of a problem and, therefore, a challenge. Thus, men began to single out elements from their "background awareness" and to reflect upon them. These elements are now objects of men's consideration, and, as such, objects of their action and cognition. (Freire, 1992) (p. 70)

The intimation of the need for psychological technique that respondents talked about in Antecedents section was essentially correct. In support of Freire's comment on the way increased ability to more in situation would lead to ever increasing awareness, one PT said the following:

> I think I've become even more sensitive to the parents, sensitive to this world. I, we worked a lot on looking at that perspective. Whether because of the traumas of the parents, [or] because [of] the expectations of the child, I think I've become a little more sensitive, I've become more patient and less judgmental with the parents. (Movement 3)

Another practitioner talked about the acquisition of a new way of seeing their practice via questioning and dialogue, and, eventually, learning to ask reflective questions internally. The practitioners would slowly depend less on the supervisor's suggestions and begin to figure out a new way to work in their own way as the next speaker discovered.

> Oh, in supervision? It was great. [...] I had group supervision. It was obviously a new experience for me and I just felt we could use supervision. [...] They would ask questions of me that I wouldn't ask of myself. So then it made me look at the situation in a different way but yet was relative to work that I do. And, in my individual supervision, that was great also. It was a little different because she would challenge if I asked a question. It wasn't necessarily she gave me the answer. It was just through our dialogue that she would lead me to the answer. Or maybe, she would give it to me. The purpose wasn't to withhold information. It was really that I think that our interaction and the way she conducted supervision—she helped me reframe things and kind of asked questions a different way that led me to finding answers on my own in addition to her helping me. (Speech 1)

Explaining the Break in the Silence

Teachers and students are all familiar with early classroom silences that precede everyone getting to know one another. Freire considered the role of silence that occurs when people confront too large a theoretical load. The way in which the theoretical load is confronted and overcome, and then utilized is the process examined in Freire's (1982) *Pedagogy of the Oppressed*. In his experience, theory was lightened by concretizing the theory. Concretizing in the context of Freire's radicalizing goal meant having the peasants explore their own work life and then help them think about it in terms of their low socioeconomic status world. He supported his students' ability concretizing in two ways. First, his adult students had to understand that they already possessed knowledge (Chapter 2). Second, the students and teachers had to be able to exchange their respective knowledge in dialogue as equals. The teachers then derived lessons based on the questions and problems based on life experiences rather than rote information (Chapter 3). Some stories of knowledge possession and concretizing in clinical supervision were presented; they will now be given a fuller showing following a more detailed look at Freire's ideas on teaching.

Freire classified education into two broad categories: banking and expository. In the expository, the teachers and students find a way to share by solving real life problems together. It is based on equality. In the banking model, the teacher dispenses knowledge. The students focus on memorization and knowing the correct answers to set problems. According to Freire, professionals who learn under the banking model usually replicate the banking model. Freire's generalization is confirmed in this example of rote application that was faced by Movement Therapist 1.

> I had one person [another therapist] working on colors. So I said, "Why is that so important?" This something is like a cultural thing. I said, "This culture puts a lot of emphasis in colors." The child was from Poland, and they [the child's family] weren't interested in colors, maybe. So she was really determined to teach him the colors— red, blue yellow— until he knew red, blue, and yellow. And she would [then] move into something else, like a bigger goal. So she was kind of stuck on that. And I felt, not verbally, the child kind of knew. We did not have to focus on it. The child knew because he knew how to match nonverbally. Why get so stuck? Why continue dealing with it because the child doesn't want to do it at the time? So maybe he would score like he didn't know it.

Parenting: Dialogue with the Self.

The ideas presented at the Institute were also concretized in personal experience in relation to motherhood. As indicated earlier, all but one of the respondents was female. All but three of the thirteen female respondents had children. One respondent was pregnant during her coursework. Especially for her, the ideas presented at the Institute were more than classroom theory or purely professional training as she was forming her own bond with her unborn child.

> I remember thinking about what was my attachment like with my mother and based on what she talked about when I was younger. You know, my experience being pregnant, and what was that like. There were some revelations about that. I feel, "How can I go to this program from 9 A.M. to 9 P.M. [...]? But the fact was I was drawn to it. […] I found that on the one hand I was away from the kids. [...] I just had my son at the time. But I really loved it. I felt like it was feeding something I really needed. And I think there was

> some element of thinking about my own childhood and how I wanted to raise my own children. But I loved it, and it didn't seem totally far from my capacity to understand it. (Movement 4)

The previous respondent was conflicted about her unborn child coming due. She wanted to be at home with the child and she wanted to be at the Institute. Once her baby was born, in order to accommodate both needs, she often had a nanny accompany her. Compelling maternal concern towards the child in the pre- and postnatal periods is called *maternal preoccupation* by Winnicott (Stern, 1995, p. 176) . The term describes a mother's overriding concern and attention directed at the newborn in accord with her desire to be a good mother. Her concerted attention manifested in protective concerns, actions and gaze create firm attachment.

> There was an article about, what… Oh, oh, what was it? It was on preoccupation or maternal preoccupation. And I said, "I don't think I was preoccupied at all," but then it sort of came up that I was completely and utterly exhausted. Not just the kind of exhausted that you experience because you're pregnant, but I think I was emotionally exhausted just from the idea of it. So there were lots of moments when I was relating things to my own experience. (Movement 4)

Once mothers began to understand and "take in" attachment theory, it was no longer an abstract idea. It was directly concretized in their life. Similarly one respondent who was childless described how the dynamics of mothering was subject knowledge that affected her as well.

> I think because my husband and I didn't have children, we couldn't have children, we had some pregnancy losses. I think I had to find a place to channel this nurturing and this real desire to connect and to make a difference with the parents that I've worked with to help them know their babies and to have them learn about their babies apart from being part of a medical entity. They are not a baby with CP; they are not preemies; they're their babies and it's like that's the path God or whatever you want to say has made for me. […] Because I think that is a driving force for me. (Nurse 4)

Turning Point

Silence, withheld knowledge, ceased when the somatic workers saw they possessed knowledge as Freire observed.

> [B]ut [another respondent] is wonderful. And it was wonderful having another discipline. [she] is also very psychological and very interested. That was very helpful in that class, in our group of 9. There was her and there was me, and then there were the social workers, psychologists, whatever, mental health people. It was great. Well, everyone embraced [the other respondent], too, and I was embraced by my class, which was different from [another teacher's] group because I didn't have relationships with them. I had a relationship with people in my class. And I found my way in that. And that was the best part of the Institute because there was a class where there was diversity. I think the beauty of the Institute is to have [diversity] across professions. (Speech 1)

As anticipated by Freire's discourse, the barriers created by the next two respondents in opposition to the mental health professionals' role and educational attainment vanished through dialogue.

> [E]ven though this was a psychologist or this was a psychiatrist, we all had that same focus regardless of what your discipline so that made me feel, "No, this is the right place for me" because in the beginning I thought 'What the hell am I doing here? I don't fit in the same league as most of these people with PhDs.' I didn't even have a master's degree at that point. So I thought I was a fish out of water. But, I think when they came to know a little bit more about me and I saw they didn't they didn't half of the experience I had with infants and parents. It shifted. (Nurse 4)

> But I think the beauty of the Institute for me was how they really embraced different ways of thinking and different disciplines […]. I think everyone knew I was in a whole other discipline. [...] I was nervous. I thought, "How did I get here into this situation." My usual neurotic reactions, whatever. So I was always nervous to present. [..] Once I was able to calm myself, I felt I could offer insights with people who have language and communication problems, certainly, to start with. (Speech 1)

According to three respondents, it helped having great teachers.

> You had the bright stars of Zero to Three[3]. Gordon Williamson, what's her name at Bank Street, I'm forgetting her…You had the best. The best! (Nurse 2)

> And again Rebecca [Shahmoon-Shanok]'s very nurturing and walked me through it. (Speech 1)

> But I learned so much from each one of them. So I think it came from the group process which happened through the skill of the faculty and then carried over to group supervision. (Nurse 3)

Role Exchange in Action

The process of hierarchical and expository learning is related to *role exchange* at the Institute. Role exchange is the technical term for beginning of the practice of another role (Table 1). The exchange is the start of the novice's implementation of the theoretical and practical skills from the new discipline. One goal of the IPSC program is for the psychological and somatic workers to explicitly exchange some knowledge of each other's professions. The respondents do learn how to practice in the mental health domain but the mental workers do not get equivalent training in a discipline based on realistic science. This unidirectional exchange of practice knowledge is another way the Institute implicitly establishes the preeminence of psychology over physiology in keeping with the essentially local nature of the IPSC.

Once the mental health and somatic health professionals begin to converse with each other, the somatic workers entered role exchange internally, they could see themselves as co-equals with their mental health colleagues. Practically, role exchange requires that persons undergo clinical supervision as they work with a family. Clinical supervision is another new experience when the somatic workers encounter mental health practice that establishes the hierarchy of mind over body.

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[3] Zero to Three (zerotothree.org) is the popular name for the National Center for Infants and Toddlers. .

> I didn't know what they were about. This was like a mental health paradigm. I have never had supervision. In the hospital setting we were mentored or we had a nursing supervisor, but nothing that was supervision. […] I felt like it was a session almost like a mental health therapy session. (Nurse 4)

The process of supervision, more properly called *reflective supervision*, entered the program along two sources. One emanated directly from Dewey via the progressive education movement stream that fed IMH (p.38, Romano). Dewey's influence also appeared indirectly through the work of Schön(1983), whose ideas about reflective practice, were well-known to Dr. Gilbert Foley, one of the Institute founders (Gilbert M. Foley, 2011).

Reflective supervision also has roots in the training of psychoanalysts such as Drs. Foley and Shahmoon-Shanok, two program founders. Institute students are sent to practice IMH as soon as classes start because, in Dewey's words, "knowing is doing." The ideas and methods of the school are presented in book form in: *Infant Mental Health in Early Intervention: Achieving Unity in Principles and Practice* (G. M. Foley, & Hochman, Jane. D., 2006). Unity of practice is transmitted in this empiric manner through personal exchanges between practitioners and mental health mentors exploring the way physical practice melds with psychological practice. In addition, the sessions provide a way to explore feelings in order to develop inner sensitivity as part of the training to interpret the actions of the therapist and the patient.

Guidance comes from teachers grounded in the world of mental health practice and who also have experience with early childhood psychology as researchers. Supervisors introduce d enrollees to new ways of thinking *in* working. This has to be added to ways of thinking *about* practice. Importantly, as supervision progressed, the sense of equality that underlies Freire's notion of honest dialogue emerged. Instead of passively taking the advice of their supervisors,

respondents began to challenge the same people who initially intimidated them. Honest disagreement, as Homans (1958) is a way of exchanging and establishing status in a group.

> Whenever he would make a suggestion, I would put it through what I could do. And if I could not do it, I said. “Okay, well you know, forget about it. It’s just not, you’re not with me here. I can’t, you can’t be my director like a movie theater.” Or you, I could actually do exactly with it the play or role. So I just did what I could do. (Movement 3)

Inclusion of the Family

One of the techniques and basic practice principles of IMH is inclusion of the family in treatment of the child. To include the family’s and child’s world-views is considered a way to help rather than a barrier to help. Providing therapy in the family context is referred to as *therapy in the natural environment* (Hanft, 2004, p. 85). The natural environment is any place where non-disabled people carry out their everyday lives as opposed to therapeutic environment.

For example, a physical therapist can provide therapy in an office, a therapeutic environment, or prescribe stretches and isometrics in a yoga class, a natural environment. For a child, the natural environment can be a playground or a digging in the dirt to address sensory issues. When parents implement therapy at home, it is called *indirect therapy*. In order for indirect therapy to take place, the therapist working with the child has to have positive regard for parents. That trust and positive regard must be learned and can’t be applied indiscriminately. Part of the reason that therapists have problems getting parents engaged, as shown by Lieter (2004) is that many parents do not see providing therapy as part of their job and resent being asked to do that extra work. Alternatively, many therapists do not trust parents to apply therapeutic principles and practices.

> I've become more patient and less judgmental with the parents because in my profession the parents are often an obstacle. I mean, we say if you're not treating the family, the parent, you are not treating the child. [O]ur main motto of this kind of work [in IMH], but not in PT [physical therapy] land. Not for PT. We often look at the parents as the obstacle. (Movement 3)

Freire describes the students' experience of meeting insurmountable obstacles. In the world of infant and toddler care, the parent is often considered the main obstacle as we just learned. If the obstacle is perceived as insurmountable, then no creative thinking and problem-solving with parents is possible.

> If individuals are caught up in and are unable to separate themselves from these limit situations, their theme in reference to these situations is fatalism, and the task implied by the theme is the lack of a task. (Freire, 1992, p.105)

Practitioners often find that the important adults in the child's world who are focused on something other than on the child's therapeutic goals. Getting family members involved in the child's care is often an obstacle to be overcome.

> That's why I got into the program because I was dealing, for example, with grandparents from one culture, parents from another, dealing with a child— and each one had a different agenda. Each one had a different agenda, different religious backgrounds. I was in the middle of the frying pan. I was very aware of having to negotiate, and to being very diplomatic about including them, and trying to not antagonize and all that stuff. (Movement 1)

Relationship is central to IMH theory and practice because the dyadic therapy focusing on the relationship of parent to child and is mirrored in the dyadic quality of reflective supervision. As the previous speaker indicated, another important pairing is the parent-therapist relationship. Dyadic supervision is a collegial, coaching process concerning practice problems,

rather than theory. However, our somatic workers experienced their IE education as a totally new area because the theoretical model, training and practical language of the school is psychological. In order to engage as students and participate as equals in a dialogic process, they had to learn an entirely new vocabulary.

> Actually, it took me a while to get used to it. Their [...] lingo that was new to me and unfamiliar. However, I didn't feel intimidated I was not embarrassed to ask something that was new to me and I was encouraged to ask. And, I guess, also as one [person] was very inviting and wanted my input as well. So we, all sharing […] our knowledge […] were able to learn from each other. (Movement 5)

The experience of new language is also discussed by Freire (1982). "Once named, the world in its turn reappears to the namers as a problem and requires of them a new *naming* [sic]. (p. 70)"

Without learning psychological terms for new inner and observed experiences, silence will result because these things cannot be discussed meaningfully. The lack of name for the role of transdisciplinary practitioners was touched in the findings from the period prior to enrollment. Learning and understanding a new technical vocabulary takes time. Respondents also had no choice but to be free of their physical profession and long after psychology. Names of things are important because they help explore feelings that also went unnamed or unobserved because they had no known names.

During supervision, the apprentice infant mental health professional is confronted with the new awareness behind the psychological terms. That new awareness is that mental health work means working with one's own emotions as well as one's intellect (Hirshberg, 1997, 1998). Another challenge lies in switching from seeing problems located externally to the therapist such as seeing weaknesses in the child or family to beginning to see their reactions and themselves as part of the process. These processes relate to countertransference and the therapist's own psychic

state while they offer physical care. Focusing on the personal factors of the therapist creates space to learn by embracing the complexity of the situation. The old and new roles may appear as contradictory until they are perceived as one. Consequently, part of the clinical supervisor's job includes introducing the therapist's presence as a psychological force in the family.

After this aspect of clinical psychology is introduced, the student can no longer see herself as a decontextualized actor. Blame formerly ascribed to the family now redounds to the therapist. In the third chapter of *Pedagogy of the Oppressed* (1992), Freire discusses how themes for study arise from life experience in dialogue (p. 93). At the IPSC, themes in supervision are generated from actual practice problems. As the respondents work becomes more psychologized, students have to look internally as well as externally. In fact, supervision gives priority to the former. Trainees are encouraged to explore the inner blocks they encounter and, thereby, become more human, a process that in IMH that is seen as necessary for consciousness to expand to include more of the practice reality. (p. 92). Later on, Freire says, "[A]ll authentic education investigates thinking (p.101)."

This supervisory process was hard for some. People no longer working as direct care providers still needed a family to work with to concretize the intellectual aspects of the program during supervision with a mental health specialist.

> It was stressful. It wasn't smooth. When I started the Institute, […] I had to get a client. I hadn't had any clients I was working with. So I found this young child on the autistic spectrum, and the family was bilingual and Arabic. (Speech 1)

Sometimes, students are asked to record sessions for both individual and group review and supervision. Recording prevents the student from filtering their sessions. Everyone, the

clinical supervisor, the student, and, maybe, the entire class can see the student in action and inaction.

> When I started we were oriented towards these cases. He wanted me to bring in videos of my cases. And talk about the cases. In the end, really, I wanted to talk about my stuff. How I felt. I didn't feel comfortable with the parent doing the *xyz*, or, how I am criticized by them, how it makes me feel. How I feel, as a consequence, when I was criticized by that parent. (Movement 3)

Because it is so transparent, the learning process requires an emotional rapport between supervisor and supervisee.. Hence, reflective supervision involves trust as well as expertise in the supervisor. The student has to have some trust in the mental health professional, and this trust must be earned.

> [I]t really has to do with the length of the relationship. That then allows the supervision to go into that other place. Because, I think, initially, […] when you feel safer in the relationship with whom you are seeking supervision with, you go into the deeper levels. (Movement 3)

In at least one case, working conditions did not lend themselves to the positive relationship-building with the client associated with the IMH treatment model. It came up in one supervisory session from the respondent who had never been in therapy herself.

> I think that I always felt like, because of the nature of the work I was doing, which was not any real individual, ongoing therapy—a lot of the people in that group were doing psychotherapy already—type stuff. But there wasn't enough kind of leeway for people to apply what we were learning in the context that we were working. […] For example, my supervisor wanted me to get involved with one particular family, and yet that wasn't the context of my working. So it would be more appropriate to figure out ways to apply the knowledge we were getting in exactly the way I was working—which we did. I'm not saying we didn't. But I think I probably ended up resenting having to go visit that family in a more frequent way and in a context which wasn't set up, because it just wasn't what I was doing. […] In the end I was not sure I was very good at it, and then what she got out

> of it. And maybe it would be better to do that in the second year? […] Yeah, I think I talked about it, and how I was limited. They seemed to understand me. They did, but the focus was—I felt the focus was always on the more traditional way of doing psychotherapy. (Nurse 1).

Sometimes, the gap between somatic and psychological practice appeared too wide, as it did for the previous speaker and for the one who will speak next. Naming formerly hidden forces increases awareness of the self and increases the ability to act in the world, according to Freire (citation?). The next speaker, increased her understanding of her own self through supervision which relieved her mounting stress levels.

> I wasn't so off put. [...] The psychologists were trained to work individually [...] Speech pathologists aren't trained for that kind of dynamic, that kind of experience. [...] It was very helpful to put a theory, put a name to what I was experiencing. It helped me manage my way through it before it became overwhelming.

People eventually acclimatized themselves to these new ways of learning and the interpretive way of working came into focus and became more manageable. In Freirian terms, the formerly unnamed events become named and, thereby, objects for study. The previous speaker mentioned how just knowing about others' and their own inner worlds made practice less stressful and more manageable. Two others addressed how difficult it is to work with a greater inner perspective but how knowing about countertransference makes the experience of unpleasant emotions less difficult and threatening.

> It stinks! It's hard because it is you. […] Acknowledging [the] self. And then figuring out why that strikes you. It is not based on that [other] person. It's based on your history or that person knows to touch the place where you're most vulnerable. I felt comfortable with it I guess. (Nurse 2)

> I think it made me think about how I reacted to people, which presumably is what you'd want to do. And sort of think about the feelings that it brought out in you—me. The thing that was big for me was the idea that it was okay. (Nurse 1)

In the following response, we see how a movement therapist managed the countertransference and other emotions. She takes us through her own management of her negative feelings towards the mother including hate. We might add something like resentment or regret because she is one of the women in the studied who had no children of her own. This story comes from the person whose countertransference reaction also derive, in the speaker's words, from her childhood experience as being a child of nine and feeling ignored by her mother as we presented earlier in Section 1. She describes how she went past her negative feelings and changed her view of the mother. The mother slowly became less of an obstacle because of the speaker's inner work.

> It was tough to identify with the child and hate the parent. And then I would go in her body and think: "She is an intelligent woman, she's trying." I would hate her as a parent, and maybe brought up a lot of personal feelings about, maybe, my mother didn't have enough time for me, whatever, maybe I would explore those, too. And then, [thinking of her] as a parent I would look at her and think, "She's not a monster, she's trying. She's trying, she's very anxious about this child. And she's relying on me somewhat." And then my goal was to make her find more time for her child. She was rushing to my sessions. I got her to come […] from her work, rushing. And the child was so anxious about it then and associating me with the presence of the parent. When the parent wasn't there, [just] me, having to deal with the loss of the parent not being there because the child wanted the parent to come. […] It was tough. [I]t was a very tough place. (Movement 1)

Despite inner difficulties and outer challenges, no one reported any serious overreactions during the sessions. "No one came into group supervision wanting to run out the door and saying, "That's it. Let's get out of here." I don't think anybody did."

Role Dialogues

In keeping with transdisciplinary nature of the training at the IPSC is the observation that teaching is not exclusively dependent on the teachers. Students are expected to be active participants as well; perhaps moreso in a transdisciplinary context. All post-graduate teaching probably anticipates student participation but Institute is dependent on what the non-mental health people have to offer and cannot function fully without them. Part of the reason for this is that the mental health workers need to learn more about the body. This includes knowledge about the different kinds of developmental delays that affect the body, their treatment and how to understand the delayed child from the physical point of view. While the program has a few speakers to teach about the physical aspects of early childhood delays, much of the teaching concerning children who do not express themselves or move in expected ways was introduced into the curriculum by the enrollees who registered in a haphazard and unplanned fashion over the years.

Exchanges between mental and somatic workers occur in didactic classes as well as within supervision. Videos were essential in this exchange because of the extensive us of case studies. Not surprisingly, when the teacher's own videos were presented, respondents made their greatest contribution. Details that were missed by mental health professionals were caught by those with training in the body and its problems, the respondents. From this position, students could feel more like knowledge possessors.

Discussing problems from the differential perspectives of mental and physical health creates conditions of parity for a at least two reasons. One, when the respondents begin to add the physical view of the problem, complementary readings can start for the all of the students and teachers. From the perspective of transdisciplinarity learning commences once the body gets

introduced into the discussions. When the respondents turn the tables on the instructors, they now become the experts. In becoming the authorities, they create what Freire (1992, p. 67) calls teacher-students and student-teachers. The respondents' comments are their professional contributions and disagreements that are a response to a univocal view. It is a reaction to the smith's wrongly placed blow. The fact is, the students want to be smitten, in both senses of the word, but sometimes the blow has to be parried. They then explain why. Fortunately, the teachers and the students from the mental health professions respect the material and appreciate its qualities. Different metals respond differentially to the blows of the smith's hammer. The smith learns about the metal by the response to the hammer.

The following story brings us back to the theme of silence and the importance of breaking the silence in this form of education. A physical therapist offers her view which enlightened the teacher. The teacher and other students are concerned with the position of the child's head in relation to attachment. Generally speaking, if the mother's and child's eyes do not meet, it is a sign of poor attachment. The physical therapist is looking at the same event in terms of the child's overall need for physical support because of the baby's weak muscles, or low tone the technical term used in the narrative. The PT also sees that the mother has an emotional connection through laughter and through physical support. The mother cannot hold the child's legs, torso and head at the same time but only a PT would notice it and also notice that physical attachment promoted emotional attachment. As the speaker tells t he story, there is a cameo of the silence breaking process that needed an invitation for the speaker to state her opinion.

> I brought a unique perspective because I was the only physical therapist. […] We were watching a videotape. It was a group of parents sitting on the floor with babies. There was this one mom and she picked her baby up and her baby's head was down. And everybody we had to asses this interaction. [E]verybody said, "You know I don't think

> that there was a good attachment between that mom and that baby. I don't think that that mom was intuitive to that child's needs." And I sat there and I listened to everybody. And then the instructor said, "Does anyone have a different opinion?" "Yes, I have very different opinion of that. […] First of all, that's a very floppy baby with low-tone and by virtue of the fact that mom's supporting the baby at the trunk and shoulder blades, she knows that her baby's head is going to go down." I thought she was incredibly intuitive and yet she was laughing and he was laughing. And I said, "I don't see as it as problem of attachment. I see it as an intuitive mom who sees her baby is going to flop and she wanted to get eye contact and she supported him the best way she could." And even the instructor said, "You know, I have never noticed that. You are absolutely right." And so that was the first time that I spoke up in this group that I felt highly intimidated in, and I no longer felt intimidated by the group anymore. (Movement 2)

Another PT gave a critique of a video that had been used in prior training situations prior the session under discussion. In this session instructor became student and student the teacher.

> He showed us this videotape of this [...] PT, who was working with this child. And he particularly liked her very much. He liked what she was doing and I looked at it and I said, "I'm sure she is very kind to these kids." [...] I could see she's a very good person, she cares a lot about those kids. Well, I wouldn't use the same technique she is using […] She is using a five foot ball, [with a child] who is barely two feet long." [A]nd she was trying to elicit something from that little child." I said to the group, "Can you imagine if somebody took you proportionally on to a ball like that to elicit a particular response? How would you feel about it?" And they did not like that, like they said, "Oh, no, but she is very good." And I said, "I am sorry. But, that is just not good practice. […] If you're not thinking through the child's eyes, then you are not thinking." […] You can't apply a therapy like you're applying a coat of paint on a car. It doesn't work. Now, it's not to say that I'm perfect. That I don't make mistakes but I could look at something and critique [and] say, "What can be done better?" And hope that somebody would say that to me. I'm not often in that position, and if I was to be in that position, I would hope that I would work, unless I saw something so egregious I just couldn't shut up. I would attempt to work with that therapist. Maybe do some therapy with that therapist and like, partner with that therapist to do something to see what maybe we could do different.

The same PT critiqued the work of a professor of occupational therapy [OT] who gave a presentation. She continued with the theme of thinking about the child's best interests and she did so without mincing words.

> [S]ometimes, I just say, "Okay. You don't get it." It came up once at a lecture. One of the people who gave a talk at the Institute for our class is an OT, a professor at Columbia, and much of what he said was okay. I liked the guy, some of his presentation. There was one part that I was so totally adverse [sic] to, that I, when we came back as a group, after this lecture. And I challenged this guy. But I did not what to be so challenging. I know what it is like to present. I don't want to be, I don't want people to be a pain in the neck to me, a real big pain in the neck, when I am presenting. You can go so far with your colleagues and peers. You can either make the case or you don't. It is not a debate. It's just a presentation. So, when we came together as a group, I said, [...] "This is bogus. This is total bullshit. Anybody who does this is an idiot because they are not thinking about the child. They are thinking about something else. They're not thinking about the child. They are thinking about their plan of what they would like. But they're not thinking about the child." And I explained it and people either got it or did not get it. And I was very insistent about it because it was not trivial.

The PT's remarks provide the basis for having multiple perspectives in the room. She, like the other physical care providers, provided a complementary reading. Mental health specialists are likely to have a generalist perspective on somatic care whereas the somatic therapist is a specialist with deeper knowledge and insight in that domain. The same respondent discusses the way relative specialization in different domains creates differential conclusions.

> When you listen to it [the presentation] from a mental health perspective, [one might] say, "Oh, it sounds okay." I listened to this mental health perspective talking about Freud and, then, for me it's okay but a Jungian or an Adlerian or somebody else would say that that's bullshit. I don't think anyone should practice like that and I can give you the reasons why, well, and I felt the same way about this. So that's what I would do. That's what I did.

In the next anecdote, the same emphatic physical therapist presents her view of an essential difference between the physical and mental health work perspectives with her clinical supervisor. The student is resisting demands to work more psychologically since it appears to be slower and delaying the progress of care. Even though the Institute's model gives priority to psychology, this person declares that the IMH model conflicts with the need to provide timely

physical remediation. In her mind, the idea of directed treatments and time goals in physical care conflicts with more open-ended models of care that exist in the psychological treatment model emphasized by the Institute. For the disciplines to be effectively integrated, the two modes have to be balanced in a way that was not worked out in this supervisory session. Resistance to the psychological model is expressed in an unwillingness to provide play therapy as the practitioner understands it. The lack of accord has to do with the apparent contradiction between the emphasis on control and certainty, grounded in physical sciences versus the acceptance of uncertainty or open-endedness in mental health theory and practice.

> I had supervision with a psychologist on the Upper West Side [of Manhattan] and he was kind of steering me towards addressing this child I was bringing up a lot in supervision with him. [H]e had some PDD[4] and he also had a variant of CP [cerebral palsy] at the same time. He [the supervisor] was more interested in addressing issue around his PDD. And I thought it was helpful. It just made me look at this at this a little bit more. What he did not realize and he acknowledged it at the very end of our supervision... He said, "I see that you have some specific things that you want to accomplish with him […] That is very different from what I do. You have a specific goal you're trying to work with him." And I said, "Yeah. That is what I am there for." I wasn't there for me to do play therapy. I am there to do PT with him. And it's something. It was epiphany for him more than it was for me. […] He's more open ended. I am more goal-oriented.

Ultimately, this PT learned to incorporate play therapy into her practice with children, but she appeared to be one of those people who must disagree first or, at least test a suggestion before adopting it. Her maturity as a practitioner is evidenced by her ability to admit that she is wrong.

> He would suggest that I did not call what I did with that boy *exercises*. [...] Exercise is something that he sees his mother, his sister, father do. Okay, we are going to do it. And the psychologist said I would have difficulty couching it like that. He said that now

[4] Pervasive Developmental Delay-Not Otherwise Specified, a less serious form of autism.

> exercise would be something that he would not want to do. And it turned out that he was right. He did not want to do exercise. So he kind of pushed me to think about it another way. That was helpful. So I found another way of framing what I was going to do with the little boy.

> He said try to put it into a play... into a play thing. Instead of making it the word *exercise*. And in the end, I thought, I could not do that because it was really to exercise, even though I could a stop a little bit and do it. I then called it warm-ups. And warm-ups really worked; cause this kid said, "Oh, were gonna *warm up* and, man." He let me do the warm ups and we did the play. And then I felt I was doing the work I was [supposed to be] doing. The kid felt happy in the work. So really, what the psychologist helped me to do, just helped me to reframe what I was doing. Even though what he suggested wasn't the best thing. I found something else because I can was prodded to do something.

In the dialogues with teachers and clinical supervisors, students began to display their increasing ability to apply psychological information and approaches. Parenting, a primary theme that led to some enrolling, becomes a source of grounding the ideas that were taught.

> You see it was just a thought. I never thought about it when I was in the house. It was only afterwards when I went to the [IPSC]. When I started attending the Institute we started talking about maternal depression, watching the *still face videos*[5]. Things like that. And it was one of the cases I did discuss in group supervision. (Movement 5)

Not only was being rooted in a somatic practice accepted, it provided a valued knowledge resource to exchange with Institute mental health practitioners. The next speaker returns to how speaking from her somatic professional expertise created a pathway into the psychological world.

> I think everyone knew I was in a whole other discipline. I think, when I talked, though, I had a whole lot of insight, for some reason. I think my way in there was when they were presenting people I could talk about some of the issues in development that they couldn't

[5] This video is a basic demonstration of attachment illustrating the role of eye contact in infant self-regulation and depression.

> talk about. I'm pretty sophisticated about, you know, children who struggle with language and communication. So I think that was probably my way in, that I would offer my own insight from my discipline about that. And I think people welcomed that. So I think that was my avenue in. And sort of it was a given that I didn't have the mental health training that these people had. So I had to live with that. But my feeling was that I was very, very reticent. I was very nervous to even play with the ideas. (Speech 1)

New Colleagues

Trust in the teachers and fellow students are necessary parts of the process of adult education. Ultimately, this may emanate from a desire to affiliate. Knowles (1981) says that some people wish simply to learn with others. Differences that initially created silence now supported dialogue even when there was only one allied health professional or nurse in the group. Once some degree of equality and fellow-feeling existed, the ability to open up increased.

> I have a lot feelings about little things when I am interacting, becoming aware of what they mean in the whole picture. [...] It was very helpful, the group supervision. Also, the different backgrounds [...] were very helpful, the different backgrounds of the people that were people that were part of the group. It's very helpful, and the support. Well, one was a psychology professor at Columbia [University], another was a social worker, another social worker, a social worker and teacher, [...]another social worker, and then me. It was important. I think it was their empathy [and] their willingness to listen and support the process. [Y]ou lose your fear about really going deeper. (Movement 1)

> Because, I think, initially, I could say for both the first time at supervision. The psychologist, and the psychiatric social worker, it began with the technical aspects. When we/you feel safer in the relationship with whom you are seeking supervision with you go into the deeper levels. (Movement 3)

The dialogic process could now go both ways. Mental health students enrolled in the Institute program also helped bridge disciplinary divides.

> One of the other things I learned from one of the fellow students who was and is a trained analyst about how a really deep sense to being able to get to understand somebody, to really understand what they were going through, that that was part of the therapeutic process. That resonated well with me and stayed with me. To try to really feel what other people were feeling. I'm not sure that I can do that. Also, because I think my life has been

> with pretty much handicapped children, I have learned to find space where I can hopefully still be empathetic. (MD1)

One practitioner with prior experience of reflective supervision enjoyed renewing her experience. Such supervisors are hard to find outside of specialized, highly-resourced settings.

> I was craving it. I came from a position where reflective supervision was the norm. So for me it was the norm. To me, it was like, I was craving it. It was needed. I felt very comfortable. I felt open to share. [...] I was, like, thirsty for it. (Speech 4)

Sometimes, practical skills helped moved the respondents from the physical body to the verbal domain of psychotherapy. In achieving this, one skill taught is called “speaking for the baby.” Here is a respondent’s description of how that technique is applied.

> At one point in supervision that came up. Use words for the child that's going through something like, if the child is hypersensitive to something, say, “Oh, mommy, that doesn't feel very good at all,” rather than my saying as the therapist, “You should understand that the child doesn't really like that sensation.” I felt like I needed more stuff like that. […] I mean it was sort of this feeling that it was all very fuzzy. Except perhaps that there was the importance of the relationship was very vital to the whole treatment process and that I had to acknowledge it and in some way support it. (Movement 4)

On other occasions, students were encouraged to enlist the mother as a “co-therapist”.

> I had supervision on this case. [...] One [technique] is to invite the mom, [...] “Mom, let’s do some of this together.” Another thing is to show her some of the improvements that have been made and say, “Oh, if you want to see, how to further this along a bit, if you did this with him, this might really help.” (Movement 3)

Didactic Classes

Classes provided a didactic setting for communicating IMH knowledge and values. One of the students found the classes were, infrequently, beyond their intellectual range or had no practical value.

> Only one course became a little too psychoanalytical from me and I tried to at least come one little bit of information or knowledge that I could use. But that wasn't till I believe, spring of the second year. […] It was just one course that I just felt was just not as helpful as all the others. But I have to say there are plenty of times when I go to continuing ed courses within my own discipline and don't walk away with what I was hoping [for] (Movement 5)

Another enrollee preferred popular psychology books to the more abstract technical tomes that were assigned. One compared the written work of psychologist Daniel Stern, who writes for professionals, to the work of a psychiatrist Daniel Siegel, and Mary Hartzell, an early childhood educator, who write for parents. She found the professional writing hard to grasp.

> And also the writing. You talk about being comfortable or not comfortable. I remember the writing being sort of flowery. In terms of the writing, that writing was a little hard for me to grasp, if I'm remembering correctly. Whereas Dan Siegel, it's a whole different story. So maybe some of the writing sort of had a magical quality in the way he was describing things. Siegel was very straightforward. (Movement 4)

The person who just spoke had a good reason for finding it hard to read the texts designed for professionals. By this time, this student had her second child and found an easy way to get around reading the assigned texts. She relied on other students to do the work.

> Yeah, so there's an example of material that didn't feel as easy to do. I think I really tried to keep on it initially. And then I found that I just couldn't, and with some classes we had a situation where each person would read something and then report on it. And so I would rely on that. [...] But I loved it and it didn't seem totally far from my capacity to understand it. (Movement 4)

For another, the more advanced readings were helpful but challenging. For her, challenging articles became part of the “forging” process.

> It didn’t feel like my area of expertise and the knowledge [...], a lot of it was new for me. I feel really, really comfortable in my own arena, but this was a new arena for me, and reading some of the articles, I was really challenged by some of the more sophisticated studies, etc. (Movement 5)

Somehow, the feeling of being different, therefore silent at times, continued for at least one respondent but in an ambivalent way. She blamed it on her own anxieties and insecurities rather than the curriculum or the theories promulgated by the program. Remarkably, this student already has published and a conference speaker on the relation of IMH to speech therapy. Perhaps she is, as she says, just nervous around people in small groups.

> Well, I always thought they had better insights, because they had a psychological mind [...]. I think that stuck with me over the year. I don't know. I can't retrieve all my feelings. But I liked going and I didn't like going. So it was clearly was interesting to me, just cognitively interesting to hear how people approached clients and terrible stories [...]. It was more my own issues about performing and not being smart enough and not being psychological enough, and how did I get in here. (Speech 1)

After a while her natural anxiety yielded to a greater comfort and appreciation of the experience. The variety of professional perspectives became a valued resource rather than a source of intimidation, and her ability to work from an emotional stance increased. In addition, the care of the teachers aided this student as her facility with the theory and means of psychology grew.

> But I think the beauty of the Institute for me was how they really embraced different ways of thinking and different disciplines. I eventually thrived in that. I would say the best thing I found at the Institute was people [...] who knew how to work from a strength-based perspective. It sounds so superficial, but I think it's so significant for professionals to learn how to embrace people from not-a-deficit-problem. Most of the disciplines are all about the deficit. So, there was something in that experience that really helped me move forward. [T]here's some kind of nurturing Gil [Foley] and Rebecca [Shahmoon-Shanok] were able to do. I don't think everyone did it there as well. That enabled me to just kind of play with the ideas, and when I screwed up I could come back and tell them, and it was ok. It was ok not to know. It was okay to struggle. That's a gift.

The last comment about struggles shows that even though she was generally reluctant to speak with her classmates, she still found students and, at least, two teachers with whom to share her personal struggle. It was not just absorbing theory, it was absorbing theory with congenial, encouraging teachers. In the next section, a greater barrier than shyness existed to conversation.

An Insurmountable Barrier to Dialogue

The prior section described how the AHPs and nurses began to learn about applying clinical psychology once they began to value and share their discipline-specific knowledge. It appears that the exchange of information as a form of self-validation was a prelude to the acquistion of the some skills of clinical psychology. The next set of narratives shows what happened when the sharing process was not actualized. Nothing was shared when the Institute teachers wanted to present their concerns about child abuse and trauma. The difficulty seems to be a confusion of ideas of social class and the meaning of trauma that was hard to fully understand. It was possible, though, to see the lack of sharing because the topic was rejected. For example, some of the students associated trauma and abuse with the poor as was the case for the following two students who thought that, as professionals, they would have very little to do with the poor in their practice. However, they both evince some curiosity suggesting that, with some effort on the part of the teachers, these two students could have been brought into the discussion.

> I'd like to interrupt you on that one. ‘Cause I have to say you asked about how I felt in there. I have to say that's the one area where I have to say, “Whoa. That’s not my world.” There was a lot of talk about trauma and abuse. There was one of the people in the program was a very high up in that one organization, whatever the organization is that looks into abuse […] so maybe that's why it came up, but I felt like a lot of the talks were around trauma. […] Also, a lot of welfare kinds of cases that are not so much in my world. I always felt a little guilty about that, too. I always felt like a little bit of an outsider in that respect. That I'm working with private families and, you know, there was the person from Head Start. So that whole world felt very foreign to me. But I also felt, ‘Wow! At least I'm coming in contact with it a little bit.” (Movement 4)

> I did feel with the parents, you know, that, the socio-economic group was very different from any I had worked with or understood. [H]er mother's a drug addict. She's not in the picture so much […]. This is a single woman dealing with her niece. You know, what am I going to tell her? What can I tell her? I know nothing about this lady's world. She's coping, great. I could never cope like that in this world. I do remember feeling that. (Speech 2)

When the topic of childhood abuse and trauma was broached, insufficient dialogue occurred or, at least, was captured. No stories of interaction with the mental health staff or students emerged in the interviews on this topic. It seems that this series of “forging” blows was evaded or the blows were delivered inaccurately. The tongs, the tool used to hold the pliable metal in the forging process, where not well used. The Institute teachers could not, it appeared, hold the interest of the respondents when it came to the teachers and the mental health specialists who often came from trauma backgrounds in child protective services. There was no responsive conversations and, in the eyes of the respondents, there was nothing to share, it seemed. As we saw above, some practitioners simply stated they had no contact with the poor whom they thought were the primary victims of the problem. The theme is developed here from a systems perspective because the the next speaker felt that the poor were already quite well served though programs whereas her private practice patients had to fend for themselves. As her personal and professional experience grew, her alienation from the topic increased.

> I think also I was frustrated because I feel, and I still feel that way now even I think [...] that a lot of people were interested in talking about were your more at-risk populations. And it wasn't the group that I was working with. […] And I couldn't really connect with that. I wasn't seeing families where that was the issue. So I think that also frustrated me too, and now as a mother, I have a whole kind of completely different perspective on what's needed for the general population. Because there are sources of health for your more at-risk populations, but there really are not sources of health for the well populations. Your sort of normal neurotic people who need help and are getting it at really wacky places. So I would say that was another frustration. (Speech 3)

It may have been that there was confusion between trauma and abuse. Trauma can exist without abuse. It can be any difficult experience such as dislocation due to natural disasters that can happen to anyone as happened to many in the case of Hurricane Katrina in Louisiana as presented by Osofsky (2004) in the *Preface* to *Young Children and Trauma* . Trauma can also derive from extremely premature birth, to take a situation relevant to the study's respondents. According to Wolke (1998), birth at or near 23 weeks is very likely to lead a to life of developmental struggles for parents and children. The earlier a baby is born the more they miss physical and neurological developmental time in the womb not to mention the precious time lost to being held and loved while they are subject to extreme but essential high-tech care in the neonatal intensive care unit (NICU). The babies arrive at home with a physiologically diminished emotional capacity to manage common stress and the parents are often not prepared for an excitable or withdrawn child.

Furthermore, the delayed or premature child may receive all the necessary physical care yet remain emotionally rejected as one nurse with NICU experience described. She attributes this trauma to the better-off.

> There were some parents who ultimately got over the guilt or they accepted the fact their baby was going to live and their baby was probably going to have developmental issues. [...] Some of them embraced it incredibly and went overboard in becoming advocates for their babies. And others who kind of hired nannies or au pairs, nurses, and they delegated the aftercare and they went on to their work. (Nurse 4)

Completely unmanaged parental stress due to developmental delays contributes to the high incidence of abuse in delayed children. Atypical children with physical delays are 3.4 times more likely to be abused than non-delayed children and those with behavioral delays are 21 times more likely subject to abuse (Kendall-Tackett et al., 2005). Thus, some of the silence was denial, a negative silence, or ignorance that could not be addressed due to lack of verbal comments to alert the program's teachers. This is same difficulty arose when the respondents found it hard to begin to speak as professionals when it came to presenting themselves. When they could share, they did it without support. When they could not share, they also had no support.

For one respondent, statistical knowledge cancelled out experience for part of the interview. She mentioned that her home state had one of the lowest rates of child abuse in the country, an assertion which turned out to be accurate. Nevertheless, she still had a story about domestic violence and the importance of a socially competent allied health professional. In this story, the social worker did not understand the issues involved and had to be let go.

> It was a licensed clinical social worker that worked in a very small program and she really didn't know what her role was in early intervention and I think that she could not take a step away from her traditional role as a social worker. You know, case management, resource allocation. Talking with the parents etc. And the mom couldn't build a relationship with her I don't know why but she couldn't build a relationship with her. And the occupational therapist was going in as well and the OT was able to develop with this family efficiently enough to disclose that [they] lived in a domestic violence relationship. And the occupational therapist came back to me [and said] "You know what, we really need to do something for this family so set up a time to meet up with this

> family and social worker." We brought the social worker in and I tried to for the social worker and the family just didn't bite and I took over the role and modeled what this social worker should do and in a short period of time we were able to open up [with the mother saying "You know my big problem is that I have my little girl she is 2 and half years old, she has speech delays; I have these boys one's 5, one's 7 and one's 10 and I force my children out of the house and I'll pick a fight so I'll plan when the abuse happens when my children are away from the home." And she said and "I can't do it anymore because my boys are getting old enough and are going to start modeling this behavior." And so we were figuring how to get the family out of the house and actually we were very successful. However the social worker just didn't get it and because she just didn't get it no matter how much we tried to engage her I had to let her go and, I mean, sometimes no matter what you do go ahead. No sometimes no matter how much you try to support somebody through supervision no matter how much you model to somebody if they don't get it. They don't get it. (Movement 2)

Perhaps some sociological information would have helped. The social work students who attended had this background as part of their training. One practitioner had a profile for foster families in the projects. The narrative conflates the poor physical condition of the projects with the poor conditions of parenting in the home. The word "stink" may be carrying the mean of "poor quality" along with the denoted meaning of "bad smell."

> In foster homes, I would often see the parents; first people would use these walker things for kids. [...] I felt often that the way they would smile at the kid was fake. The way that they would tend to the kid was very fake. There wasn't the attention in that it was kind of like to showing to somebody else that they cared. But they weren't really giving the care. Care for me is that you give them focused attention. Care isn't being smiley faced. And that's what I saw a lot of in foster care, a lot of smiley face. I don't mean to fault foster moms. It s not like I am trying to *dis* the system completely because I met a lot of foster moms who were great. Who were tremendous with their kids and they moms and they were grandmoms. [...] I go into a project where the buildings are a disaster and they stink, and there is no room for the kid at all, and there in the tiny little playpen, the foster mother put them in. There is no room for the kid to move. There is no stimulation, the people who pick him up are always, there are doing this kind of stuff with the little baby, there's no relationship, and that was very dis[turbing].

To be fair, the Institute had to deal with such a small number of allied health professionals that it likely made it hard for the teachers to become familiar with the students'

needs for sociological information. Over the time period of the study, 21 students from somatic disciplines attended over 14 year period. This may have made it hard for the teachers to get a clear understanding of the individual needs of the students who did not offer any remarks that might have steered the discussion to address their needs. The teaching problems may also have had roots in the role features of the program. The students with mental health backgrounds were primed for abuse and trauma in their prior training with their training and experience that insisted on engagement with family problems in a social context. The nurses shared some of that background as will be presented later. First, it will be shown that the allied health professionals were far less likely to possess the any experience with the poor and be, therefore, less likely to share. The resistance to learning about abuse may also have been in part, therefore, of the latent way the Institute maintained dominance of the psychological domain over the physical. The allied professionals were outmanned and outgunned in this aspect of training when they were not in denial or simply unaware of social forces. In the next narrative, the speaker talks about the variety of mental health students in relation to her professional training. This topic was touched on earlier but here the comment is directly tied to abuse and trauma. As the speaker completes the narrative, she distances herself instead of sharing herself from her fellow students who were grounded in mental health.

> People worked with battered wives shelters. [...] Someone worked with women in recovery. Another worked with kids, families, was a foster care agency director. Everybody had their own place. And each of us exposed each other to what our interests were. [...] I could say for me, I never wanted to work with battered wives or with women in recovery. [One of] my classmate was a film maker, as well as a psychologist-in-training. And she was interested in generational issues. […] It is not that I would change anything, but it certainly alerted me to the issue. (Movement 5)

Nurses, when compared with the allied health professionals, were more likely to have broad social experience due to conditions of their work which often occurs in hospitals, public and private, which take patients from many backgrounds. One nurse in the study began her career in the public wards where babies were born to mothers addicted to crack cocaine and she persisted in working with that population. Another made a career in various public health care settings while yet another works as an advocate for low-income children. On the basis of the respondents' remarks, the allied health professionals had difficulties understanding the social factors that undergirded the problems they encountered while the nurses did not. With this understanding in mind, the amount of somatic practitioners in the program with no broad social experience or simple experience with low income populations was even smaller. This fact made it even harder for the teachers to get an idea of student needs.

Despite the practical experience of the nurses, nurses still needed a more sophisticated training on the effect of socioeconomic status on trauma and abuse. The following tour of society in New York City reveals one nurse-respondent's idiosyncratic demographic attributions. In her travelogue, "Queens" [County] refers to the ethnic and immigrant neighborhoods. "Jamaica", a largely African-American section of the Queens, is a code word here for low-income African Americans living in South Jamaica even though the Jamaica section of the borough also has middle-income African American and people from other backgrounds as residents. The speaker was quoted earlier when she described the kind of aftercare given by some better off parents, the journalists [and other career women] who rejected their child emotionally. The poor and better off simply had, in her view, different reasons for rejecting and traumatizing their newborn and the speaker experienced the spectrum of emotional distancing at birth.

> The mothers and the families there [in Queens] are very different than the Upper West [Side's] Roosevelt Hospital. We have the journalists on the Upper West Side and we have the junkies in Jamaica. [A] lot of these [Jamaica] mothers were actively using but they had to stop, you know, in order to maintain custody of their children and there's a lot of relapses. And when I would enter into the "Mommy and Me" [classes], their parenting style and focus and ways they perceive their babies was so different than the Upper West Side parents and the Queens parents. Because in the Early Head Start and Head Start Programs in Corona [another section of Queens] we had a lot of Mexicans and South American immigrants and they are very, very family oriented. In Jamaica, a lot of these women, who had a lot of life long history with substance abuse, they had a totally different focus in parenting. [...] We had, junkies, journalists, lawyers, and they all had different sets of expectations for their child and for being a parent. They [the educated parents] wanted the perfect baby in many instances. And if they didn't get it, they weren't sure if they wanted it. They knew that they were legally and socially obligated. It was a very, very strange practice. (Nurse 4)

The theme of the emotionally uninvolved professional mother was raised by other respondents and, there were very few mentions of fathers. Another speaker took of the theme of the professional woman who paid little emotional attention to her child as far as the therapist is concerned. The speaker supports her view with that of a colleague who also has had run-ins with this stereotyped financially well-off mother who delegates the child's care to others. While she says this kind of mother is rare, she managed to have a collegial conversation about this kind of mother who is used to support her opinions. However, the speaker had additional stories of her own including one of misparenting among celebrities so she, like some of the other students, had some kind of class bias when it came to this topic. In terms of the data that was gathered, the family problems middle and upper class family received no special attention. No one, students or teachers, brought up the role of socioeconomic status in terms of therapy. The speaker, Speech 3, said she did not see the poor and their problems. She just sees the problems of the better-off but these, somehow, do not require special knowledge or experience to manage. The emotional problems of the stereotyped financially successful single mother is presented in the next story.

> If I find a parent—and it's rare—but there was one like last summer that was a crazy, crazy mother, and she was working full-time crazy, and driving me crazy, and the babysitter was a real slug, I mean, just, sat on her chair, the baby's on the floor. It was unworkable for me, and the mother was very hostile, single mother, very hostile, angry, lawyer wanting copies of notes. I said, "You know what, if I was in a situation where somebody was reining in the mother, it would have been more workable." But that wasn't. The situation where I am at a point now where, you know—it's funny, because like years ago I was talking to a colleague, an OT downtown, and I wanted to refer a mother. And she said, "What kind of person is she? We don't want any wolves in our den." And I was really impressed that they were able to actually verbalize what I've always thought [...]. That's sort of what I do now. (Speech 3)

The children of the better off could be denied services, therefore, if the parent did not behave in a manner the therapists liked. While dropping a case is the privilege of a professional, the inability to manage countertransference does not benefit the child who is the actual patient. The failure of the program to generate any exchange in this area ultimately hurt the children of the better off. Their mothers were often described as difficult and not excused their individual stresses when they were perceived as a constellation that included being too demanding as the next two speakers confirm.

> I will tell you what an issue is. An issue is when a parent of wealth wants multiple services multiple days a week. They will bring in an attorney to fight early intervention system, I want pt 3 times a week; I want OT 3 times a week; I want education 3 times a week. That is the kind of issue with affluent families. (Movement 2)

> Even with this child that I was describing before, the child with CP, ADD/PDD, the mom was [...] looking for many different therapists for this kid. Oftentimes, when the parents want to do much more than the child is possibly capable of doing, they want to throw everything at them [...] especially who are well off. They want to do many things. [...] He was booked to [the] hilt. (Movement 3)

At the same time, the wealthier mother could be perceived as disengaged and needed to be roped into the role of therapist as we see in the next vignette. In many cases, parents object to

being part of the therapeutic team and the idea of the parent-therapist is dominant in the Anglo-American world (Leiter, 2004). Meanwhile, the therapist is, after all, hired to do a job. From a feminist perspective, the father is not part of the picture even though his work is not different from his wife's. Just the same, the mother becomes the neglectful parent. To the credit of the therapist who tells the story, she is at least aware of the countertransference and trying to manage it. The speaker comes to terms, to some degree, with the fact that the mother is not really neglecting the child. What really had to happen was that she had to come to terms with her own childhood as one of nine children whose mother could afford a nanny while she ran a large household. The speaker's attention to the countertransference very likely made her work successful because she had less unmanaged hidden negative emotions than the other speakers who simply went along with their unexamined negative countertransference experiences. The speaker also returns to the theme of using the body as a way of understanding emotions. She first described physical transference reactions in the section detailing pre-enrollment experiences. Her engagement went so well that she felt she had entered the family sphere to an inappropriately intimate degree.

> Both were psychiatrists. I had to negotiate that. It was tough to identify with the child and hate the parent. And then I would go in her body and think: "She is an intelligent woman, she's trying." I would hate her as parent and maybe brought up a lot of personal feelings about maybe my mother didn't have enough time for me, whatever, maybe I would explore those, too. And then, as a parent I would look at her and think she's not a monster, she's trying. She's trying, she's very anxious about this child. And she's relying on me somewhat. And then my goal was to make her find more time for her child. She was rushing to my sessions. I got her to come into the session, too, from her work rushing. And the child was so anxious about it. [A]nd associating me with the presence of the parent. When the parent wasn't there, me, having to deal with the loss of the parent not being there because the child wanted the parent to come. [...] It was tough. [...] It was a very tough place. [...] The child was very attached to me and the parents were aware that I was helping the child so they were valuing my work. That they were doing. So I

> went with that, crossing that part. They were really valuing the work and the child's attempts to talk. I feel I was intruding on their life a little bit. (Movement 1)

The last speaker on this topic talks about how the low-income parents received sympathy and understanding for their parenting and poverty-problems such as not cancelling appointments ahead of time, forgetting something the therapist thought essential or other family problems. The better off did not receive comparable sympathy for the workloads they managed as members of the professional class. Children of the poor were treated as deserving of services irrespective of their parents' flaws and lapses unlike those of the middle and upper income groups.

> [U]sually families, some of the families have so many risk factors, so many issues that this [delay] was just a small dot in their lives. You know, [my] going, making and home visits and then [their] not being home. Forgetting the "whatever" and then dealing with their frustrations. This parent really needs it. This kid needs it. (Nurse 2)

Adult Education and the Infant Parent Study Center

In general, teachers had limited success in getting transdisciplinary students to accept trauma content as part of the larger IMH picture. Problems transmitting the ideas of trauma had to do with lack of shared theory and knowledge. A new theory challenged the thinking of those who could not accept that trauma was not only a problem of the poor. Exploring the experience of shared and new theory can be seen in the reports of Knowles and Freire. Knowles transformed executive retention and executive performance at the Westinghouse Corporation based on the use of shared theory. Creating sociable access among the lower and upper level executives was enough to generate change. One reason for Knowles' success is that all executives share

fundamental business goals and need no theoretical training. The junior executives were willing team players who only needed the heads of the firm to change its own theory of human resource development. After Knowles' project, the organizational culture of Westinghouse now fostered a natural mentoring process as the juniors had direct access to seniors of their choosing. The hierarchy remained but became more porous. The project worked, in part, because no one had to make any theoretical changes to their work.

Despite, the best efforts of the IPSC instructors, they could not get everyone to share their view in this area. Part of the reason for this was that the somatic workers had to undergo a theoretical shift far greater than did the executives. More than access to psychologists was needed as it was in the general acceptance of IMH. We heard them speak about how they struggled as they began to include antirealistic science in their work.

A person unfamiliar with the theory of the process related to the task not only has to learn facts but also the intellectual method associated with those facts (Freire,1992, p.112). The method was learned in dialogue. His goal was to transform through dialogue by creating conditions for dialogue. However, no dialogue ever got established about trauma and socio-economic status even though the students had set up their particular profiling system of bad well off mothers and worthy poor mothers. The profiles had geographical components that included the projects, the Upper West Side of Manhattan and the whole of Queens County of New York City. It is unknown if these schemas came to light in the program.

Denial of trauma never became an overt topic and could not be discussed for unknown reasons. One possible reason is that the program focuses on relationships rather than sociology and made no claims to teach sociology. It might have helped. The program was successful in spreading its message about the importance of relationships but not adequate in relation to social

problems which require a separate theory. In place being taught a well thought out theory of society, the students made up their own theory. For example, a theory of bad foster care failing to generate good attachment was constructed without the knowledge that orphanages were shut down due to thinking that the orphanages generated poor attachment. From the perspective of relationships, it may be that the better off respondents did not want to see the problems in their own socio-economic backyard. Ultimately, problems in a school fall on leadership and, as in the case of the silence that came before sharing knowledge, the silence on trauma may have been hidden from their view. After all, in 15 years, only 20 people like the respondents enrolled and completed the program.

To have people solve social problems, according to Freire, adult education students must master the method associated with the theory that led to the facts that support it. In *Education for Critical Consciousness*, Freire (1973, p. 41) says that one part of a good educational program is to learn “the transcendental meaning of human relationships.” He continues with this thought and how teaching must lead, recursively, to more creative acts.

> From the beginning, we […] considered the problem of teaching adults how to read in relation to the awakening of the consciousness. [A]program which itself would be an act of creation, capable of releasing other creative acts, one in which the students would develop the impatience and vivacity which characterizes search and invention (pp.38-39)

The following pair of stories show how two Institute students met Freire’s criteria for successful transmission of knowledge and theory. Transmitting knowledge and theory is what failed in the teaching of trauma because the teaching did engage emotions in a manner necessary to absorb new knowledge. As just quoted, those emotional states require a vivacious impatience

with existing knowledge and a method for ingesting new knowledge. The first tale is about a somatic worker using a standardized assessment usually used by other professions while mixing in counseling work as part of an occupational therapy session. She has learned to delve into the differential effects of psychosocial maternal depression on the child and the child's inherent autism.

> [J]ust as we were learning about the MCHAT, I needed it. It's a very simple, quick interview, but very reliable, to test for autism. This family came in and it was very clear to me, [...] as an OT, I can't make this diagnosis at all, but I can do this and say, "It looks like you should search for somebody who can." So, I needed that and this whole thing was very complicated with this family. I guess thinking back, there probably was a feeling that: "I'm at the Institute, I'm learning about these things. It is ok for me to make, formulate ideas about what is happening with the mother." I guess on some level I felt some degree of confidence in addressing it. That one case with that very young child, she was about 18 months, seemed to have autism.[6] You know the mother was, again, somebody that was talking. I have to say this: "It seemed like people were talking to me so maybe something was going on." This mother told me she had gone through this pretty serious post-partum depression and that she thought that was why things were going on with this child, and she was still suffering from depression. So things were coming up. But did I know how to handle them? I don't think I felt like I knew how to handle them other than to listen. (Movement 4)

The limitations of checklists in practice were mentioned among the factors that led up to enrollment. The school was not teaching "checklist or no checklist"; it was teaching creative use of available materials, including the self. The following story is an example of applying theory creatively went in the opposite direction for this practitioner who liberated herself from clinical checklists while in the program.

> [I]n my private practice [...] things changed a whole lot. When I evaluated a child, as I do now, I don't start with a questionnaire on paper. I now work the way I want to work, so I bring a parent in. We do an intake. I feel that in that intake I'm establishing a relationship with the parent right then and there. They feel heard. I pick up a lot more about the child than I ever would from any questionnaire about the child. I feel free to ask questions

[6] The diagnosis is made no earlier than the second year of life. The MCHAT is a rapid autism assessment.

> about the kinds of questions I asked about the early relationship to the parent. "What was it like being with that infant, etc. I'm asking questions in a whole other realm." (Speech 2)

In time, this last speech therapist began working more deeply with the parents, the child and her own anxieties due to the attention she received during supervision. The supervision included ways to apply what she was learning in classes at the IPSC as well as helping a novice therapist get past her anxieties about expanding her role.

> And the following year, I was supervised by a psychologist who very much knew the children I was working with. [T]hat was great because I could really get into what the children, [...] let's say for a particular child who began to use me, there's play. I work through play. And he was beginning to use me, in play, not only for language but the things that he was playing out that I didn't want to turn away from. [...] I would get very anxious. So I was able to go to her with all the anxieties that it would raise. What the child was showing me through his play. And, you know, she [the supervisor] helped me to understand and to say, "It's okay. You can do this. It's okay." [...] I was holding the child and his anxieties; she was holding me and my anxieties. [...] And also I could go to her with all the questions and issues and problems I was having. [...] And she, she helped me to understand them and to deal a lot with my own anxiety. How? [...] I would talk about what I was anxious about. […] And, you know, I guess as we talked, I understood, it helped to relieve some of that. And I felt like I wasn't in this alone. (Speech 2)

The above quote refers to the practice of *stopping* to let things emerge. In the last story, the therapist had to wait on her own anxieties about the new practice. Stopping, or studied inaction, was used by one student prior to enrollment while volunteering and in the nurse's story of intersubjectivity in the NICU.

The process of learning to apply play therapy, or simply playing with the child in a nondirective but purposeful way came, but only with struggle and support. The above quote also shows how Speech 2 was beginning to transition to see the child's mind and learning to manage the possibility of a mistake due to lack of experience. Here, we are looking at the application of realistic science, i.e., speech therapy, while working with anti-realistic science; she has gone

from working with the visible world to working with the invisible. The speaker learns to willingly face the invisible world. She stops to observe the emergence of the child's inner world in play. The therapeutic process stops to support rather than proceed. Holding and being held are forms of stopping for the same reason.

The next speaker describes what happened in the IPSC when she made a mistake. Mistakes are made by seasoned as well as neophyte practitioners in any field where uncertainty is a given and experimentation is required. Schön (1983, p, 151) calls such attempts "transactional" because the practitioner is in a "conversation" with the situation. When practitioners are not stuck in familiar patterns or rote information, it is appropriate for them to attempt something new based on experience and increasing understanding of the situation. The speaker's willingness to experiment that had to be transmuted from fear. Converting fear to confidence was also described in the narrative from Speech 2 in the prior narrative. First, one speech therapist described her transition to being free to experiment.

> That enabled me to just kind of play with the ideas, and when I screwed up I could come back and tell them, and it was ok. It was ok not to know. It was okay to struggle. That's a gift. (Speech 1)

Part of being willing to make a mistake has to do with having a total vision of the treatment goal and the confidence in being able to achieve the goal, rather than despair over a detail of the process that did not work out. In the next quote, Reg Davidson (Levi Strauss, 2010a, p. 46), a senior woodcarver and multi-skilled artist talks about making a mistake. He works in the visual tradition of the Haida, one of the culturally important tribes just off Canada's Pacific coast on Queen Charlotte Island, or, Haida Gwaii. The Haida are of particular interest here because their art and mythology is based on moving between and maintaining borders thereby

sharing some concerns of this study as stated by Bringhurst and Steltzer (1991, pp. 35 & 79) Davidson's inability to manage a mistake would mean starting from the beginning again. Not a pleasant prospect in a carving project that might involve a cedar log longer than 30 feet. He talked about the difference in a mistake made by a creative person and a mistake made by a person who only knows how to work from rules.

> If an artist makes a mistake no one will ever know because he has the knowledge to work the problem out. A craftsman is a technician, copying someone else's plan. When he's copying something and makes a mistake, he can't correct it, because he does not know the way the whole works. (p.46) (Levi Strauss, 2010)

Learning how the "whole works", is its theory as Freire might say, means learning how to play and invent. This process was also concretized with the application of play therapy and open-ended psychodynamic and reflective questions within the closed system of physical care. The important feature of skill building was that the practitioners learned how to play with ideas they had intuited but could concretize on their own. Some of the students knew that there was an intuitive aspect to their work. They just needed the intellectual framework to understand it

> It's an opportunity to sort of learn the basics, if you will, of what you may intuitively do or know intuitively. I think that was sort of the thing for me, that I had a chance to read and discuss [things with those] who were the people doing the work. (MD1)

Peak Experiences During Enrollment

During the pre-enrollment period we spoke of peak experiences that illuminated enrollees' desire for transdisciplinarity. While enrolled in the Institute, three additional peak experiences were reported. In contrast to those that occurred prior to enrollment, the peak

experiences that occurred during the enrollment period can be seen as pinnacles of a kind of experience associated with training methods employed at the IPSC. These illuminations fall into three categories. Two of the categories, recognition of the value of one's own knowledge and stopping or studied inaction were already presented in this section of the findings. The graduated intensity of the experiences suggests the teaching methods at the IPSC can create profound experiences and can be expected by the faculty during the enrollment period. The third experience follows on material explored in the Antecedents to Enrollment section. It provides support for idea that the IPSC is tapping into the deep, unconscious desire of the respondents to be a mental health professional.

One reason that these experiences occurred at all can be seen in terms of the adult education programs that have transformation as a stated goal. Knowles' training program aimed to transform an organization's very formal hierarchical structure into a less formal one and, thereby, change the organization. He viewed his trainee executives as competent performers who just needed only more information and a less structured hierarchy. The organization needed the change, not the people. Freire had a different goal. He set out to transform people and his was to transform society by minimizing the attitudes that underlie hierarchy and create greater social and economic equality. He saw that the predicate for the change was the peasants' individual transformation into a sense of being social equals to others in society. Freire felt that the attitudes that supported the social hierarchy supported oppression while Knowles thought that the organizational hierarchy needed only softening to support the organization. To be fair, Knowles' scope of practice was the organization and not revolution. Freire, to the contrary, saw the whole of society as his field of practice. Knowles was a reformer and Freire a revolutionary.

In relating Freire's theories to the experiences of respondents, "parity" is a better than "equality" because one meaning of parity concerns equality of status, often in salary, when other factors are not the same. For example, firemen and police perform different functions and face different risks yet they receive the same pay, at least in New York City. To acknowledge their parity in danger, they are both referred to as uniformed services. A statement of another kind of parity comes from an illiterate shoemaker who saw himself transformed by Freire's teaching methods (Freire, 1973), p.42). The cobbler described his new sense of social worth and parity after he transformed from, in his a view, a socially insignificant person into a person possessed of special knowledge: "I make shoes and now I see that I am as important as the Ph.D. who writes books. "

The social gap between Freire's teachers and the illiterate peasants and workers was vast. The gap between the IPSC's somatic and psychological students was also vast, though not based on education or social class. When the respondents experienced a shift in consciousness, the shift in viewpoint could be equally as powerful and mind changing. The antecedents for this next narrative were presented earlier when the students described how they came to share knowledge and broke the silence. The striking thing about the following narrative is that the speaker describes her change in relationship to PhDs in nearly the same words of the shoemaker. To heighten the narrative, she introduces her story with the first three words of the King James Bible. The words are italicized for emphasis. This quote provides an apt frame for this illuminative experience of her own reevaluation of her own experience and knowledge.

> *[I]n the beginning* I thought, "What the hell am I doing here? I don't fit in the same league as most of these people with PhDs." I didn't even have a master's degree at that point. So, I thought I was a fish out of water. But when they came to know a little bit

> more about me and I saw they didn't [have] half of the experience I had with infants and parents. It shifted. (Nurse 4)

The person who just spoke is the nurse who had the illuminative moment of intersubjectivity in the NICU. She may the kind of person who is predisposed to integrative experiences. It is impossible to prove absolutely why such experiences happened at the program but it is fair to mention that such experiences are associated with the program. Part of the reason for the presence of illuminations is that the IPSC inadvertently follows a Freirian model of training which specifically aims at transforming people by altering their theoretical outlook and trains them in the methodology of the theory. The word inadvertent is used because if the program leaders do not intentionally work with the silence in the way Freire does. The lack of appreciation of the silence enforced the failure to teach about trauma. In addition, the program is generally focused on the larger numbers of mental health professionals not the small percentage of physical care providers. The focus of the IPSC has to be on the overwhelmingly local role orientation of the program.

Two other women offered descriptions of transformative experiences during the training period. Their transformations require contextualization because they represent different degrees of experience that emerged during the time in school. First we will look at how, prior to completion of the program, one student integrated the facts, methods and theories associated with transdisciplinary work of melding mental and somatic function. She met the program goal to create transdisciplinary practitioners who remained within their original role. The first transformation is related to *studied inaction* and brings us back to the idea of stopping.

Studied Inaction

Studied inaction is a term used by Winnicott who, by simply staying present to the moment and listening, came to understand the therapeutic pace hastened (Phillips, 1988, p. 52) . He had to teach himself to stop interrupting with interpretations as taught in his psychoanalytic training. We do not know, based on the interviews, if the words *studied inaction* were taught in the IPSC when Winnicott was discussed. Rather, the words *slowing down* and *stopping* were used by the respondents. We also saw that slowing down and stopping was part of the pre-enrollment process as manifested in actions such as additional trainings and volunteering. Just the same, Winnicott's approach of leaving things to play out by the therapist's keeping still was learned.

Similarly, we can consider Zen, a transformational religious discipline of the mind, for more explanation as to how stopping might work as a transformational method. Zen Master Thich Nhat Hanh from Viet Nam gives some reasons for the way stopping creates conditions for insight in a meditative path. Stopping in order to look, according to Hanh (1990), is one of the two aspects of meditation that lead to enlightenment, the Zen illumination, because stopping allows for objective investigation of phenomena, the second aspect of meditation.

> Thanks to our ability to stop, we are able to observe. The more deeply we observe, the greater our mental concentration becomes. Stopping and collecting our mind, we naturally become able to see. We do not need to search for anything more. (p. 39-40).

Winnicott concurred with the idea that too much interference with the patient's talking or, in the case of children, playing, denied both sides a fuller therapeutic condition for health and insight. Stopping is also a skill that is learned and taught that calls forth a natural ability or hidden potential. Stopping, pausing in midcareer was a theme that appeared in relation to

enrolling in the IPSC. All the students in the program, in Westinghouse or in Freire's classes had to take time out from the concerns of daily life and work. This time allowed for instruction and reflection. Many students learned studied inaction and we can explore it as it manifested in different degrees. The speech therapist who speaks next learned to inventively combine disparate but flexible elements from speech and psychotherapy. In the following description, speech therapy and psychology create a new approach to meet an old aim. In learning to stop, she has learned to see as the Zen master and Winnicott propose. Her task is like the shoemaker's who takes a fully flexible piece of string to stitch two pieces of leather for the upper and sole to make a shoe. In slowing down and watching herself, she created a space for the child to enter the same way a shoemaker creates a place for a foot.

> There are things that I learned about sensory work or developmental play. It gave me more tools for how to create a structured environment. How to create [and] structure the environment. I think I got better at waiting for the child to come to me. Like much more, in terms of child-centered play. Like slowing down; just sort of slowing down to child time, to infant time. Slow myself down to really know what is going on with them. Once I saw what's it's like to go slow, I knew I was too fast. (Speech 4)

Schön links the ability to transform to paying attention as well (1983, p. 151). He is talking about a quiet, focused attention to a problem that somehow lets an unexpected solution reveal itself. Here is what Richard Shrobe (2010), a Zen master and psychotherapist born in the Bronx, has to say about this kind of attention and how it links to intersubjectivity.

> For us, attention primarily has to do with caring. If you attend to something, you care for it and give time to it. To give time and attention is to give caring. To pay attention to the mundane, simple, small details of life is to live in the world with a spirit of caring, as if each and every thing were in your stewardship, as if you have a responsibility to care for every moment and each thing. That attitude expresses an absolute valuing of all experience. Attention, from the Zen point of view, has much more to do with caring than

> with some strong, focused concentration. It is true that when we sit in meditation we pay attention, with a certain kind of focusing and stabilizing of energy. But, primarily, attention is about caring and being careful. And, ultimately, caring means to become one with the object of care (p. 10).

Therapeutic patience became a necessary part of transdisciplinary work as the somatic students understood more about the inner lives of mothers whose children were born to delay and trauma. The NICU nurse enacted care for the parents in the NICU where she saw acceptance and rejection of the premature infants. She also gave special attention to teaching the rehabilitating mothers who might otherwise lose their children to foster care. In the process, mothers had to pick up some bit of theory about competent parenting but they especially needed someone knowing how to stop and keep still in order for them to transform themselves into better mothers.

> A lot of times if the babies would be fussing. Half of the time it would be because the baby was withdrawing from drugs. They often, I would often listen to them say, "She's doing that to make me angry. I'm going to teach her." And it was very hard for me not to want to immediately stop them. I had to explain to them. The baby wasn't crying to get them pissed off or challenge them, but they were going through this developmental period of either fussiness or trying to develop a secure bond with them. (Nurse 4)

By the end of the classes, the nurse felt successful. The mothers got an essential bit of attachment theory under their belts to keep their infants with them and out of the foster care system. The nurse taught theory and facts grounded in experience. Everything happened because she knew how to wait for the mothers to arrive at solutions.

> Well, I think, after a few weeks of being in the program, being in the play groups, I think the moms began to see me as someone who knew a lot about babies so they could ask me a lot of questions about baby health, and then I would interject with them what was going on with the baby emotionally and then we would do a lot of play. So, I think, just through play and though discussion and answering all of their questions [...] they became comfortable and realized that this white girl knew what she was talking about because

> they could see how the babies would react to me and then them. There were some mothers who would connect with the baby, and the ones who didn't. They would be watching other mothers and seeing this process occur. And over the course of many, many weeks and months, because I had a long period of time [they would learn to understand more about their babies' behavior].

Next is a story about stopping in relation to grief. One reason for the parent's intense grief might be that she is no longer in denial for she finally found a sympathetic ear. After the first year or two of her child's life, she openly admitted her child's problem to herself and probably ended her denial, admitting her grief (Foley, 2006). The narrator reports she could wait on the mother not because, she says, she was taught about waiting but because she wanted to test the idea she had learned at the Institute. The speaker is the person, previously mentioned, who has to disagree or test, first, in order to agree. In this vignette, even the tissues that might normally be offered to a grieving mother were part of the studied inaction.

> And she began to cry. And I did not reach for the Kleenex, [...] I [do] not think I said anything. I looked at her and she kept telling her story. And she just began grieving, [...] "Wow!' I'll just listen to her." […] And she cried and cried and cried. It must have been for about 15-20 minutes. […] And she got up and said, "You know that I am going to go home now." And I said, "That's fine." I finished working on her boy. That's an example of ideas. It's not really the Institute gave me that, but it's kind of like I was, um, testing this theory. […] And, in the end, I felt that it really bore out to me a very good way of being with somebody in that secure situation. Reaching for the Kleenex means you want to turn them off. They can express it. That's the thing. You just let them cry. They express it like in any grief situation. If you've a relative or close friend, you've just smashed up [...] (their) favorite car. What are you gonna tell them? "It's okay, don't cry." They have to grieve their loss, these parents, especially these parents. This mom I told you about. She's grieving with me. She doesn't have the opportunity. The child is so disabled. (Movement 3)

For another nurse, stopping gave her a greater sense of appreciation for the work of psychologists and social workers. She eventually applied the method to herself but it is not an easy practice for her. She is action oriented, in her words, because of her role, yet, she finds

stopping essential in her work. At the time of the interview, she had a senior management position in a large health care facility and has to watch others during meetings as well as herself. She also brings up the difference between the action-oriented work of the allied health professional and nurse and the reflective orientation of the mental health worker that was brought up earlier. She also describes the difference between paying attention during the event and reflecting afterwards.

> That's always been a struggle for me. So I'm really working on being present and being mindful. Yeah. In other words, stopping to act, right? But it's still not easy. It's hard. Not just to react and say, “Let me just do it or, let me just try to see why people act the way they do.” It's hard. It's easy with someone outside your circle, but with your family, it's tough. Why do I have this reaction? I don't know. How am I going to change this person's reaction to me? It's not easy. Well, I really learned a lot about working with social workers but I learned that at the Department of Health. Because as a nurse when I was a nurse manager […] social workers would just drive me crazy. ‘Cause they, even when I was the chairperson of the New York City Program and it was run by a social worker. And they would wait. Social workers seem to wait for people to come to them. [S]o, I got a respect for, also, I did the training with other social workers. […] One of the things that I had voiced at the Institute was that there's a difference between nurses’ preparation and social workers’ and psychologists’ preparation. So our thing, and it may also be a personality thing, is: “ACT!” What I learned at the Institute that I try to apply, I don't say I'm always successful, is reflect first then act. Think about it. Don't try to fix it right away. Try, as [I] said at the Institute, hit the pause button. I'm not always successful at that, but at least I can reflect after.

Stopping for Breakfast

At the pinnacle of the stories of studied inaction, is one about a family transformed by a transformed worker. The scene occurred after years of work. This therapist struggled to get the mother, a child psychiatrist in training, involved in her own child’s therapeutic life. The tale returns us to theme of the professional mother who ignores her child and it is sad that the mother needed assistance with her own child. The background of the therapist is in movement but she knew how to use her prior and Institute training to help children speak. She had to learn when to

replace her action-oriented training with her new skill in stopping. By the time this event occurred, the child was improving, he could speak more than before. The mother became attached to the therapist to the point of wanting to socialize with her. The possibility of friendship was not acceptable to the therapist. She was, though, willing to accept the idea of paid, therapeutic appointments that entailed breakfast. It was hard for the therapist to transform herself and the situation by sitting still, in part, because she is paid to provide movement therapy and, in part, because of the inner struggle it took to keep still and observe the family. This is a peak experience because the therapist sees the conflict between her drive to provide physical and emotional care, her stopping and setting aside her personal feelings towards the parents. The tension of managing the forces and people is summarized in her statement about the need to model and hold herself as she observed her inner and outer world.

> Sometimes, I sat with them for breakfast, on Saturday, they were both [parents] were there. I remember […] they invited me […]. I remember talking in supervision […] and they're [the supervisors] totally validating me, thought it was wonderful. […] I'm sitting there losing my time sitting there for breakfast. […] So I sat with them. And, you know, having a conversation, and the child sharing the moment with them. They were having, I think, […] a positive interaction. But I had to absolutely model. […] All the feelings I have to hold to myself. So the supervision was very good. I just, like, let it out because I felt very conflicted about all the feelings that I had, a lot of feelings, a lot. Talking about, how to trust them. (Movement 1)

Becoming Transdisciplinary Psychotherapists: Regrets and a Career Crisis

The last illumination reported has to do with the combining of the forces of latent and manifest desire to become a psychotherapist. As we heard earlier, a few of the respondents had, at various times in their careers, conscious desires to become psychotherapists. They saw it before enrolling yet they made other choices. Unconscious manifestations of the desire to become involved with psychology manifested in marriages to psychologists and the peak

experiences themselves which all had a reflexive and psychological cast. Regret is part of this theme because this topic returns us to the unmet, conscious goals people felt early in their careers. This thread also returns us to the essential need for stopping as part of the career trajectory. The first speaker is ambivalent about being some kind of counselor.

> If I could have a credential like a social worker and I could do that, I could do counseling and I would love that, but I haven't been able to find a path that I could do that. But, then, do I want to talk to people about PTSD and suicide? [...] I'm not sure. (Nurse 3)

Another nurse has a definite regret. There is no ambivalence at all. She thinks she made the wrong choice. The theme of taking time off appears again.

> Well, if I was a psychiatric nurse specialist, I would have all kinds of … I would do therapy. Whereas with this, I do teaching; I'm mixing therapy, psychology with other things. [,,,] When I went to graduate school. I took time off so I didn't work and when I finished graduate school, I took a job at St.Vincent's to be a supervisor in their parent education program and that was working in a clinic and doing groups with parents and children, and I developed a new parent warm line, with calling parents. It kind of was community health. You know, I struggled with should I be a psychiatric clinical specialist, or community health because that's broader. I chose community health [...] looking back, I probably made the wrong choice. (Nurse 2)

The process of role exchange leading to role release, the limited ability to practice in another professional sphere, led one respondent to almost to abandoning the initial role. First, we will explore an evolutionarily process of role exchange and expansion with another speech therapist who expanded her role into autism therapy with a communications component. She remained a transdisciplinary practitioner and never quite left speech therapy even though she wanted to be 'free' of speech as we heard from her earlier. She maintains the broader sense of speech, communication, in her current work. This is the speech therapist who worked in the early

childhood group therapy, other non-speech programs and had the peak experience with her baby and his ball before entering a recursive trip back into speech. She also has no one word descriptor for work.

> I would call what I do as sort of an interface between language therapy and play therapy. Or, umm, what I say when I recommend therapy after an evaluation is, “The child needs relationship-oriented, developmentally-based language therapy.”

The epitome of wanting to be transdisciplinary psychotherapist comes from another speech therapist who went the extra mile and took on another role or qualification as a clinical social worker. She nearly abandoned her somatic role completely hangs on with her fingertips. The background led up to the crisis was begun earlier when we heard her tell about how her sessions increasingly involved what most people would call psychotherapy. This is the person who felt like she was a fraud because she had aptitude but no training. Even though the Institute does not promise to create psychotherapists, she enrolled and had regrets. The lack of any psychotherapeutic training stymied her but, in Knowles’ terminology it was not part of the “learning contract”. She also vainly felt she had more psychotherapeutic experience than many of the other students. This is unlikely because the majority of the other students in the program are already mental health professionals. She called herself “vain” during the interview implying that there was something negatively egotistical about her search.

> I think that my frustration, ultimately, was that there wasn’t a clinical (psychology) piece to it at the time. I think, I felt like I was, I had clinical information but nobody else did or that very, very few. Really, I think my feeling was I was the one that was doing the hands on work, and I felt, I think, it didn’t teach you how to be a therapist. I think that’s—it’s not like going to a psychoanalytic institute where you leave feeling like you can do psychotherapy. I didn’t feel like leaving I can do anything. It sort of gave me a career crisis, it reinforced some aspects of my perception—right, but I didn’t feel like I was left able to do anything. (Speech 3)

This respondent realized midstream in her response that she was not getting the training to be what she really wanted to be in her professional life but attending the IPSC placed her firmly on her path. She then went to social work school for clinical training and eventual licensing. The strength of that experience was equaled to her having children, a theme associated with enrollment, learning and peak experiences. Here is the first step towards her peak experience.

> Clearly, I would not have gotten a social work degree if I did not do the Institute. […] So, it also set me into a career crisis, an identity crisis in a big way. […] I sort feel like it's, [...] equal weight with having children which has sort been like my internship. So I think [...] it's there, it's part of my experience. So has it guided my experience? I'm sure in some way it has guided my choices, but… I think the Institute attracts people of a certain mind. So, okay, it reinforced that part of me. I don't know if I needed it, maybe, I did at the time, I'm not sure. But, certainly if I didn't do the Institute I would not have gotten a social work degree. So, yeah, one thing did lead to another in that way.

She confided her concerns about career to her perspicacious instructor, Dr. Shahmoon-Shanok. Recall that Shahmoon-Shanok also coached the speech therapist who worked in the early childhood group therapy program. She has that mentoring eye. The result was that the respondent's next step was placed by Shanok in a professional frame of reference that could address her sense of fraudulence and support her growing professionalism rather than the need for reimbursement. For most of the practitioners, the final and satisfying step was in uniting psyche and soma but in this example, the final step entailed the separating of soma from psyche. To accomplish the break, she still had to manage both her own mind and body by shedding an old skin for a new one. Her "vanity" reappears again.

> When I finished, I didn't want to do speech therapy anymore. But I couldn't bill for anything but speech therapy. Rebecca had said, "If you want the respect of your mental health peers, you should get a mental health degree." So that's what I did. And I did the accelerated program at NYU. […] And I hated it the entire time that I did it. I was

> kicking—I had hives the first day of classes, I did not want to do it, I mean *hives*! […] I could have slept through the program, but it got me where I wanted to be. And, I think, it was a good thing that I did [it].

Learning infant-parent psychotherapy at the Institute was insufficient for this respondent. The term infant-parent psychotherapy may, inadvertently, give that impression that psychotherapy is being taught but infant-parent psychotherapy focuses on the relationship with the child for a parent, not on the totality of the parent as person. An antirealistic presence gets conceived then treated. This speech therapist turned psychotherapist struggled within herself and with the presence of psychotherapists in the program. She wanted more professional psychological engagement with people. Furthermore, she compared her training experience to that of her husband who began as an OT and became a psychotherapist. In the following vignette, the difference between the psychological workers who come to the Institute for honing of existing skills is contrasted strongly with the somatic workers who come for a broader view for their practice and a n entirely new set of skills.

> It's that, because most people who do go don't need to be taught how to be a therapist, because they are. […]. For example, my husband went to the White Institute, and that's where he did his training. And it's a very prestigious institute, and he can call himself a psychotherapist, psychoanalyst. I feel like it's important because it didn't make him a therapist but it was training in that you leave that institute knowing that you can legitimately say that this is what you do. Whereas the Institute was, it looks nice on my résumé that I did this institute, but nobody really recognizes it. [I]n other words, at the White Institute you had to do a certain number of hours of clinical work. [W]hen you leave there [the IPSC], you've gotten a smattering of psychoanalytic literature under your belt. You leave there with a perspective, not with real actual training.

Looking Back at the Transdisciplinary Training

Next we will examine a final comment in this section to see behind the complaint about the training. The last speaker correctly states that the program made no pretense about turning

the non-mental health students into any kind of *bona fide* mental health therapists. No one went there for that kind of training. The mental health people come for specializing in early childhood practice and the respondents come for a way to apply IMH in their physical practice. Their ability to perform as IMH practitioners was presented as well. The complaints can be seemed in terms of a program theory which implies a hierarchical model of transdisciplinary work under the heading of infant mental health. The theory is presented in the IPSC catalogue (2008).

For the most part, the students were pleased with the didactic content and supervision they received. They did have comments about transdisciplinarity along the lines of the UCP model and the teaching staff. There was not enough attention given to the individual physical disciplines. Part of the reason for the lack of intense teaching about the body is that the program is about teaching IMH, a model of mental health, primarily, to people already in the mental health professions. As we described it, they go for honing or specialization within their field. They pick up odds and ends of physical care since few of the teachers are qualified as physical care professionals. This means that physical practice is informally taught primarily by those students who are most likely to remain more silent than program leaders would like. There is little forum for their practice and along with the problems with learning the epistemology of interpretation, they see, subliminally or consciously, that their skills are secondary and at the same time essential. Their skills are essential in that the mental health practitioners cannot get this insight elsewhere and the physical care skills are essential for knowledge exchange.

The complaints express this contradiction and are heard in two remarks. One is the realization of the psychologist that the PT he is supervising works under conditions of time limits and goals rather than open endedness. The second is the general complaint that not enough physiological ‘lenses’ are in the room. That would be impossible. There is only one model of

psychology being promoted but numerous models of physical care being proposed and practiced. The specificity of the mental health model is not matched. When the PT says that that people like her would accept any reasonable information from a psychologist but a roomful of psychologists might not due to disciplinary differences. Here is an example of specificity within the speech and language profession.

> If I were to do those courses they would be quite different. They would be real interdisciplinary courses. Like, there's a course on infancy. I don't want to talk against anyone, and the infancy class was a disappointment because there was so much there about physical development, language communication development. Yes, mental health. But there's so many other lenses that people could look through, but that's my ideal course. To look across professions; to look at client and families through everyone's lens. There's not enough of that at the Institute. [F]or example that there are two occupational therapists that they seem to refer to a lot. They've actually had one of them [...]. And, so I think the people in the Institute seem to be more connected to the OT world than the PT world. And I know that they've also work closely with speech language pathologists. Sima Gerber, who is also [...] integrating the whole idea reflective practice [...] with students. [S]o I know they've been working very closely with speech therapist[s] and occupational therapist[s]. [T]hey had a sense [of] what it means the child to be tactilely defensive, things like that. [I] think it's too bad that they preach across disciplines, but the faculty is not across disciplines, except for that. They have what's her name, the dance person. She's an OT. There are so many pieces to be integrated. I'm not sure the institute does that. There's not enough different lenses in the room. Depending on who your class is. If you're lucky in some sense, I think my class was lucky because I do know a lot about language, I know a lot about play. I was talking about that. That was not in the curriculum. Just as Harold's stuff, he could talk about touch and the physical, how to hold the baby, and the physical pieces that no one had in that room. So there's a lot about. There's a respect for the discipline, but you don't really see them in action. (Movement 4)

She continued with her critique that she did not get a way to fully integrate the IMH training into her practice.

> I'm still working on [...] how you really integrate the two, because I still feel like I got this interesting perspective and it's basically coming from psychologists who would talk about their thing. And then the Institute brought in an OT who talked about their thing and a speech therapist who talked about their thing. But there wasn't really lot with an OT

> saying, "Here's some case examples of how I both use my OT skills and also infuse a psycho-social family dynamics perspective into my work." There really wasn't that. So I'm still struggling to see how it comes together.

In her view, the transforming of psychological knowledge into her original field did not succeed because she did not get enough technical support for integration. This is an important finding because one important goal of the IPSC is to have the respondents marry care for the body and mind. The OT refined her observation about the way the program managed the diversity needed to teach across disciplines and epistemologies.

> I wish there were a bunch of places where somehow somebody tied it all together. I sort of wish and OT came on – Gordon Wilson is phenomenal but I wish he would say – I'm stealing this idea from my supervisor who commented about him that he was so wonderful because he was the only OT she saw who turned the child around. Usually the child sits on the OT's lap and faces that way [outward away from the therapist], and she thought it was wonderful that the child was facing him. And that was her observation as a psychologist that they're sitting face to face and they're engaging. And I guess that's an example of how maybe an OT could get up and say, "You know I turned this child around because I'm thinking about engaging this child in this whole human interaction, not just 'I want to get their head and neck aligned,' you know." So a little bit more of a thinking process than (was) talked about, you know, things like I was saying [before, like when] the mother coming in and talking a lot through the session and how you handle that as an OT and where you put that and kind of. I [...] wish, maybe someday I will be that OT that can say, "Here I was I was this OT that had this mother that was unloading all this stuff, and I decided that I would [apply some technique thing with her]." I don't know, [maybe] speak to her at the end for 15 minutes in the waiting area, or whatever it was.

Meanwhile, one respondent reported that she had learned enough about other somatic practices so she could work more directly with members of other allied professions. That is the UCP model of transdisciplinarity different professions working collaboratively rather than single individuals internally integrating multiple disciplines. As an OT, she was also able to compare the kind of mental health training OTs usually get with the training at the IPSC.

> When I could describe what I saw, the type of equipment they had, I could get their opinion about it. Yeah, and how does the treatment work? How does an OT work with someone who has schizophrenia? [I]'s really very specific to mental illness. It's not in general how do you look at the dynamics of the family. Though, now that I say that, I remember we had a class like that, but it wasn't very good. So maybe they attempt to, but there's sort of this. There's not a real learning experience for us to begin to understand what's happening with families. (Movement 4)

Again, the problems experienced can be explained in terms of hierarchy and parity. The program promises a program based on the idea of the primacy of mental health and basically delivers on the promise. The respondents felt they were ill served in relation to their own profession. The catch as catch can enrollment from the allied health professions and nurses makes it hard to have a dialogue within their worlds. From this point of view it is not surprising that a PT had to inform a psychologist that physical care is not inherently open-ended but directive and focused on measurable goals.

To sum up, transdisciplinary students learned IMH skills and some had transformative experiences along the way. One skill is called *speaking for the baby* and it will be a way to sum up the experience of the somatic practitioners while at the Institute.

> At one point in supervision that came up. Use words for the child that's going through something. Like, if the child is hypersensitive to something, say, "Oh, mommy, that doesn't feel very good at all," rather than my saying as the therapist, "You should understand that the child doesn't really like that sensation." I felt like I needed more stuff like that. I mean it was sort of this feeling that it was all very fuzzy. Except perhaps that there was the importance of the relationship was very vital to the whole treatment process and that I had to acknowledge it and in some way support it. (Movement 4)

The last sentence might best sum up the honest complaints of the students about their learning experiences. No training program is perfect, especially one that is founded on forging, a painful process pounding people into a new shape. Like all other new recruits, their next step was

into the field where training gets applied. The respondents' words, however, will not deliver the final verdict. In the next section, we can look at their actions after graduation. These tell a different story. In a narrative study actions must speak louder than words. Reflecting on the remark traditionally imputed to Socrates, Bakewell (2010) asks, "Don't you think that actions are more reliable evidence than words?"

Joining a Nameless Professional Community

When the preparation for this investigation began, transdisciplinary theory and practice were linked to ideas from social cognitivists who concern themselves with how individuals fill roles and then remake them. One social cognitivist, Lynch (2007), used the term complete overlap, to describe how a person managed multiple roles and identified transdisciplinary workers, as being alone in that condition. They were alone, but their loneliness was balanced in Lynch's schema by the presence of abstract communities and leaders with whom they could identify. Though working alone, the overlapped professional enjoyed the freedom of being self-defined in their prescribed professional role in relation to their work situation.

Previously complete role overlap was further linked to Lipsky's (1980) idea of the street level bureaucrat, another lone agent engaged in role expansion. When another provider wanted to gain control over the next speaker, she resisted the other person's demand for strict, by the book, ABA[7] work. The speaker, by this time, had lost interest in protocols that do not yield results. Her work is based internalized standards and external results. Internalized standards are another benchmark of complete overlap. Returning to her previous position, one respondent provided a narrative of internalized standards.

[7] ABA: applied behavioral analysis. A behavioral approach to autism that uses small, repetitive actions.

> She took it on like supervising me. I ignore her. I play dumb, maybe. And she was coming to my session one day and I kept working and the child was doing a lot and she was looking. So, I saw my work not with her but with the interaction with the child, [...] so she could see what was happening. [...] I did not want to interact with her that much. [...] I had to choose my battles, I feel. To show with the work. I feel it is more valuable to show with the work, sometimes, than with words. Sometimes, more effective. I wasn't running her through a discrete child program of look at me. Look at me. Like ten times "look at me." Ten times, twenty times in a row. [...] I guess I don't care about the complaints any more. (Movement 1)

Institute graduates are now members of the abstract community of IMH with its books, journals, conferences and advocacy groups. Respondents mentioned many experts during the interviews, and these citations conform to the idea of the lonely, completely overlapped person rooted in an abstract community. For example, here is one person quoting the psychologist, Winnicott, an iconic figure at the Institute.

> [W]e have to look at the whole child and [...] if I can quote Winnicott, [...] I'm trying to find the actual quote here because I don't want to take away from him. Basically you know you can't think of a child unless they are in a relationship. Oh here it is, "A baby cannot exist alone. It is essentially part of a relationship."

Unlike Lynch's completely overlapped person who works entirely and comfortably alone, we found that no such practitioner existed in our set of respondents. None existed like Winnicott's babies, completely alone.. Instead, at the very least, it was clear the graduates often connected with each other after graduation. At the broadest level, one was a state level program director for early intervention and busy getting grants and starting projects. At the narrowest level of practice, one was an occupational therapist who primarily practiced at home on the minor delays in her children as she restarted her professional career. At the broadest level, there was a state director with a wider scope of practice. Participation in the Institute program created

an informal community. Entering formal communities because of the training connected them to an intellectual movement.

Part of the reason for limiting their external involvements was simple geography. The travel that characterized prior enrollment changed into a utilization of proximity.

> I was considering, uh, looking into it [NIDCAP], but it was based in Boston or Maine or whatever it was. I really didn't feel that I needed to. I had so much experience in the NICU and then I had the 2- year post graduate program At the Jewish board, I just didn't feel that I [...] need[ed] any further tools or training. (Nurse 4)

Being a member of a community meant being with people they liked. It is not just that the existence a community of peers united by a training experience. That kind of community could easily be a virtual, on-line community instead of one with more intimate interactions. In this real community, meals play an important part.

> I was saying to someone this morning, earlier this week I had dinner with a friend who was in that first class. (MD1)
>
> We did keep our group together for quite a while. We used to all go back to the master's program. We try to get together for dinner. We try to get together for things. (Nurse 3)
>
> I'm on the mailing list and I have not attended anything. I maintain a relationship with people who were in the class with me, but not formally with the Institute. (Nurse 1)

Related to the idea of keeping maintaining personal contact, word got around about my research via the grapevine which is another sign of a community. I was told this during one interview: "A friend of mine just gave a talk. Actually you met her because she said she remembered you." (MD1)

Other graduates do attend meetings. There are occasional master classes held at the IPSC, professional meetings and conferences in New York City. The Institute presents master classes. In the following comment, “Charlie” Zeanah is a psychiatrist in practice and who teaches at Tulane University in New Orleans. The second speaker talks about being on the board of a local professional association with the people who were formally her instructors. In her professional work one of the instructors is on the board of directors.

> I was particularly interested in this because I attended a seminar that Charlie Zeanah gave that was sponsored by the Institute. (Movement 3)
>
> I loved Dorothy Henderson. Rebecca was great. And Gil Foley. They were all fantastic. Even now when I see them, [...] ’Cause also I’m on the (NY) Zero to Three board [...] Dorothy was a board member for us, for advisory. (Nurse 2)

Another graduate affiliated with another group in the IMH world that was geographically closer. Part of her professional affiliation takes place in her home state while another brings her to Boston where proximity is the main reason for not continuing to associate with the people in New York.

> And every EI program has licensed clinical social workers on their team and all of them [take part] in the in the infant health teams so we have a state wide organization called the Association for Infant Mental Health [...]. So we have a vast network of support around working with families within the context of early intervention. So I’m actually on the state wide interagency council that oversees the federal compliance for EI. So we have worked really hard in the past ten years to build the capacity within each early intervention program to address all those just those issues. [...] I am part of BIPFS. [...] It’s the Boston Institute of Parents and Families Services. It’s Brazelton and all of that so I stay connected with the Boston. They have a comparable program in Boston. And, in fact, I was thinking that might be something easier for me to attend [than the one in New York City]. (Movement 2)

The graduates in the New York greater metropolitan area have access to a small world centered on the Jewish Board's teachers. The group is open to those IMH novices willing to join the seniors of the movement. Ready access to senior practitioners mirrors the experience of Knowles' executives. In the IMH community, mentoring and spreading the ideas of IMH outside of the Institute, including reflective supervision and the unity of body and mind are the sources of interaction. One of the graduates directs a training program for graduate speech and language pathologists at a local university. She has been writing papers on reflective practice with two of the program leaders, Drs. Foley and Shahmoon-Shanok (Geller & Foley, 2009a, 2009b; Shamoon-Shanok & Geller, 2009). Her work has appeared in infant mental health journals and in speech and language journals. She presents her experiences with colleagues and students.

Is it a perfect community? Of course not, it is made up of real people who also have rivalries and dislikes of people they know. Some people did not get along and felt rejected even though they adopted the ideas of IMH. They left the program with bad taste in their mouths because of poor programmatic follow-through.

> At the end, I sent X an email and I said this last piece I promised to do, the integrative project and the supervision, I said I just can't do it now. I feel like I have to have my break. And she sent this email back, all supportive and nice, and she said she'd send it to Y. And I never heard from Y. And I just felt that after being part of supposedly this really tight group, and I really did feel very connected with the group, I just felt that was appalling. One of six people. You know, two sentences, one sentence. So that really put me off. [...] I don't know, not quite as supposedly caring and warm and fuzzy as it seemed in the moment. So there's a little bit of bias, a little bit of negativity. [...] She was my DIR supervisor, and she never gave me my... you know, you go and present a case which takes a long time to organize, and I came in as an OT, and everybody was a [psycho]therapist. And, somehow, I never got my review. I just never heard from her again after this. And then I said, "Can I talk to you about this?" when I joined the Institute, and she said,

> "Yeah, yeah, yeah." So that's a big, that's a criticism I would have. It's not a good thing. (Movement 4)

For at least one student, personal dislike was an alienating factor but that is not surprising given that the dislike is attributed to the speaker's unpleasant and deceased parent. "My discomfort with X is very much of a personal issue. She reminds me a lot of my mother." (MD1)

Along with the only human likes and dislikes of the graduates, there is a more fundamental aspect of the community. The community is a base from which people can reach out, professionally, to the wider world.

> It's just I think that, you know, special infant mental health specialists, you know, they're trying to get their concerns brought out into the open market and increase the awareness as well. (Movement 5)

After Graduation

After graduation, the respondents entered the condition of role release, the final step in becoming a transdisciplinary practitioner. They were now IMH practitioners without supervision (Table 1). This findings section is about how transformed graduates transformed their work situation and their inner state. The primary theme here is *recursion*. Recursion is a mathematical process describing the way repetition is built into the process to reproduce a pattern. Along with the mental health training, then, the respondents learned to teach what they had learned. This happened, in part, because they had acquired IMH theory. With the theory they could adapt what they already knew from their education at the Institute and apply these into a transdisciplinary practice. First, though, let's look at how they viewed their own experience. By and large, they felt validated by the work they put in and the training they received.

> I think they validated what I knew, strengthened my belief in the body, the interaction with relationship. [...] I feel, like it made me commit this zero-to-three population more because I wasn't as committed. I was working with older children, sometimes. Now I am committed to the zero to three [age group as a professional]. (Movement 1)

> Speech pathologists aren't trained for that kind of dynamic, that kind of experience is like… It was very helpful to put a theory, put a name to what I was experiencing. It helped me manage my way through it before became overwhelming. (Speech 4)

At the same time, at least two respondents discuss the professional dilemma they feel they are in because they still lack more advanced psychological training and the title that goes with it. It sounds like they are ambivalent, oscillating between the wish to work with the mind and with the body as one unit. This first appeared with the respondents who started in psychology and become physical care workers as they also, consciously, wanted to also work psychologically. At least two respondents experienced regret even after graduation from the IPSC because they still felt that they had not reached their true goal of being engaged some kind of clinical psychological work.

> If I could have a credential like a social worker and I could do that, I could do counseling and I would love that, but I haven't been able to find a path that I could do that. But then I well, 'Do I want to talk to people about PTSD and suicide?' [...] I'm not sure. (Nurse 3)

> Well, if I was a psychiatric nurse specialist, [...] I would do therapy. Whereas with this, I do teaching; I'm mixing therapy, psychology with other things. [...] You know, I struggled with should I be a psychiatric clinical specialist, or community health because that's broader. I chose community health because, probably, looking back I probably made the wrong choice. (Nurse 2)

On the whole, the respondents say they benefited from the training they received at the IPSC. "[I]t was validating for me, a little frustrating at times. It was validating."

Reasons for the validation come from the ways in which their dissatisfactions were changed into satisfactions in five professional domains. The next sections describe the creation of community, becoming teachers, system transformers, transformed practitioners and an apparent end of peak experiences.

Becoming IMH Teachers

Some students went from being students of IMH to becoming teachers. Two of the graduates are active as academics. One is physical therapist (Movement 5). She promotes an IMH-informed physical therapy syllabus at conferences around the country even though she has no faculty appointment.

> I mean some people just you know glanced at it and you know there few people that really felt that it was applicable to the work that they do with the little kids and the families in early intervention. And, [...] there was someone there, she was a professor from a physical therapy school in Florida. And she was interested in [hiring me] which is great you know. I'm not moving to Florida based on the poster and just talking to me. So that was positive. [T]here was some person out in California who was very familiar with all the different concepts and she was excited to meet someone that had the same interest as she did.

In the next narrative, we see how a college professor uses reflective supervision as would be used in an analogous way to the previous PT. The professor provides the professor supervises speech and language pathologists prior to certification and solo work. The problem of managing an open-ended process within a goal oriented project also appears again. The dilemma he faces now is providing a reflective relationship, which is intimate and relationship based, while at the same time having to provide marks, which is based on standard benchmarks. In this example however, tables are turned. The supervisor wants closure while the student wants an open-ended

process. As the anecdote proceeds, the themes of waiting and tolerating crying reappears in the context of accepting and rejecting students along with giving them grades. It is not easy.

> And I think I've learned to really listen better. I don't think I'm done, but I think I've really learned to not jump in as quickly as I could. And let students cry without- I had a student that was thrown out of the program last week. [I] was very ambivalent about the student staying. I voted to keep her in and then changed my vote to throw her out. She came to me asking for help, wanted to know if I could help her. I felt like a piece of garbage, thinking "Oh, [referring to herself], you don't know what you're thinking." I go from strength-based to "what's ethical?" to, like, a lot of confusion about training students. When you work relationally you have boundary issues, you have so many issues. But I was good. I felt like I bit my tongue. She came in; she was crying; she asked, "Could I help her." I said I couldn't help her. I recommended that she get psychotherapy. She was quite disturbed. I think she was having some kind of breakdown. I gave her the names of therapists. [...] But I didn't jump to try to make it better. I said that she needed the time to take a look at what had happened here. I told her how to make a grievance and complain, but I didn't do what I might have done years ago. I had some distance and some more perspective. But it's very hard to do this work with graduate students, because you can get close to them and then you've got to keep that distance to be the instructor and give them grades. It's very hard in that sense. How you introduce the work, stay with, but maintain some space. (Speech 1)

In other instances, collegial relations are part of the community experience. The same speaker maintained her own reflective supervision and that helped her manage her interactive approach at work. The speaker is also part of the community of speech and language pathologists in the New York metropolitan area and transcends two communities. This task is also not easy.

> This is the supervisor [...] I supervised. Her name is Maria. I felt her client, not the student, the client was being very abusive towards Maria and I didn't know how to deal with this. The client was very aggressive. She [the client] was a well-known speech pathologist, and […] she [Maria] was in this situation. After a while Maria brought all these problems to our group. I felt […] everyone was trying to make Maria feel better and that's a theme that happens a lot. Make the person feel better. Fix the problem. Give an answer. I thought, "Get rid of the client." Barbara [Greenstein, her own clinical supervisor] helped me a lot to move away from what was happening. I wasn't really clear about that. It took me a long time to get my head around that. That was very good supervision. But I don't think that problem goes away. In [speech] supervision people are

> there to help people feel better or to give direct answers or to be helpful […]. So to really pull back and be more reflective and less directive and really see what happens, that's work I need to do.

Her experience with her students has to be considered carefully due to the power she wields over them. The power differential puts reflective supervision on a different footing than when the supervision is not attached to grades as it was at the Institute.

> With the students, they're not always honest with me, because of the differential in power and stuff, but I think they have been open to these ideas. I have them for a year in a seminar, so when I start I think they really don't know what hit them, and they wonder what I'm doing, but over time I feel like there's more interest. There's always the occasional student who's been in psychotherapy, which makes them more interested. And I think they're defended, but I think they're willing to play with the ideas. I use books like Segal's *Parenting form the Inside* Out in the seminar. It's a great book for students and for everyone. That's a very easy book about to get the ideas and how do you form an alliance or how do you develop the attunement. I mean, I don't do heavy-duty things. It's a fairly superficial level in terms of understanding yourself better and being open to families in a different way.

She continued to discuss the resistance her colleagues offer her to adding a psychological element to the speech and language program. She is hoping for progress but also sees that there she has to be careful.

> But I think there's enormous resistance in the discipline to add new ideas. I don't know how much that's every really going to change. If I said to somebody, let's add a course in this, they'd say, "What are you crazy, students need to be certified, they need to know about stuttering and voice and what are you doing..." That's going to be slow to change. The question is how do you help people to change without really threatening them. That I'm working on.

It is not just the licensing requirements and the program's status within the speech and language world. She relies on a flexible and open-minded department chair to fend of the opposition from other professors.

> Negatively. Not my friend colleagues, but more traditional academics? Negatively. I'm very lucky the chairperson here has, when I came to [this university] 13 years ago he said, "Do what you want with the educational model." And that's what I did. That's really what got me to the Institute. Not him, but my desire to really change something. I think I've been very lucky that the people in power in terms of the chair really support everything I've done. I do not think it would have happened in many graduate programs in speech pathology. It would be highly unlikely. This is a very creative, forward-thinking person, so I think that really helped me [...] And now it's sort of become well-known that we do relational, reflective speech pathology, whatever that means. I think I've placed myself in a situation where I was able to do that. The other faculty here, I don't think it interests them.

Some of her colleagues think that the students are neither old enough nor seasoned enough to do relational work. Here is an example of the criticism she receives.

> A lot of people have criticized that. A lot of the supervisors have said that if you think developmentally, which I do, that it's too much for them. It's too much to learn how to do language therapy and also worry about the relationship.

Even though there are difficulties and successes in the borderland where teaching and reflective supervision meat, she successfully works with some the students' training supervisors but supervisors do not all wish reflective supervision. The idea of the power differential reappears and as does the idea that she has to finesse her approach because she has seen that there is a certain type who will be drawn to reflective work and those who are not drawn. She begins the story stating she had already released herself into the role of a reflective supervisor.

That, technically, is only done by psychologists (Table 1). However, she was being counseled and not entirely on her own.

> I've had a supervision group here for, I would say 10 years here before I started the Institute. Originally when I started it was very traditional. You would talk about the graduate students, how to work better with clients. I decided when I started at the Institute, I started the next step. I had more support to talk about, to more deeply go into some of these ideas. I think there's been a lot of resistance. And very, very slow change in embracing some of these ideas. The supervisors who came in being more psychological and introspective really liked the work. And others who were not really interested in understanding themselves, there was more resistance to the work. They did have to attend my supervision group, so it wasn't like they all signed up, [...] which I try not to deal with. But at this point, I think some of them are invested. And this is why I see Barbara Greenstein. I do supervision around my supervision group. She helps me figure out how to work with people without scaring them away. How far I can go in terms of boundaries and how to really work from a very strength-based perspective which I think all the disciplines need big time? So that's been a struggle, but they're willing to play with me, the supervisors. They're willing to engage me.

The theme of working with colleagues about relational methods was told in another story. Here, the professor is getting a subordinate colleague to adapt relational work within a goal. The respondent expends a lot of effort in spreading the message and getting others to engage in role expansion.

> And then there's another supervisor here who has worked with an adult client who has progressive language disorder, not adult aphasia, but a loss of language and cognition. I've been trying to help her kind of embrace the family, and the family doesn't come and the family is not interested. She wants to tell them what they should do at home. There's a lot of telling and doing and whatever. I've done a lot of work with her to help her get the family in without an agenda, that's been huge work. Because SLPs always have an agenda [about] what everyone should be doing and saying. She's made a nice shift about forming an alliance with the family without being directive. [...] So, little by little you see people accepting some of these ideas, but they're really hard. We've do a lot of readings on whatever, alliances, whatever transference/countertransference, though people are more afraid of talking about that. I use a lot of C. Seligman's work because it's very approachable.

This respondent's ability to get others expand their role goes beyond her. At least one colleague converted to her perspective through a secondary route. The conversion occurred not through the respondent's efforts but through the work of her students. The students probably learned enough IMH theory and had enough positive practice experiences to pass on the IMH message. In Freirian terms, the students became student-teachers and the teacher, a teacher-student. Some parity had been achieved that allowed information to flow upward. Her efforts worked recursively through her students to a formerly reluctant colleague. The roles of students and teachers get transposed in the story which follows. The process of institutional change, supporting conversations between juniors and superiors, is at work in this story. The difference here is that the juniors teach the senior.

> One supervisor, who was my student when I was at Queens College, years ago […] then came here and became a supervisor. […] And she was very resistant to the notion of forming relationships with students where you give them some power to share their ideas and their insights. She is very resistant to working with families. She's very intimidated working with families, whatever her issues are. She had some of my students who had been in my seminar, and after they were in my seminar they started working with her. And they really helped her shift her perspective about the parents, so she's talked a lot about how her students became her teachers. Really great work. We have a lot of her stories and transcriptions on it. She was really able to develop some insight about the parents and their struggles from the graduate students. That was a nice breakthrough for her.

Despite her mixed experience at her home institution,like the physical therapist, she has found additional support at national meetings.

> I've also done a lot of national conventions the past few years, and I've been surprised that some of this has been accepted. So I did a short course this year at the major convention on relational and reflective clinical practice. Last year I did something in Chicago on relational reflective supervision in speech pathology. [...] I'm not being

> rejected for some of these things. And the articles that I did from my integrative project went into a major journal in speech pathology.

Her academic training, ability to withstand criticism and capacity to play and invent has let her turn a problem into a project. That capacity is another indication of the transformation that Institute involvement made possible. She is now collecting the experiences in order to understand the process as it affects the young students.

> I'm not there to tell people they have to change. They obviously know better. But what I started doing last year was collecting stories from speech pathology from the supervisors from my students, transcribing them. And kind of talking about how traditionally people would address a particular issue and how you might deal with it in a relational and reflective perspective. So I've kind of taken what people are good at in terms being strength-based with the audience, and not intimidating anyone, saying, "This is important, you should know this." to kind of comparing, contrasting how I might work with it from this broader perspective. That I think is a good way in. [...] We'll see where thinking about these new principles has really deepened the work or helped clients or students. I don't know if they're far enough along to really talk about it enough. But I think the big thing is the alliance. That I really push with students, the alliance and perspective taking.

She continues with her goal of wanting to change the way her students see problems. In her view, they should continue along mental health lines and learn how to make alliances with parents and other family members instead of positioning themselves in opposition to them. In doing so, she is extending the reach of IMH.

> Because for some reason they feel like students form their relationship with the young clients but they can't wrap their arms around the family. The family is always like the culprit for the students. I do a lot of work in attempting to understand why the mother's angry or why that mothers this or how hard that person's life is to try to broaden their perspective here. And I think that's helped students a bit, but I don't think they've had enough experience yet. They're just starting their clinical work. They haven't really had clients. Maybe, they have maybe two clients a semester, so we're not talking about a lot of time and a lot of intensity. And not every supervisor is going to embrace my ideas. But

> I think I just sort of develop their consciousness and awareness about multiple perspectives and what it means to attempt to understand somebody else, how somebody else comes to us. They're really young.

Looking back on her experiences, she is making a real difference with students and colleagues. Despite all the tales of professional metamorphosis she told, she somehow feels the a transdisciplinary future has yet to arrive.

> I guess I feel like I'm planting the seeds. I don't necessarily think I going to see the seeds. I think I'll hear about them over time, but I think it's very overwhelming as a beginning student to figure out how to do a goal in speech pathology and also worry about relationship or something else. But I do help them sort of acknowledge their feelings whether positive or negative, how to really talk about their emotions so they can let them go, so they can return to the work. I try to do that, but there's lots of issues there, too, in terms of how much their going to open themselves in a seminar in a class with a professor. You know, there's a lot of stuff happening there. Students are guarded in terms of that. Some students feel freer to explore their reaction than others. But I don't really expect to see it yet.

System Transformers

In this section, the work of graduates at the social systems level is described. One system transformer is a movement therapist. She was described before as the traveling academic who presents her physical therapy curriculum around the country. In addition to that effort, she makes time to be active in New York Zero to Three, an unofficial affiliate of the national Zero to Three. She presented testimony at hearings on the New York State early intervention program in 2009.

> I did attend a public hearing and submitted testimony and spoke. [...] And it was basically open to anyone [...] So I was able to speak from New York Zero to Three as well as being an advocate for physical therapy. [...] Because of all my training and the readings and my focus of what I've been doing since I've been in the program, I really look at the value of parallel process and the relationship between the child and the family. And what it means to be learning in the context of the situation. (Movement 5)

One of the nurses in the study started in community mental health is now an executive in a non-profit early childhood service and advocacy agency works, among her other duties, to introduce infant mental principles into the New York State early intervention program.

> There is a white paper. [...] There is a whole committee about statewide, up in Albany, speaking with the state about the need a lot of the problems that a child who gets speech therapy where is the problem is really a psychological problem with the child and the family. And [...] you don't have the infrastructure to deal with it, people to identify it and you don't have the people to treat. So we are talking about it in Albany and we are talking about it in New York City. (Nurse 2)

Much of her time involves disseminating ideas of child development and IMH to various early child care agencies and day care programs in the region.

> I coordinate this team of infant-toddler specialists. So, there are four of them. They work for four different agencies. This [her employing] agency has the contract [...] we're funded by the state, so I have 2 jobs. [...] I was hired to start this group for the NY [City] region. So, there's been of series of people coming and going with different qualifications, expertise. And these agencies, it's like Chinese American Planning Council and the Committee for Hispanic for Children and Families. The team are people who speak other languages and [are] from other cultures and other communities. So that is the beauty, that we can reach a broader range of people. The hard part is that people have different training and experience from and none of them are training in psychology or mental health. [...] They're either been teachers or health and safety trainers. One is a social worker. She did social work in EI but this they don't have the mental health background.

One of the problems she addresses regularly is that most of the organizations that provide daycare do not know that children under three years of age have different educational needs than preschoolers, 3 years and older.

> I only do zero to three. I work with directors. There is a tremendous need for training and education for zero to three. Because what I find is that the directors of programs that care

> for children under 3 have a preschool orientation. There are very few programs that you can come out with a degree in infant-toddler, whatever, Bank St. maybe, I guess. So the people who are directing the programs have a preschool mindset.

She also offers testimony in public hearings as part of her job. It turns out that one reason why agency heads are unaware of the particular needs of infants and young toddlers is that the regulations support another kind of ignorance on the part of the teachers. The current system promotes vernacular parenting with its strengths and weaknesses without providing new information to the teachers and day care providers. She and her fellows in the early childhood movement pushed for and received some supportive regulations that serve very young children.

> I testified to change the DOH *regs* because up until last September, you have to a high school diploma or a GED and a year of experience in infant-toddler teaching. With no pre-service [sic] for ongoing training, like zero. So you do what we did at home. It's like, outrageous. It's outrageous.

In another state, another movement therapist who graduated from the program runs the Early Intervention program. The state is small enough for her to have direct contact with local program directors and providers. Ready access allows her to spread the ideas she learned at the Institute in a personal way that affects the whole state. The following is an example of the UCP model of care where a lead practitioner does the work of many, at least to start. The first transformation is the change in the mother's view. The mother sees that the idea is about working with the child to improve his overall abilities rather than to focus on receiving scattershot care that may not be necessary. From the IMH perspective, the mother and the therapist had established a positive relationship that would lead to help rather than hostility between the parent and the therapist. As we heard in prior narrations, allied health professionals often see the parent as the obstacle. The skill displayed by the social worker is, therefore,

essential because it leads to helping, not hindrance. This story is also another example of a two set recursion. The local director is supported by the state director, the narrator. The local director is passing this skill on to her staff.

> The director of one of the programs is actually a licensed, clinical social worker. She worked really hard to support her staff's understanding psychosocial dynamics and the emotional regulation of a family and not just the child and all of that and she was doing a home visit with the child and the family and she was working with the mom and the mom said to her, "Yeah, but when are you going to work with my child." And she [the social worker] said, "What would you like me to do with your child?" And she says my child needs support and development. "You know what, let me get down on the floor and we'll play." And she started to talking about communication, cognition and motor development. And she said "If you want, I can bring in the experts in this area," and the mom says, "No, it sounds like you know what you're talking about." Again, it wasn't an intrusive situation and the OT and the PT and the Speech had to come in but the mom just had confidence in the social worker so that she could aid the child's development. (Movement 2)

The next story is another example of two recursions. The state director first mentions how attending the IPSC changed her practice and ends the passage with the same thought. It supports the significance of the transformational change she underwent in the program. Part of the change is enacted in her providing her own early intervention staff with reflective supervision. She went from a recipient of reflective supervision, to a provider of it. This is the second recursion. Now, everyone, including support staff, benefit from her training. In addition, the respondent is taking on the role that is usually held by a senior or doctoral level mental health worker. The process of role expansion continues.

> It totally changed my practice with my staff. Now every single staff person has once a month individual supervision and monthly group supervision whether you are an OT, PT or speech, a secretary, a license clinical social worker, a psychologist, an autism care core specialist. Everybody gets individual supervision and it's not, "What clients you have and how is it going." It's "How do you feel about your job; "What feels like it's going well;"

> "Let's talk about how you feel about some of the circumstances you found yourself in this month." And it's just, it was eye opening. So it totally changed my practice as a director.

Effect change on the systems level involves building in IMH into programs. This speaker mentioned three programs she has shaped. Two of them, *Baby Steps* and *Watch Me Grow* directly involve infant mental health workers and, pair with a local medical system to promote developmental screening in community and pediatric settings as part of the medical home movement.[8] The funding often is cobbled from many small grants. Here is a summary of how IMH and related services gets built-in by collaborating.

> Child Care Bureau, Part C Head, State Collaborative Office, Maternal and Child Health, Bureau of Special Services, Division of Children Services, Mental Health, Special Education. [W]e formed an entity by which little pockets of funding have come together to develop these state-wide programs to insure access to developmental screening. In addition to that, we have received ERA funds part c [...] and our Part C state coordinator has provided a significant amount of money, $85,000 dollars, to fund my provision for technical assistance and support and has purchased material for all family research centers so that they can engage in developmental screening.

> [W]e work very closely with Dartmouth Medical Center [at] Crochett Mountain [...] to increase capacity for medical home[s]. And as result of his [MD at Crochett Mt.] medical home grant [...], Jeanie McAllister, [...] I work very closely together so that we can train physicians on how to do developmental screening in the context of primary health care practice [...]because the American Academy of Pediatrics has mandated that there are certain peak times [...] when [...] developmental screening activities must occur. [I]t's kind of a hodgepodge of funding and a hodgepodge of people but because [home state] is so small. We really get all these partners together to be able to lend funding for many of the initiatives.

[8] A medical home is one central location through which all care is delivered and coordinated.

Because her home state is so small and not well populated, she also works directly with medical practitioners. Like the university level speech therapist, spreading the message happens through a combination of reflective supervision and modeling.

> [I]t's a challenge because you're working with doctors and nurses and so we do it in a little bit of different way. A lot of it is in done in coaching and modeling. Now, the *Watch Me Grow* program, [so far] I've got all of 6 sites out of a possible 12 [...]. I'm mentoring how these people ultimately develop their systems within the context of their communities. And, one of the things that I'm helping to support is their development of steering committees [...]. One of the things we are talking about. "How can we can build the capacity for them to have [...] a little bit more of a group supervision." Now we also have regional infant mental health teams and it's part of *Watch Me Grow*. It's required that the regional [infant] mental health teams partner with the *Watch Me Grow* teams and steering committee and so the infant mental health teams are also working on many of the initiatives [...]. However the way it's set up there is not a lot of time to build in capacity for individual supervision given that I am [applying the technique of] training the trainers.

While training and trainers are important, it is modeling in daily practice that this respondent thinks will spread IMH practice through modeling from professional to professional in almost imperceptible style.

> I don't think of naturally spreading. I think it will be facilitated, but it will be facilitated in a subliminal and very comfortable, calm way. We all believe that you meet people where they are at and guide them in a little different direction. [...] We've trained 60 physicians maybe around 80 nurses, many medical assistants through this program. So this is the message I wish we teach and in model.

The transformation of practice that she describes occurs on a number of levels in the following vignette. First, there is straight modeling by the developmental specialist. Second, by not bragging or chastising the medical staff, she is engaging in parallel processing, means to teach by actions. Moore (2006) says that the way managers treat staff will determine the way

staff will treat parents and the way, in turn, parents will treat their own children. The staff is treated with as much respect and consideration as the "biker-mom" in this illustrative tale.

> But I would love to give you an example to show you how practice had changed. [T]here was mother who had a new born baby [...] and he was coming in for his two-week visit. Now, this woman came in on a motorcycle. She had fishnet stockings that were ripped, leather boots, she had a leather skirt, a leather jacket, frizzy long hair and a leather cap. And when she walked in the door with her baby many of the primary healthcare practitioners made comments not so she could hear but immediately formed a judgment.

At this point the patient is getting the rapid psychosocial evaluation that leads to bad care and misunderstandings but, Randy, a trained developmental specialist intervenes. Developmental specialists give parents age appropriate developmental guidance so they can understand their child's growth better. Other funders, notably the Commonwealth Fund has set up a similar program in North Carolina and reported on its success (C. Minkovitz, Strobino, Hughart, Scharfstein, & Guyer, 2001; C. S. Minkovitz et al., 2007).

> My *Baby Steps* person met her at the door and said, "Oh, what a beautiful baby! May I hold your son, your precious son," and the woman said, "Of course!" And so came in for the well child check. And the *Baby Step* staff in the developmental screening room talked about how enriching it is that when the baby looks at mom he just opens his eyes with wonder and how mom looks at him and is falling in love with him and all of that. Anyway the next day I get a phone call from this mom and I don't know who I am getting this phone call from. And she asks if she could speak with Randy the developmental specialist and I said, "Well, let me have her call you. [A]nd I didn't hear anything more and then two days later Randy called me back and said, "Do you remember that phone call you got?" "Absolutely." She said, "Well, that was the mom who everybody had made a judgment except me." And this woman was incredibly buxom, like a size Q, and she felt so comfortable with our developmental specialist that she called. [A]nd she said, "I want to nurse my baby but I'm so afraid I'm going to suffocate him and I need someone to help me." So Randy picked her up, brought her to Wal-Mart, bought elevated pillows. Brought her back and showed her how to breast feed her baby and clearly that's going to change that whole relationship that that mom has with that baby.

Now the transformational foundation moves from the mother-child dyad to the clinic. The parallel process of not-criticizing shows its effect.

> So Randy went back to the doctors and nurses and they were dumbfounded because they had admitted that they had formed a judgment with this mom. And Randy never said anything negatively regarding their reactions all she did was recount her own personal observations and feeling and said to them, "How did you feel when you heard this story? How did you feel when mom first came in? So she was doing this supervision and ultimately it totally changed their practice. So that's what I mean by coaching and modeling.

The effect of modeling can travel out of state spreading the transformational effect as in the case a family physician. The physician uses almost the same phrasing and words to describe his change in practice orientation as the speaker did earlier on. The physician telling the tale did not just learn a technique, he also learned the theory.

> [T]here was a doctor in another one of the community health centers and [...] he was a family practitioner so he did babies and up to seniors. And he was in the habit of being gruff with babies and not thinking of babies as human beings but, "Oh, this is just an exam. I have to do this." And then we worked with him for probably a year and then he ultimately left [the home state] and he went to the Mayo Clinic and I got a letter from him saying, "I can't even begin to tell you how my practice has changed as a result of having the infant developmental specialist. Randy had taught me that babies are precious and that when I hold a baby, I have to [..] be thinking that that parent that's the most important thing in that parent's life and that every action and every interaction for that baby is contributing to that baby's overall well being and that parent-child relationship and if I model good interactions with the child I'm modeling them for the parent as well." The letter was so wonderful because this was a family practice doc who really wasn't even interested in working with babies but [he changed] as a result as of the infant development specialist. If I was to ask Randy what did you, she'd say, "I don't know what I did. I just did what I do." So it wasn't that she did anything. [S]he created an opportunity for him to get a better understanding of what it's like to have a relationship with the child….this man had children of his own!

The IPSC's effect on systems also crossed an international border. Unfortunately, this information came out after the recorder was turned off so an exact quote is not possible. Once a year, the speaker, Speech Therapist 4, goes overseas to with an orphan-advocacy group. Currently, as this is being written, orphanages in Eastern Europe have a poor reputation for providing anything beyond the basics of food and shelter. The problem appears to be particularly bad in Romania and has been studied by Rutter and the English and Romanian Adoptees Study Team (1998). According to this speech therapist, the children she works with received so little verbal interaction that they suffer from what is called *selective mutism*. In selective mutism, the child is able to and begins to speak but, after receiving no responses for too long, they cease to speak. The respondent's work, if adopted, will prevent some of the international adoptees from needing. Perhaps not by coincidence, the speaker also has no children of her own.

Becoming Mentors

Mentoring is activity that should also be recursive. Ideally, people who were mentored pass the favor on to others. When we first heard from the respondents, they were mentored. Having graduated, they have gone from IMH students to mentors who can recognize others who might benefit from training at the Institute. This is from a nurse who is an executive in a child advocacy program passed the favor on to two people.

> The two people that I encouraged to go to the Institute, I can speak about that. This social worker and this EI service coordinator and a very, very excellent social worker. And she was interested learning more about psychology and that. So she went to the Institute and found that she went on to do some play therapy with children and parents and like she used it more clinically. Like she moved out of EI, EI was just painful for her. (Nurse 2)

This example comes from a line practitioner. The mentor does not need an exalted title, just the ability to see who might benefit from the program along with the desire to pass information on to that person.

> [S]he works part time, and she's an older woman, and she's been working in this area for a long [time] and she's done a lot of work with new immigrants—Spanish-speaking, Central American—and I know that she gets involved with the families more than the job would necessarily require her to do [a]nd in terms of what kind of services and how far she's willing to go with them. [S]he's a nun also—so I think she has a sort of different way of approaching it. She's very spiritual, obviously, um…but also, interestingly, very down to earth. [...] We were talking about families and I realized that she didn't think of them as little computer boxes. So that's how we got chatting about it, and I was telling her about the program. She was interested in what I had done and so forth.

Transformed Neighborhood

For one respondent, parenting was expressed vicariously in her avocational as well as her professional life. In this example, recursion takes the form of nurturance. While she and her husband were unable to have children, as we heard before, she has a desire to nurture that extends beyond her work. She volunteers. The topic came up before the interview began and later when we noticed a cat on her back porch.

> [I]f you build upon what really excites you and what you feel passionate about and for me, it's the mother child, parent-child experience. I'm just constantly aware. That's mommy back there. [referring to a stray cat she has feeds on her deck] That's my other area, animal rescue. [Laughs] It makes sense: nurturing. […] I have the special kitten formula for the nutritional needs. Sorry. […] I think because my husband and I didn't have children; we couldn't have children. We had some pregnancy losses. I think I had to find a place to channel this nurturing and this real desire to connect and to make a difference with the parents that I've worked with to help them know their babies and to have them learn about their babies apart from being part of a medical entity. They are not a baby with CP [cerebral palsy], they are not preemies. They're their babies. And it's like that's the path God or whatever you want […] has made for me. (Nurse 4)

Transforming Direct Practice

Transformation occurred, too, at the line-level of direct practice. Some examples of transformed practice appeared in the section that described the respondents' time in the school and just a few examples will be added here that describe other kinds of new practice. The first direct service provider went from wanting to learn about psychology to working with it. In the following example, a visiting nurse describes how she goes out of her way with the very new families she visits. It starts with some simple human contact that might lead to more specific help or a needed referral instead of going straight to a checklist.

> I think most of them are just really happy to have somebody to talk to, that isn't just going to the doctor and being told the baby weighs the right amount of pounds. And quite often, I try to go into the visits and say, "Okay, what's on your mind?" Because the insurance will tell me what I'm supposed to check off in all these little computer boxes when I go and do a home visit for a newborn. [...] I can check those off and it won't change anything. So I try and focus on what they're really concerned about, which most often they're quite happy to verbalize. (Nurse 1)

This nurse works with uneducated and low-literate women. At the same time, she assumes that these women love their babies but are not always quite sure about what to do when something unexpected appears. In her direct practice, she provides developmental guidance once the professional-patient ice is broken. It breaks because she starts her home visits with a human contact to start with as we already heard.

> Because I think that a lot of times parents don't really understand what they're looking at. At least, they don't have it verbalized, put into words. They intuit it. Or if they don't, that's when they need help with it. But when you can actually say, "Look he's doing this because…" it helps. [Y]esterday, I went to see a mom who's got a five week old who's preemie. And she said to me, "I think he's got something wrong with his eyes, he keeps moving them to the side." So I was talking about regulatory issues with her and what that

> meant, and she was very happy to understand that that was normal behavior. And that's rewarding to be able to explain that to her. [F]or the most part, all of them genuinely want to love this baby, and if you can just help them do that by helping them understand what they're seeing or what the infant's behavior is, and sort of acknowledging that they have the capacity to do that.

She also brings herself to the table. She finds that many of the new mother's she sees are isolated as she is. Her family is overseas and she has lived her for over 30 years.

> Okay, that sounds good. [A] lot of it comes out from my own experience of having kids. [...] Meaning that, having had them and being fairly isolated in that my family wasn't here and his [her husband's] is not close, then you—there's no such thing as too much support and sort of validation of what you're doing. And in general people don't have that enough. And I talk about that when I go on newborn visits. I encourage people to join a support group or I'll give them a referral. I mean, not everybody wants them, but—and if they have lots of family around maybe it's not such an issue.

An OT described her direct practice as being more child-centered and she, herself less protocol driven. She understands IMH theory and practice well enough to include the child in the process as an equal.

> I have to say I feel like my kids are improving. The fact that they're comfortable with me; the fact that I give them a little bit of leeway on the activities. I might start off with the protocol, but I'll let them invent another kind of way of doing it that provides a very similar kind of input. And I feel like the kids want to see me from week to week, so that's got to be useful. And the parents want to see me, so I would say the parent feels comfortable. (Movement 4)

In the next part of her description of her current direct practice, she brings to mind Freire's thinking about people learning by concretizing. Her little patient becomes a student-teacher. He understands the theory and learns to apply it himself. She is also aware that she is

now working differently from her colleagues. She is also aware that if a child learns something in the natural environment it more likely to be globalized in his life.

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> It seems like the OT's feel like we're on the same page, even though they're probably working very differently. Maybe the way I work is subtle. Maybe it's subtle. Maybe I just offer more choices. Like I said, I provide a little bit of leeway so they can invent it, they can feel like they own it, they invented the exercise. [I] really believe that by giving the child, by having this positive rapport with the child and by allowing the child some flexibility in the program, that there's something happening neurologically that is making things stick for them more so than they would if I just came in a said, "Okay, do this, this and that." Like, do I make a conscious decision that I'm going to intervene here? Or just, "I can't be bothered today." Yeah, either one'll do. You can respond to either. Yeah I'm aware of it doing it. [...] I just do it. I just see it as part of what's useful, more than—just as useful as giving a shot.

Institute training notwithstanding, it is still difficult work and engaging parents requires that special IMH skills and self-knowledge be brought to this challenge. Just stopping and listening seems to help when the next speaker cannot do or even hear that much. The speaker is the same person who could not get sufficient information on brief therapies. At least she knows how to get to the root of the problem to offer an appropriate referral to someone who can offer more time.

> Sometimes I say it and I wish I hadn't. Because then it opens up a whole can of worms which I don't have time to address. Just, acknowledging the feeling is a step. I think it's—they like it because people aren't necessarily saying that [the situation is difficult] to them, or they're struggling with it. Usually they're just verbalizing some kind of agreement, or expanding on whatever they said which made me say it. Well, this is something that I struggle with right now because I go see, for example, a prenatal mother a few weeks ago whose main problem, supposedly, was her high blood pressure. But when I got there it was clear that she had all kinds of—probably related to her high blood pressure—all kinds of conflicts in her head about being pregnant, having a baby, her relationship with the father. And luckily, I had three visits allowed for her, so that enabled me to sort of talk to her about perhaps getting counseling. (Nurse 1)

It shouldn't be surprising that a graduate would have sympathy a low-income mother. That issue was explored at length earlier and is to be expected. In returning to the busy, professional mother, who was less likely to get a sympathetic hearing from some of the respondents there was some change there as well. One practitioner moved beyond resentment to understanding. The next speaker found a way to maintain communication and a positive attitude with a very absent parent. Here is how a connection is maintained with a professional parent despite distances and language.

> I have traveling parents. Like making sure I write emails, to keep them in the session as part of the session. Right now I have a child from India. The parent, the mother is traveling a lot. I have the caretaker with me, so I try to communicate the caretaker does not speak English. It is very difficult because I cannot give feedback about the child. I go like this [gesturing]. [...] So she knows this is good. So she gets feedback. So I communicate so she [the mother] feels included, how wonderful it is to hear those little things while she is traveling. (Movement 1)

Transformed Parenting

The final aspect of transformation reported by graduates comes from a narrator who was primarily a homemaker at the time of the interview. She had a few private clients when we spoke and during most of the interview, one of her young sons present. One of them is hyperactive and has some low level sensory delays. We will look at how her views of parenting and practice work together. She left the program without finishing the integrated project, the final hurdle, but is tying is it all together at home. First, there is her relationship to her very mildly delayed son. Despite a diagnosis, she blames herself for somehow transmitting a behavior her mother told her that she never had as a child, a negative recursion in her view. At the same time, she can provide what she calls a breakthrough for her child, a positive recursion, based on her new knowledge.

> I'm aware of things. I maybe try to, you know, as I say, I think about the *Parenting From the Inside Out*, (Segal & Hartzell, 2004) and repair and all that. And even with my son's sensory issues, “How am I doing as an OT for him? Not that great.” I sound like I'm really hard on myself, don't I. Well, I feel terrible about it. He's gets very, very hyper. And that gets me hyper. Here's an example of being aware of things. I understand that seeing him as he can be probably reminds me in some way of myself and that triggers me. And there's this whole thing with that triggering business. So I am aware of that. [...] No, she [her mother] says that I was not like him. But I feel as an adult that I am like him because I have this anxiety thing and he clearly does too. So I think we sort of trigger each other. And yet, I can say I'm working on ways for that not to happen so much. (Movement 4)

Her efforts with her son involve the two of them gaining more insight into daily, human behaviors in a safe way. She does it in part by helping him create a narrative.

> I guess I'm aware of the fact that the way that I model and experience things and behave has this huge impact on the kids, especially in the early years. So if I do flip out, then [...] I'll go back to it, and I'll try to help my son create a narrative. I don't want him to misunderstand it. I think we sort of had this breakthrough. I want him to understand I lose my temper, so at least he can say, “Okay, my mother loses her temper.” So there was this moment where he was in the tub with his brother and there was this moment and he stuck his fingers in his [brother’s] eyes. [...]. And I grabbed him and he was screaming and then afterwards, a couple hours later, I said, “Do you know what just happened?” [...] He said he didn't know. And I said, “You lost your temper,” and he said, “Like mommy and daddy do.” And I really felt that was a way for him to create an understanding of how things are and that in some way that, on its own, is helpful. And then, in terms of repair, if I do get upset, I do think about how important it is to come back to it and talk about it and say, “It's not your fault.” And to try to at least, you know, repair and make their feelings better than the way that they had ended. [...] I think that at least it doesn't end with this big explosion where he goes and just feels badly about himself and I worry that he thinks he had done something wrong. I think that at least he knows that I care and that I love him and that, you know. I hope he understands that it wasn't him.

The professional distance, a theoretical stance, makes possible a close bond between herself and her and child. Her child now how some way share his emotions with his mother in a collected way, as she already modeled for him. The recursion in the household is completed. She is doubly ready, as trained practitioner and parent, to pass the techniques on.

> I think primarily I’m able to better step back from the presented problem and look at it in a bigger picture, so that when the mom talks about the baby’s not sleeping well and how she handles it, then I can think about her own experiences and why she’s doing what she’s doing in a different way.

Her own parenting mistakes and own child’s condition gives her additional insight that could not be given in a training program. Her insight from children came after enrolling and return to the role of children for the program experience. She developed some reflexivity.

> It's very interesting to be on the other side of the coin. That's been a huge learning experience in my practice. ‘Cause, you know, I often say, “Ok, so, this week brush every two hours,” and all that stuff. And I could never do that. There's this brushing program that's very, very common to recommend. And if you really do the protocol it's supposed to be every two hours, and there's just no way that would ever happen. So I've gained a real appreciation for what it's like to actually ask families to do some of the things that I have asked them to do. And also I'm coming up with ways to make things happen in a more natural type of way.

Now that she has realized that standard protocols are unlikely to be followed by most parents, she developed a more doable approach for each parent. She describes the neurochemistry of why therapeutic play is more effective than plain therapy.

> You have a child that's tactilely hypersensitive. An OT would say you have to do this brushing program every two hours. And then you have to do these pushes and all that. I would say, “Yes” because you understand the neurology behind that. You need this neurochemistry to happen. Or you could do the brushing, or you could do a massage with lotion and have the mother actually touching the child and maybe sing a song while you’re doing it. Because how the mother and the child feel in the moment is going to make that de-pressure experience far more effective than if you just sit there with the scrub brush and go 1, 2, 3, 4, 5, 6, 7. It's obvious. It's more engaging [...] what's happening is when you are engaging more parts of the brain simultaneously then it really sticks. [...] Whenever there's this feeling, you know as a mother you learn that when you're breastfeeding there's this release of, I can't remember the hormone, there's this touchy-feely thing. That, I imagine, would be happening, too. [...] And the auditory, the depressure, that's more effective than the scrub brush.

The idea of using singing is not just for the client. Her playfulness and reflexivity puts it in the home where her own problem is located.

> We've stopped the TV [...]. We play music together. Again, it's I guess also there was some neuro. [...] I would say that maybe that's the place where the sensory and the psych came together was in the neuro, that's for sure, you know. For example, the idea of singing together and how that creates this kind of feeling of feeling good together. And rhythm, that's very much psych and it's also sensory. And you could imagine how a psychologist could recommend and also how an OT could recommend that kind of thing. [N]ot only is it a nice thing to do together, it's a way to spend time other than turning on the tube. But I feel like it's a way for us all, our brains all kind of get in synch when we're all singing together. And Isaac plays guitar and I play flute. [...]

She also sees the general theory of her work concretized in another setting. She finds a way to integrate the educational methods used in the Waldorf Schools, the educational model founded by the early 20th philosopher and educator, Rudolf Steiner. She sees that the school contributes to the child's experience of rhythm.

> They don't talk about routine so much, they use the term rhythm. [...] There is a modeling that the teachers do that I feel like it's incredibly helpful to family life. And has been, really has been the most helpful, even more so than the Program.

As suggested by Lynch (2007), she centers her role in herself and sees the Waldorf School within her own framework. She can see the theoretical similarities between Steiner's pedagogical aims and those of the occupational therapy. Steiner's goal to provide concrete experiences of life for children is not different from Dewey's.

> I think the purpose of the Institute is not to turn you into a zombie, that you learn this, "Goodbye," [and] there's no more to learn. From my point of view it's more important that you can see that whatever is going on, in this case, the Waldorf School is close enough. That was its intention anyway. It's not a surprise that it is the way that it is. And

> so when someone like you goes there, they can see it. They didn't say, “We're going to set up an OT department.” He (Steiner) just felt that urban life was already alienating children from basic experiences. [...] And they are so on target developmentally. [I]t seems very kind of New-Age-y. You read it and go, like, “What's this?” But the way that it works in practice is unbelievable. And to me, I feel like that kind of sets an example of... I want to say trans-disciplinary, obviously it's not, because you don't have psychologists, you don't have OT. I would say it is trans-disciplinary, because it does sort of blend social/emotional, it blends occupational therapy. It blends education in a natural context.

As she continues, her application of theory led her to critique the current state of affairs in her field. She talks about the difference between therapy in the natural environment and how that is executed in the Steiner schools. In her own field, lip service to natural environments exists but, in practice, only antiseptic and specialized environments get offered to the children. At the same time, she acknowledges the value of specialized environments.

> There it is in action in a completely natural kind of way. [...] And I'm drawn to it because it's very sensory rich. [...] As a therapist I would recommend it. [I]t provides a remarkable kind of sensory diet for kids. Because they spend so much time outdoors, so they are, they're really getting their hands in dirt and natural kinds of things whereas in an OT clinic, we contrive these kinds of things. We have sensory boxes and fill them with...Yes, well, we talk about that. Going to a child's home and trying to create an environment. [M]any therapists in private practice don't do that. Probably the more trendy thing is to have a really high tactile or sensory gym. The feeling is that that really provides the most input and in some ways that's true. You can't quite beat some of the things you can get in a sensory gym. You just can't get that necessarily in nature. But it's far more sensory rich than any other typical program. And the way the kids are handled [in the Waldorf School] [...] and what parents are taught. [...] I feel as a mother it's been so helpful, and as a therapist it seems to represent this idea that the importance of context and how you're providing your therapy.

No More Peak Experiences

Returning to the idea of validation, a second reflection of validation is the very absence of peak experiences in the interviews after the graduation period. One possible reason for the absence of reporting of the personal illuminations post-graduation may be inadequate

interviewing. The absence of reports of peak experiences in this portion of the interviews was not noticed until data analysis began. Another possible explanation and interpretation comes from the nature of integrative moments. For program participants, long-standing dreams were fulfilled by receiving an education in psychology they had longed for. The resolution of loneliness and other transformations resolved and presented in this section were resolved by other post-Institute experiences as well. With their newly acquired practice skills and IMH knowledge, they could now transform service systems, line practice, neighborhoods, and home life with their new skills. What was internal became externalized or united in practice and knowledge. The exchange of new knowledge for old, a process called chiasmus by Greenberg (1993, p. 18) , results in the new, transcendent, broad, intrapersonal practitioner. On the other hand, there is no reason such powerful experiences have to cease as long as the questing spirit continues. It is unlikely that the cosmopolitan spirit died with a new skill. One reason to consider the possibility of future illuminations comes from Howard Brinton (1967), the authoritative writer of many popular Quaker tracts.

> The word “mysticism” is to some minds misleading, connoting that which is mysterious, occult, and abnormal. [...] It can be truthfully said that the non-mystic rather than the mystic is unusual (p. 6). (Brinton, 1967).

The second reason for possible and higher level illuminative experiences might come from the next challenge for the practitioners. They have work but that work has no name.

Working without a Title

There is still no recognized title for the person who graduates from the Institute program. Institute training does not provide a title that adds to one’s ability to bill or be recognized outside

the small world of IMH. This dilemma was voiced earlier from the literature by a PT who practices and teaches the IMH way of working at a university. She never saw a job description for someone with her qualifications (Hochman & d'Emery, 2006a). Here are the words of the speech therapist who went on to become a psychotherapist, a person with a new title and ability to bill under that role. The speaker is the speech therapist who developed hives when she began social work school. She points to a major limitation in the program. The training adds to the ability of the mental health students to disseminate IMH ideas and service but not for the respondents to find jobs.

> Whereas the Institute was, it looks nice on my résumé that I did this institute, but nobody really recognizes it as—in other words, at the White Institute you had to do a certain number of hours of clinical work. There wasn't that requirement at the Jewish Board at the time [...] so that when you leave there you've gotten a smattering of psychoanalytic literature under your belt. You leave there with a perspective, not with real actual training.

Even though the last speaker went on to get a social work degree in addition to her speech and language and IMH training, she remains without a suitable transdisciplinary title but with a reputation. The lack of professional label places graduates in a situation of duality and vague definitions reminiscent of the taxonomic attempt to define transdisciplinarity. She does get referrals from those who have experienced her unique style of working and so they know what to expect. At this point in her career, this respondent does not need a title. But, the duality remains. Only now it is externalized rather than a stressful, internalized problem as it was prior to attending the IPSC.

> That's tricky, I call myself a developmental specialist. It kind of depends on what group I'm with. I don't really say that I'm a speech pathologist anymore. I tend to be more

> general. Well if I'm with a group of professionals, I tend to specify that I am developmental specialist with licensure in both fields. When a client calls, [...] they're calling because whoever referred them to me knows me as somebody who can do a lot of different things. So I tend to not say I'm anything. They're calling for help, and for the help that I can give them. If they're coming to me for a developmental issue and I just cover some language delay, I will explain that I am qualified to assess this because this is my background, but this is the way we're going to treat it. So it's very tricky. (Speech 3)

Another graduate described the problem as is externalized, not internalized. Nonetheless, she often qualifies her self-references in negative terms.

> I've talked at these national conferences, and I always say, "I am still a speech pathologist. I'm not a mental health worker. I'm not interested in being a mental health worker. I'm not a social worker. I'm not asking speech pathologists to be social workers." But the other piece is, if you have the relationship, it'll help them get to the next relationship they need. It's an important vehicle for supporting them to get other help that they might need. Somebody has to do that. (Speech 1)

Another person manages the lack of a suitable title by assuming multiple titles based on her numerous and different part-time jobs. She is in between jobs but in a new sense. The idea of a person as the center of overlapping roles is discussed by Lynch (2007) and she sees it as stressful. That is not the case for this person. Whatever the title and role, she likes keeping busy. One reason she had time for the interview was because she was recovering from surgery at home.

> Nurse consultant. Also I'm on the faculty at Roosevelt Hospital. The Parent-Family Education Department. My title there is Nurse Educator. Lastly, at the Child Center of New York, I do Early Intervention Childhood Developmental Assessment. So, developmental specialist and [...] running a breast feeding support group at Roosevelt hospital. So, I'm really busy.

She prefers the variety of part-time work to a single position and was planning to turn down a full-time position that might be offered to her. Her reasoning is based on clinical scope she has in her currently cobbled-together work situation. She also developed a new way to work in Early Head Start, the federal education program for children under 2 years and 9 months. This supports the idea that the graduates work in the transdisciplinary space, an in-between world, both externally and internally. Her strategic actions represent another example of role expansion.

> I started in the role of health consultant. Originally all of my work [was] allocated just reviewing medical files but I would find issues. [I] would find that I had questions about. I developed this whole different area. I started doing home visits because I had questions about this family. The staff had no clue. So, they would invite me because it was a home-based program to join the home visitor or the teacher and I started doing parent consultations or they would come to the center and they would ask me about their babies, either developmentally or medically. And then I started doing staff in-services 'cause they had no idea about what the parenting needs or medical needs, or the pediatric needs.

Another speech therapist can only describe but not name her new kind of work. Her work-around is to define the nature of the proposed therapy in an inclusive way.

> And so when I'm working with that caretaker, I [...] facilitate the relationship between the parent and the child. So, for example, with a kid who is on the spectrum that I'm seeing now, the kinds of things that I'm talking about to the parent is 'Where do you feel most connected? Let's do more of that.' You know you want to get a back and forth going, 'Where do you feel connected. How did that feel?' A lot of what I work with kids on the spectrum would be the stuff that goes on beneath the language, right, the pre-linguistic stuff. I would call what I do as sort of an interface between language therapy and play therapy. Or, umm, what I say when I recommend therapy after an evaluation is, "The child needs relationship-oriented, relationship- oriented and developmentally-based language therapy."

The respondents can transform physical, family problems and institutional weaknesses by applying IMH relative to the situation. Others recognize what they can do. Yet, there is no

recognized title or credential. In narrative terms, the graduates have gone from one named state to another with no name. That is the minimum qualification for a narrative but it is hard to characterize.

Prior Definitions Do Not Apply

Along with the terms transcendent, broad, intrapersonal transdisciplinarity, terms such as cosmopolitan and street level bureaucrat have been used to help describe the respondents' current state. Working outside of one's immediate job description or scope of practice defines someone as a cosmopolitan worker. Lipsky's (1980) street level bureaucrats make policy on the "street," or in the situation because they have a high degree of discretion and some distance from the actual organization (Chap. 2). The respondents who remained as direct providers of remedial services included unsanctioned therapies such as yoga and the Feldenkrais method as we would expect from reading Lipsky and from the research into early intervention practice (Rapport et al., 2004). Despite the analogous situations, there was a limit to the comparison. Lipsky looks at human service workers working within a single epistemological domain. Lipsky further predicted that street level bureaucrats would find refuge in academia. Only two of the respondents fit that prediction but it still is not sufficient and even if everyone who joined the study meets all of his predictions we do not fully understand their work in two distinct intellectual spheres. Thus, it is necessary to search further to understand the people under study because we have established that they are working with two distinct epistemological domains.

Schön (1968, p. 23) describes a class of professions called minor professions within which are AHPs and nurses. These professions take technical information and apply it in the human realm and are like the graduates. The work of the minor professions that Schön describes has uncertain aims and ends it is differentiated from professions such as medicine or law where

finality is involved. Schön sees these minor professions working under special rules that require a great deal of skill in applying their techniques. He touches on it as he does with the example of the urban planner who has to use counseling techniques with the developer and the psychiatrist who functions in the psychological and medical realm (p. 41). From his vantage point, the worker has recourse to a way of working that leads into a way to solve problems. The workers go between problems and problem solving strategies but his view is generalized. He does not discuss, in particular detail, learning to work within two theoretical domains which is the challenge for the people in our sample.

The space between those two epistemological domains is the in-between space inhabited by the respondents. Brazelton, the pioneering developmental pediatrician, is referred to as an example of someone who works within with two realms. While Brazelton and the speaker use the word fringe, they really mean working in two areas as the speaker says. The speaker also brings us back to Kuhn's idea of dual paradigms science (Masterman, 2004, p. 74). She performs her medical role under a biological paradigm at the same time using a social work paradigm thus placing science in the human realm as Schön (p. 23) describes when he describes the work of the minor professions.

> I heard Brazelton talk once and he described himself as a fringy person. He was in pediatrics but he was on the fringes. And, I thought I was always on the fringes, also. The patients used to think I was a social worker because I would talk to families and talk to the children but talk to the family also and not talk at them. I actually listened. (MD1)

One speech therapist expressed a similar idea of stretching past professional norms as all cosmopolitan workers must. She elaborated on Brazelton's sense of being on the fringe. She calls the fringe a boundary. A boundary, like a fringe, marks a space where two places meet of mix. A

fringe on a window shade mixes the coverage of the shade and that which is being covered. That fringe place is establishes the two and their mixing at the same time. "When you work relationally you have boundary issues, you have so many issues." (Speech 1)

When people work between realms they have to create a space mixes and separates at the same time. That idea of the transdisciplinary space was discussed by Gehlert as the place where the ideas of the team meet (Gehlert et al, 2010). It can be broad or narrow in accordance with Klein's (2009) taxonomy. Taking a psychoanalytic view, here is how one person made space for her emotions related to countertransference, her place as a therapist and her need to have her therapeutic tools kept at the child's home. Incidentally, the reason she needed the toys kept was because she recently was injured and needed to carry fewer things on her home-visiting route.

> It happened recently. I get phone call from a parent and she is canceling tomorrow. But then it gets all blurred […] and then it gets clear. I am getting a little bit upset and then it then it gets more clear. Oh, then I get a note. These parents do not let me keep toys in the house. I get upset that they do not make space for me and for my toys, not for me, for what I'm going to use for the child's learning, for the child's development. So one day I went out and brought a bag. I left it there. I did not ask. I put it in the closet and this is after I get this message. […] And I couldn't hear all well. I made a whole production myself. [...]. But it turns out I had this huge reaction and I didn't answer the call. I need to just calm down. I am going to talk to her later. [...] So she said, "Oh by the way, I am going to try to make some space for some of the toys." I felt better. I realized had this whole explosive reaction of my feelings. Feeling, like, I want to leave the case. [...] They are not making space for me. I do not leave the case because the child is doing great. This is a child who spent four months screaming. How can I leave him now, he started talking? We have a relationship. He's making little steps so I don't leave the cases that often, even when I want to leave them. […] The mother doesn't want dirt, nothing. [E]ven Play Dough was even difficult to enter the house. He needs finger painting, he needs sand playing, a little bit texture. He needs like messed up work a little bit. [I] recently said to mother. We need to do finger painting. I brought her the present of a smock. I gave it to her so she's not getting dirty but we are going to do finger painting soon. […] They are seeing changes so I don't think they want me out of the house. Not now. They want me in.

An associated domain of working with complex problems involving many disciplines involves the study of what are called *wicked problems*, in contrast to normal problems. Normal problems get solved by direct application of known theory whereas wicked problems need nonlinear approaches (Batie, 2008) . Approaches to wicked problems use transdisciplinary thinking and the problem solving usually takes the form of team work. Among the people who see complexity in terms of wicked problems, Kolkman, Kok and van der Veen (2005), however, understand that wicked problems must sometimes be addressed by individuals. To help the team and the solo practitioner, they suggest that mental mapping be used. Mental mapping is a way to look at the various social and scientific forces entailed in addressing a complex social problem. Social workers will see this as an example of force field analysis. It is unclear how the person transcends the disciplinary boundaries by making the mental map. The process for understanding has to continue.

The Inner World of the New Practitioner

When Schön describes the actions of a professional in relation to a complex problem he calls it reflecting-in-action. The reflexive event is after the fact and time for reflection exists. The person steps back and considers the problem in light of prior work, intuition and tacit knowledge. He then goes forward with an informal experiment, an attempt at a solution using what came up during the reflective time. Benner, Kryiakidis and Stannard (19999) students of nursing practice and Schön, cited the existence another inner state of working called *thinking-in-action* (Chapter 2). Thinking-in-action often occurs very quickly and the process may only come to light upon later reflection as a clinical narrative. It is a way to describe the way a skilled nurse works in the moment. The internal operations are revealed afterwards. She may be unaware of

what is occurring consciously but is applying ingrained skills and judgment (p. 570). In our case, we are looking at conscious work that may be performed under stressful conditions.

Usually, descriptions of transdisciplinary care appear as metaphors. According to Choi and Pak (2006), transdisciplinary solutions resemble a cake because the various powder and liquid ingredients do predict the result. Nonetheless, the result is transformative.

None of the graduates felt the work was as easy as baking a cake or that it involved following a simple recipe. Foley (1990) on the other hand, likened transdisciplinary assessment to jazz. Sometimes, the expectations of others come into play in improvised ways. The next speaker calls her transdisciplinary practice an inner pressure but her response appears to be as well to an external force. She does not have a handy name or label for her way of working, a problem we spoke about earlier, to describe her methods.

> Like I feel that people expect to see more traditional speech and language goals. And how they're written, etc. And what they expect to hear what I'm working on. And I think there are times that I'm working, let's say, I'm working through play, and […] I'm working on helping the child to consider me as another person or whatever. If, something about my goals not being written in exactly the same way as people expect them, […] I keep wondering; "Oh, my God. How will they see this?" And what is my struggle to say, to make my goals specific enough? I don't always feel that I'm able to do that. So I feel like it's an inner pressure. (Speech 2)

The difficulty of mixing many internal and external forces and skill factors is not lost on the next speaker. Her case presentation will be guided to clarify the multifaceted nature of her skill in terms of broad, intrapersonal and transcendent transdisciplinarity. The description will show that it is far from a cake and something like jazz in that numerous skills have to be brought in to improvise or create the care. However, few jazz artists have to improvise with such stakes but they do go between emotions and technique. What happens in between is the jazz. The

speaker's personality and approach generate some kind of creative tension generated by the situation that is not always easy to bear. It is easy to sympathize with her. Tension occurs when there are at least two pulls in different directions and one is in between the pulling. The poles are physical and psychological.

> I constantly walk around with a feeling of tension. I was told when I was a speech therapy student, that that tension is what makes great therapists, because you should never be so sure. I don't know that I'm the one facilitating change. How do I know? But something is changing. [...] I have a constant tension. It's rare that I feel, "Oh this is so great and we're moving forward!" because then, "You're up you're down, you're up, you're down." Instead, I generally tolerate a very certain degree at tension at the beginning of the session, and relief at the end of the session, and hope that I don't get any crazy calls in between.

In the next part of her narrative, medical skills, psychodynamic techniques, pharmacological knowledge, and feeding therapy are cited. Along with the stress of managing the mother-child interactions, the physician is asking the therapist to help keep him from being dismissed from the case. There is no hierarchy of care. The therapist oscillates between physical and psychological care as necessary. She has to be physically and psychologically self-aware as she is in her description of the treatment.

> And they weren't sure whether the baby was going to live. I mean, they really actually didn't expect the baby to live. They expected actually, both mother and child were supposed to die. [...] Really young family, she had had to abort a fetus prior to that because of a genetic problem. And this baby was born with IBF(?) [T] these pregnancies was watched, every month. They thought it was a sure thing. That she was going to be an easy birth and guaranteed perfect baby, so it was dramatic on so many levels. [...] I suspected that the baby was having seizures, or tremors. She would cry inconsolably for almost the entire day. Couldn't feed her. It was hard also. I was the one to work on soothing and feeding. So it was this parallel process between mother and baby. But it was so—you know they would call me, "She hadn't eaten all day." She hadn't eaten all day! So I would come over. Constipation. I'm telling them how to relieve constipation, just empowering them. They would call the doctor and not get a call back. You would

> have to call again, "Call now, ask the doctor, should you do rectal stimulation? Confirm that—because here, I'm not a doctor." And I'm telling the mother how to do rectal stimulation so this baby can poop so then eat. Because, again, you have to know about the GI stuff, you have to know about pooping, and eating, and reflux, and soothing, and regulating, and nutrition; you have to know about it all. Again, need to put this baby on a reflux medication!? "They're going to give you Zantac, tell them you don't want Zantac, Zantac never works." They give the baby Zantac, it doesn't work. [...] and weeks go by! And it's tentative, and I get the call "She hasn't eaten in 8 hours." So I would go for two hours at a time. [M]y goal was not to leave until she fed. And that was my personal goal. I never voiced that, but that was my personal goal and pretty much most of the time we were able to get her to eat. But it was that much work. Major tension, major.

And now that she met her goal of getting the baby to eat, the crisis is over. She went in with the tension and comes out with relief.

> But it was really rewarding too, at the same time. I mean, it was precious. It really was. I mean it was actually—the case was a gift to me. It was a horrible tragedy that happened, but as a—it's such a rare opportunity to have that kind of impact. Because I was really able to get this mother to learn how to soothe her baby, to learn what it took. But it was, really, tense. And the pediatrician would call me up and say, "So, if they're thinking about switching doctors, could you give me the heads up." I mean it was everybody.

For reasons associated with being a cosmopolitan practitioner, complexity is embraced rather than avoided. Like a cake, the transdisciplinary physician sees her knowledge as "layered". And, she has a way of putting it all together like the previous speaker.

> The more complex it is, the more interesting it is in some ways. […] One of the guys who ran the intensive area used to call me the humanitarian of the hospital, so I thought that was a great compliment. There was also a peculiar responsibility. I was swimming upstream. Exciting things were the things that go beep, and lights flashing and all that stuff. Numbers. I could never remember numbers, they don't mean that much to me. [...] Learning about what other people knew and learning enough about enough different things that I could be a kind of a triage person. I used to think that I have a whole lot of different layers. I have a medical layer; I went to medical school. I have a pediatric layer; I was a pediatric resident. And I have this pediatric rehab layer that was very much more

> physical rehabilitation. Then I have this mental health layer that is sort of my top layer at the moment. I can put all these levels kind of together. (MD1)

The last words go to a PT who developed an IMH inflected physical therapy syllabus. Like all cosmopolitan workers, they just want to a good job in the way they understand it even though she, too, has no word for the integrated work she does.

> I'm just trying to [find a] word [I]t's a different approach but yet I am making, seeing how [...] the sensory-motoric aspect of development ties into the social emotional piece as well as the relationship piece between the parent and the child, and the parent and the therapist. [...] I'm not looking to change what we do. I'm looking to improve on what we do.

V Discussion

The purpose of this concluding section is to organize the findings into a cogent form. Condensing the findings will take three steps. The first step is a further refinement of the study's working definition of the transdisciplinarity based on the work of Klein (2009) and Pfirman and Martin (2009). The second step will expand on ideas from Social Exchange Theory (SET) and the last step will apply two ideas from narrative theory. With the refined definition, SET, and additional elements of narrative theory, a metaphor will be constructed as succinctly as possible.

In the Introductory section, a definition of transdisciplinarity was constructed that encompassed an individual's working across epistemologically distinct disciplines. The definition derived from taxonomic classifications of transdisciplinarity by Klein (2009). She used the terms transcendent to describe transdisciplinarity that spanned different disciplines and broad to describe the greatest span of difference in the epistemologies. Klein's taxonomy of transdisciplinary work refers to transdisciplinary teams. To describe the broad, transcendent transdisciplinarity process contained within an individual, the word intrapersonal was used by

Pfirman and Martin (2009). The full descriptive term for the kind of transdisciplinarity presented in the paper is transcendent, broad, and intrapersonal transdisciplinarity.

To enrich the constructed definition of transdisciplinarity, it is useful to add some words from Greenberg's exploration of transdisciplinarity in *Transgressive Readings: the Texts of Franz Kafka and Max Planck* (1993). Greenberg's work was used because, first, she alerted us to the Principle of Complementarity. The Principle states that, sometimes, situations have to be read in ways that include contradictory information systems. Complementarity explains the result of the IPSC's learning process because it refers to the skill the respondents acquired in reading their patients in a physical and psychological ways. Their ability to work in these epistemologically distinct realms is an application of the Principle of Complementarity. .

To further understand how people learned to be transcendent, broad and intrapersonal transdisciplinary practitioners, Greenberg proposes four functional elements or actions that help us explore the learning process. The actions are *recursion, hierarchy*, *oscillation, and chiasmus*. She proposed some other terms but realized that the additional categories, which she also presents, ultimately, hindered her exploration. She felt that a loosely coupled set of terms would be more practical. Of her main categories she says:

> [C]ollectively such a group of designations can take us further toward understanding transdisciplinary readings than can a purely literary or purely scientific terminology. They suggest not a metanarrative but a dynamic model of relations between literary and scientific language that not only discerns transpositions within texts but also encompasses its own transpositions by reading literature in a scientific way and science in a literary way. (p. 23)

Greenberg's selected those four words as part of her effort to show that the scientific problems facing early 20th century physics were the same problems faced in that era's Franz

Kafka, an interpretive artist. This paper is concerned with how people mix hard science and psychology, another interpretive medium, and will use Greenberg's terms to consider the inner experiences of the graduates in order to read the *fabula*, the respondents' collective story constructed from the interviews. Greenberg, like Gehlert et al (2010), noticed the idea of space between disparate epistemological domains and she was interested in their relationship. Using words that refer to actions is consonant with the narratives offered by the respondents because actions take place in time across space. The words delimit different kinds of movement in physical and inner space that the students encountered. The same four words succinctly categorize the many experiences revealed in the Findings section and are reviewed in detail below.

The first word to be examined is recursion. Greenberg uses the word recursion to describe the way patterns repeat themselves as part of their function (p. 20). This means that repetition is part of the structure. Like all schools, the IPSC has recursive feature. It is a system that continues the infant mental health agenda. In the findings, recursion appeared in mentoring, the way IMH was brought into statewide and academic programs and in the way two respondents became scholars in the field. Repetitive creation also occurs when families picked up some of the therapeutic skills and orientations of the therapists. An example of this kind of recursion occurred when the nurse taught the mothers in the rehabilitation program how to connect with their babies. The ability to connect, in the view of attachment theorists, will recur through the generations in a recursion of love. Another recursion that we saw extend into time is the story of the speech and language professor who resists the relational mode of speech therapy but learns to accept it from the students of the professor who teaches it. In this narrative, the recursion occurs

twice. First from the students, who received the information from the professor-respondent, and then, next, to the teacher who first resisted.

For Greenberg (1993, p. 19) hierarchy, refers to the prioritizing one theory over another. Knowledge systems are often ranked in order of explanatory power in order to describe complex systems (Pattee, 1978). One hierarchical and pocket definition of transdisciplinarity, and the one used by the Institute, is that a social science paradigm should subsume physical paradigms (Choi & Pak, 2006). The hierarchical definition is only part of the complete definition of transdisciplinarity presented by Klein (2009). Hierarchical, intrapersonal transdisciplinarity was enacted during the breakfast narrative. During that moment, the physical modality was temporarily dropped in favor of complete use of studied inaction, Winnicott's technique that proposes therapists let words or events unfold without interference. Studied inaction took precedence over physical care because, at that moment, the therapist was working on the family system as way to improve the child's relationship with the family as part of the speech therapy.

Hierarchies, though, have inherent features that are obstacles to communication as well.. Knowles' training project can be seen as a way to minimize the negative effects of an organizational hierarchy. When the social blocks created by Westinghouse's organizational hierarchy were made more porous, the trainee executives had more access to senior executives and their knowledge about the organization. As communication within the company improved, the junior executives became better informed about the company plans and processes, they were able to work in a more effective manner that enabled retention which was the goal of the training project. Freire's pedagogical work was different. It was about completely breaking down economic and social hierarchies. Once the peasants could establish some sense of parity with

those who they, originally, felt were superior to them, they could begin to think critically and act to improve their social situation.

In the IPSC, the hierarchy of theory kept some of the respondents from speaking. The most dramatic block to the education process took place in relation to hierarchy. The allied health professionals and nurses felt imposed upon by the Institute's concern with trauma. Trauma, as perceived by some of the practitioners, was narrowly perceived and associated with poverty. Yet, from quoted sources and the respondents, it was clear that emotional trauma manifested in all social classes. It was hard to tell from the interviews if the program or the practitioners held the more narrow view. The practitioners, such as Nurse 4, the NICU nurse, whose experience allowed other physically trained practitioners to see both sides of the trauma coin, were not always present in the program.

The program goal is to teach an overarching theory that, necessarily, diminishes the dominance of physical care and treatment. In this light, the program's theory unintentionally provokes a silence from those who are originally trained in a physical science paradigm. Ironically, the break in the silence came when respondents saw that they had something to teach as well as having something to learn. Accordingly, respondents spoke about the moments they felt they had something to offer and parity of roles was established. To repeat an example, one nurse began to learn only after realizing her worth in her ability to contribute to the learning of the mental health practitioners as expected by Freire. After this moment, learning began. "But, I think when they came to know a little bit more about me and I saw they didn't they didn't (have) half of the experience I had with infants and parents. It shifted." (Nurse 4)

Fuller (2009) provides additional reasons why hierarchy creates communication problems. If a hierarchical view is too firmly in control of an interpretation, the interpretation

cannot be challenged and corrected, and therefore not subject to experimental design. He calls overdetermined hierarchical transdisciplinary views such as dialectical materialism and Freudian analytic psychology, among others, *deviant transdisciplinarity*. Problems with the Institute's version of this came up during reflective supervision when the need of goal oriented therapy from an allied health professional conflicted with the idea of open-endedness of mental health care. If the mental health view dominated, there could be no proper physical care and no complementarity readings could occur. An exclusive psychological exploration would too open-ended and the kinds of functional goals, such as walking and talking, that interest the respondents would be forgotten. The exclusive use of the overarching IMH model was rejected by the PT who early provides material for her reflective supervisor's epiphany that psychology was essentially open-ended whereas physical care has definite endpoints. At that point, the clinical supervisor arrived at equal terms with the supervisee and became a student. This is an example of what Freire called teacher-students and student-teachers, a condition of parity.

The idea of equality just shown refers to oscillation, going back and forth in a mutually respectful dialogue, is a corrective to hierarchy (p. 16-17). Where hierarchy creates blocks, oscillation provides the antidote. Writing in a spiritual style, Freire (1992, p. 171) used the word *communion* to describe the coming together of two sides, revolutionary and peasant, in dialogue in order to create a grounded basis for shared political action. The hierarchical radical seeking to impose a view of the masses, in Freire's view, really needs to learn to share with and learn from the peasant in order to succeed. For the peasants to read and understand Marxist theory in a way to apply it, the peasant had to feel he knew something. In sharing knowledge, the peasants could converse as equals with the revolutionaries. At the Institute, the respondents learned as equals sharing insight from their own perspectives. Oscillation appeared most strongly in the role

dialogues in which the respondents had to teach the Institute faculty and the students who were rooted in mental health.

Greenberg (1993) calls oscillation the “quintessential” aspect of interdisciplinarity (p. 16). This makes sense because the bridging feature of transdisciplinarity has to do with how the disciplines go back and forth to create something new. This newness, a goal of transdisciplinary work according to its proponents, such as Gehlert et al (2010) and Choi and Pak (2006), may not always be a result of an overarching theory as some, like those at the Institute (2008) think. Greenberg’s reasoning is based on the way that way contrasting readings, complementarity, create multidimensionality. Multidimensionality is another way to describe the transdisciplinary space mentioned by Gehlert et al (2010) and is related to Kuhn’s dual-paradigm science as presented by Masterman (2004, p. 74). More than one dimensions get created in betweem the back and forth of the paradigms or epistemologies A rich example of the multidimensionality of dual-paradigm or transdisciplinary practice is the narrative from the speech therapist who earlier told about her going back and forth between the physical and the psychological when she treated the child’s feeding problem and the mother’s natural anxiety. The therapist sees herself in an between state and uses the word tension, being pulled in two directions, to describe her state of mind when she is practicing. She was able to accept two readings of the situation at the same time. Greenberg, like Bohr, thinks that complementarity is needed beyond physics.

> [N]o single point of view can ever “read” or interpret a situation in its entirety. To “read” quantum mechanical events requires applying two mutually exclusive points of view, for one without the other is not explanatory. Bohr treated this notion as an epistemological one broadly applicable beyond the realm of atomic phenomena (p. 72).

Complementarity minimizes theoretical errors associated with hierarchy when we cannot observe the phenomena directly because it lets some new information for an inductive response in situations where deduction and protocols would otherwise rule and, perhaps, mislead. For the IMH practitioner grounded in the body, the psychological element gets grounded and the psychological element prevents too narrow a focus on direct observation. Here, an OT describes about how she applies oscillation in her sessions. Social workers would describe it as decreasing the distance between the social worker and the client. First, the respondent describes how she spontaneously decided to add yoga as part of the therapy. She is not caught up in protocols.

> I [...] am doing a bit of yoga with one of my kids and the mother [...] at the same time. [I]t's a brand new thing and it just sort of came spontaneously.

In response to a follow-up question, she talked about how her new methods of working in the affective domain reduced hierarchy and created conditions for the child to design his own exercise thereby becoming a patient-therapist.

> I feel like my kids are improving. [T]hey're comfortable with me. [...] I might start off with the protocol, but I'll let them invent another kind of way of doing it that provides a very similar kind of input. And I feel like the kids want to see me from week to week, so that's got to be useful. (Movement 4)

She went on to say that she still needs to consider measurable outcomes. This concern came earlier when the PT informed her reflective supervisor that allied health professionals have meet specific objectives within a reasonable time frame. The OT restates that point in her next statement.

> I also am looking for functional things. [Such as the child understanding:] “What is the teacher saying now?” I feel like that in itself is important. We have to do testing anyway,

> but to me. "Is the child able to write the stuff down that he needs to in a timely way." And that's really important.

The last term given offered by Greenberg is *chiasmus*, meaning exchanging positions or transposition (p. 18). To give us an idea about chiasmus, Greenberg describes how genes cross over from one parental chromosome to another during fertilization. The cross over provides the physical basis for genetic diversity, something new within the limits of the system. Greenberg includes the idea of distance here. She described how the greater the distance of the gene from the center of the X-shaped chromosome, its crossing over increased the chance of diversity to appear. By analogy, then, the broader the distance between the epistemologies, the greater will be the newness of the transdisciplinary solution to a problem. The switch, though, has to be acceptable to the giver and the recipient.

Each respondent created their particular transdisciplinary practice by absorbing hierarchical and oscillating forms of education. These two processes made up the chiasmus. The students had to accept the hierarchical principles of IMH relative to physical. They also had to push back or oscillate their own practice orientation of goal setting within the IMH context. The crossover could not have happened unless the students engaged in sharing their own point of view. This often meant disagreeing with the overarching principle of the IPSC or simply disagreeing of the teachers' interpretations of the presentations. When open engagement or disagreement did not occur, as in the case of the teaching about trauma, no learning occurred. Chiasmus links us to the theories that explain how ideas are exchanged in social settings.

Social Exchange Theory (SET) is a way of framing the many intangible factors such as status and affiliation that people accumulate in social settings (Emerson, 1976). There are two sets of exchanges that occurred in the training process. One set of exchanges occurred over the

entire narrative and are related to the effects of the training program at the IPSC. In this set, we see how people create and inhabit their roles instead of being defined by them, an interest of social cognitivists (Howard, 1994; Lynch, 2007). These include the exchange of professional loneliness for community and lack of trained psychological insight for psychological practice. Other changes are switching travel for being local and the desire to be more psychological in their work to becoming more psychological in their work.

The second set of exchanges includes the pivotal moments of exchange. The most important is the breaking of silence when the physically trained respondents realized they had something to give in exchange. When this realization was made, role exchange could begin internally because by giving their knowledge, they became able to receive the new knowledge they came to acquire. The reason the exchange is social in that, unlike the methods of most other schools, the tuition was not sufficient to ensure learning. Paradoxically, the students had to validate their hard science background in order to realize their dreams of fleeing their original training and learning psychology. A complementary inner state had to be created by acknowledging the original state of mind.

Earlier, we presented the learning process in terms of adult education practitioners Freire and Knowles. From the perspective of SET, social exchanges occur between roles (Emerson, 1976). The basic roles in any exchange are the ones of giver and receiver. Thus, when overarching theory has to be acquired, it also needs to be balanced by what we call parity in order for it to be received. Otherwise, the high theoretical load makes it too big to receive. The shoemaker had to be important, too, in his own eyes. To concretize this concept for the respondents' idea we heard Nurse 4 describe her parity and realization that she had information to share with people who at first, intimidated her. The ability of the program and students to

engage in exchange is the factor essential in the transformation of the respondents into transdisciplinary practitioners. Therefore, SET, which is about observing exchanges, will be given a more detailed presentation.

The aim to teach, or dominate with, a hierarchical overarching theory is overt in the Institute. Power is displayed of the way the school is a local institution for the mental health students and a cosmopolitan institution for the respondents. The orientation of the program in the form of the teachers and the majority of the students, who are mental health professionals create a two against one arrangement towards the physically trained respondents. The vocabulary and, sometimes, complex readings further enforce this view. Physical information comes only verbally or visually. This method validates the respondents but reinforces their secondary status.

The striking matter in the findings is the latent presence of oscillation which can be conceived of as exchanging. Information is exchanged in the role dialogues. Justification for calling the oscillating aspect of the training latent is that it appears from the narratives that the silence breaking that allowed learning is not planned for or well managed by the program. While it is true that the program anticipates some exchange of information, it does not anticipate the inner processes of the students. The respondents' reactions to few physically trained teachers, such as the doctoral level OT, and the training video suggest that the program leaders require the input in unanticipated ways. The students reinterpret the videotaped lessons or seminars as inadequately perceived or even wrong. An example of a poorly perceived video came from the physical therapist who observed responsive attachment to a low-toned, [weak muscled] child who could hold his head up during play. Watching the same video, the psychologically trained teachers and students saw poor attachment. Other examples of the lessons being perceived as wrongly interpreted came most strongly from a second physical therapist.

More evidence for the saying the presence of oscillation is latent and unacknowledged is the surprise of the reflective supervisor who learned that allied health professionals had more specific goals than mental health workers. The corrections from the respondents surprised the instructors. Support for the idea of the underappreciation of the students' silence is further based on the presence of the long silences some of the respondents reported and the lack of managing the silence by the program. It is true that one respondent reported that one instructor urged her to talk and offer her experience but this respondent says she remained silent for most of her two years in the program. During the interview, this respondent remarked on her talkativeness while being interviewed while being quiet during classes. Moreover, the silence breaking was accomplished by internal realizations by some students that they had something unique to offer the mental health practitioners rather than the teachers' skills. The realizations were not part of the program and not accounted for by tuition or the curriculum. If the learning exchanges had not occurred there could be no recursion or repetition into the future because no one would have fully integrated the training in IMH. Moreover, there would not have been any chiasmus. The physical information could not have crossed over to the mental health workers and, conversely, the respondents would not have integrated psychological care into their practice. In its place would have been information and resistance to it at the same time.

SET is derived, in part, from the work of anthropologists and economists who study what are called non-rational economic systems that use rituals in place of cash to facilitate the exchange of goods (Emerson, 1976). One example of such a cashless market is the potlatch, a ritual of gift exchanges that redistributes wealth from the wealthy to the less wealthy and described richly by Godelier(1999, p. 155) and anthropologist. While an economy based on gift giving sounds nice, in potlatch societies giving a gift led to a creation of an obligation (p.44 &

p.150). The obligation was a social improvement because it substituted the obligation for force and violence. Thus, giving a gift created power and prestige to the giver in the way money and resources do in our society (p. 149). Obligations are important in potlatch societies because the debt of having received a gift gave preeminence to the giver and cut across other affiliations such as family. In reducing group affiliations, individuals had direct ritual contact with each other and put receivers under obligation without recourse to force (p. 150). Considering the IPSC's goal of teaching an overarching theory as a potlatch power dynamic is a way to help further consider the roles in the learning process. The goal of the IPSC, from this perspective, is to put the physically-based health professions under the aegis of psychology and remove them from their affiliation with their original training to some degree. As was shown in the Antecedents section, the students willingly entered into such an exchange for conscious and unconscious reasons. The unconscious reasons were powerful enough to create marriage partners who were psychotherapists.

Traditional potlatches that function under exacting traditional rules are rare nowadays (p. 157-8). Intrusions of the cash economy have eroded the strength of potlatch. In Japan, for example, gift-giving was, formerly, so excessive, that post-WWII campaigns moderated some gift giving practices. Expensive giving practices also came into conflict with need to save. Yet, the potlatches and gift giving continue in modified form around the world. To further understand the Institute as a variety of modern potlatch is the last step in the reducing process into a metaphor.

Narrative Metaphor

There are two classifications of metaphor that concern narrative students of organization. One is a paradigm. Paradigms compare like with like and are proposed by Morgan (1997. p. 256)

as way to summarize an organizational process. (D. Morgan, 1997). The columns of soup cans in the market can be compared to columns of a Greek temple because of the sequence of tall cylinders match enough to make an association. It would have been possible to use one of Morgan's metaphors (p. 405-412) such as escape from the psychic prison or transformation and flux (412-423) but these metaphors about changing a closed state of mind for a more open mind would not have provided enough specificity. Morgan specifically refers to autopoesis, a way of seeing the way people transcend boundaries of disciplines, our exact topic. Autopoesis only describes that process is a change process, not the process itself. It returns us to the comparison of one thing to another and the idea of narrative is to look at the process in time. For the purposes of this study, a paradigmatic metaphor is like the taxonomic definition of transdisciplinary. It covers some but not all of what needs to be communicated. The experience under study is rich and carries definite ideas of change in time.

Another kind of metaphor called a syntagma capture more detail in story form. Syntagmic metaphors compare patterns according to Czarniaskwa (2002, p. 31). One common syntagma is the retold and revised fairytale. Cinema makes use of syntagma whether in the form of a remake or the cinematic version of a book. The screenwriter and director have worked to take what they take as the key plot elements and made their version of the story. The key character, location and plot elements are called focalizations by narrative scholars such as Herman and Vervaeck (2001, pp. 70-79). When focalizations match sufficiently, we can create a syntagma. Sufficient is adequate and a complete match is not necessary, otherwise, the same story would have been repeated.

To create the syntagmic metaphor of the Findings, actions will be focalized. The first focalized actions are the terms suggested by Greenberg (1993): recursion, hierarchy, oscillation

and chiasmus. The key focalization in the findings occurred within the space of the four words and can be summarized in the ritual of the potlatch. That focalization is the moment the respondents went from being oppressed by psychological theory to being able to acquire the theory by offering their own knowledge and acquiring self-worth. It is the climactic moment from which learning took place. If the students did not give information and acquire self-worth, they could not receive the new role they wanted.

Narratives are surface readings and narrative theory is primarily about the structure (Pentland, 1999). However, the purpose of most analysis of organizational structures is to get beneath the surface to understand what is really happening. The words broad, intrapersonal transdisciplinarity might work within the world of interdisciplinary scholars but even they think in their own world and we needed recourse to Greenberg (1993) who wrote about a kind of transdisciplinarity unrelated to team research. She saw the actual activity that goes into the learning process for an individual and even those four words, chiasmus, hierarchy, oscillation, and recursion are words that require their own explanation. Secondly, a syntagma can provide insight by capturing a dynamic element with brevity, the goal of this section. Smith (1983), for example, used the fairytale of Rumplestiltskin to encapsulate an organizational struggle.

The narrative theorists, Herman and Vervaeck (2001, p. 105), though, object to the use of anthropological readings of narratives. They think that such readings subordinate a text into a non-literary conception of a story and that the narratives essence is discarded in terms of a pre-existing pattern. In our case, we are not subordinating a text to pre-existing pattern. We are comparing social events based on exchange that exist in life. Pentland gives positive reasons to compare social patterns (Pentland, 1995, 1999; Pentland & Feldman, 2005). He and his colleagues say that organization routines are grounded and we are comparing routines of

exchange that appear similar. Reports of routines grounded in reality makes organizational narratives different from a literary or mythological one. Pentland calls organizational routines grammars (1995) and grammar is simply the common English language word for syntagma. Secondly, as an organizational scholar who uses narrative, he sees routines as units of analysis and we have organized the routines into four categories of experience, the words chosen by Greenberg. Finally, Pentland (1995) says that we are not violating the surface with the creation of the story other than that any narrative creation has subjective elements that can be given a plain, structuralist reading without wandering into more sophisticated post-modern interpretations.

The primary reason the potlatch was chosen is that it is an exchange system that intertwined social and economic interests that informed the kind of thinking of social exchange theory (Emerson, 1976). Social exchange theory seeks to explain the kinds of exchanges that are not explained by markets based on rational self-self interest such as prestige, status or desire to learn. Potlatches are about creating obligations via exchanges. The ritual of the potlatch contains the four elements used by Greenberg to describe transdisciplinarity. The gift giving by the potlatch leader affirms hierarchy, rituals are recursive, giving and receiving are the chiasmatic act. The next step is to see the role of the oscillation or exchange from below which is identified as the key moment in the learning process. To see this defining feature of the learning process, there is the example of a potlatch that is adapted to the modern world.

Among the existing potlatch societies, the Haida potlatch is among the most studied and will be our point of comparison. The Haida are one of the indigenous nations with potlatch traditions along the Pacific coast of Canada and the United States. The culture and potlatches celebrated by the Haida are among the better known of them (Glass, 2011). The ability to mix

disparate realms is a feature of the Haida art and rituals (Bringhurst and Steltzer, 1991, p. 79). In the ceremonials now gathered under the catch-all English name of potlatch, accrued wealth in substantial amounts is given away; more rarely, objects of special value are deliberately destroyed (pp. 23-24). In a contemporary Haida potlatch everything appropriate to the ritual, is paid for by the host who can be a traditional noble or a wealthy commoner.

Our example of a modern potlatch comes from the art critic David Levi Strauss (2010b, 48-49) and no relation to the famous anthropologist Claude Levi-Strauss. The art critic's description gives a pattern that can be compared to the learning process at the IPSC. One important feature of a modern potlatch that links it to the IPSC is the voluntary nature of attending. Modern Haida are integrated into the cash economy. They do not depend on gifts for livelihood.

Levi Strauss was invited because he was befriended by some Haida artists whose work he was reviewing. Reading his portrait of the event, we see that he had done his homework and read some of anthropologists, such as Mauss, who first studied gift exchanges. Levi-Strauss read up on Haida art but he is no academic expert, only an especially acute and informed observer as any art critic must be. In fact, most of his writing concerns contemporary art such as the way Haida artists blend traditions with modernity. The traditionally themed art work he reviewed was made with the finest modern woodworking tools from Germany and Japan to carve the traditional styles. Thus, even the techniques matched modern with old and indigenous with foreign.

The potlatch he tells us about was the first anniversary of the deaths of two children of a hereditary chief and continues the theme of mixing contemporary and traditional funerary customs. Preliminaries rites mixed modern and foreign rites such as English language poems on palm cards with traditional acts such as the raising of what we call a totem pole. Guests ate from

enormous quantities of food accompanied by bags for taking home leftovers. Next, the guests spoke their piece, a part of the ritual. Upon the cessation of speeches, they received their gifts. The memorial service ended with traditional dancing and songs.

The focal moment of the potlatch for this study is the nature and timing of the speeches and gifts. The speeches lasted for about 6 hours so it occupied much time and clearly were of importance. At an event with about 500 guests, 25 to 30 people spoke, probably during the feasting. Most speeches were formal declarations of praise and gratitude to the hosts for the potlatch or eulogies for the departed boys. Significantly, one could talk about politics, culture or whatever the speaker felt needed airing. At the end of speeches, came the gifts. Without detailing what was given, and it was lavish, it suffices to repeat Levi-Smith's observation (p. 49). "All were given more than they could carry."

Gifts were handed out by the relatives of the chiefly family to emphasize the regard in which the ritual chief held the giving. The gifts were not piled on like the food on the groaning boards. Giving required human interaction because the role of gifts in the potlatch is to establish obligations between individuals. Exchanging of speech for gift is oscillation, a back and forth, or call and response, while at the same time, the noble dispensers reinforced the idea of hierarchy. The moving of speech of guests to hosts and the gifts to the guests represent crossing or chiasmus. As for recursion, all rituals are recursive. The recursion is the repetition of the potlatch into the future with the continuance traditional and absorbed modern rites, such as the carved funerary poles and the little girls in white dresses handing out English language poems. The recursive aspect of the potlatch was not implicit. Among the final remarks given to Levi-Strauss, came from one of the traditional dancers referring to potlatches that commemorate lifecycle events which are also expressions of recursion.

> [P]ay attention when the people gather for weddings, feasts, and deaths, because if we do not pay attention, we will end up like other peoples of the New World-people without names, without songs, without family ties, even without a spirit, it seems. (p. 49)

The pedagogical problem of the IPSC hierarchy of knowledge is to, in some way, give the gift and create the obligation to psychology desired by the respondents. That aim could only be accomplished through oscillation or sharing as the narrative made clear. Sharing is at cross purposes with hierarchy because it undermines prestige and power. On the one hand, exchanging gifts place the givers on equal footing (Godelier, p. 42). Supporting this is the fact that no counter gift, given in a potlatch can supersede the gifts accepted from the ritual leader (p. 56.)

The respondents voluntarily accepted the power and prestige of psychology as represented by the IPSC. They registered, some in relation to profound experiences, and completed the course, also in relation to profound experiences, but the learning could not proceed without the respondents giving something unrelated to tuition in exchange. From the point of view of transdisciplinary theory, as presented by Greenberg, hierarchy and oscillation are but two necessary features of the four functions that includes recursion and chiasmus.

In the potlatch and the Institute, the event cannot proceed until the subordinate participants are willing to speak. The effect of speech acts in the potlatch resembles the learning in the school for the respondents who had to discover their knowledge and give it away. Without speech acts, no true education would have occurred. Rituals embody some kind of transformation and that special moment in the IFPC is that climactic moment because, without it, no one could receive the gifts that were more than they could carry. They had learned so much that they had to give their gift away in the form of therapy, teaching, activism and management practices. In this exchange, they rose in the kind of status they enrolled for. Potlatches and professional schools

also allow for increases of status when others compete in the offering of largesse (Godelier, p. 149). Among the Haida, wealthy commoners, nowadays, hold potlatches. There is room at the top for the Institute students. They have become IMH scholars and directors of local professional associations in which they share responsibilities with the teachers. The welcome the practitioners feel with the teachers has to with the complementarity in which the teaching was given which is also part of the spirit of the modern potlatch as manifested in its excess of food and gifts. The recursive nature of generosity between master and student, potlatch host and guest, relationships all based on recursion of spirit and matter. From that perspective, we have this statement by another Zen master, Grace Schireson, (2011) about her own Zen master. She refers another generation back to what her own teacher learned about generosity from his own spiritual master. That person's ideas of being generous also included manifesting generosity in spirit and matter:

> He taught me about generosity by giving me gifts and said that [Zen Master] Shibayama Roshi had taught him that the paramita [perfection] of generosity was not just meant to be in spirit, but needed to actual gifts like his calligraphy on fans and a beautiful Bizen vase.

The process of generous recursion that appears in the last comment and in the potlatch recurs in the narrative of the family physician. He was the one who was gruff with the babies under his care. In terms of training in IMH, he only had contact with the developmental specialist, Randy, who, in turn, had contact with the respondent who develops early childhood program's in her New England state. In this tale of recursion, the physician broke role hierarchy and took the teaching, an oscillation, with a subordinate care giver who now had attained some parity with the physician in his own eyes. She had something to offer him and he gave a changed practice in response. The prior quote about the Zen master and the next quote about the physician are linked by the time it takes and value placed on writing whether it is a traditional oriental calligraphy or

the rare letter in our internet age. The report of physician's experience provides us, as well with the opportunity to end with a final transformative experience. In a letter, the physician describes how he has taken to heart the teaching of infant mental health, a chiasmus, transposition of role. He accepted his part in the exchange. He is now saying, "Thank you!" which is a proper gift in response to a gift in the form of an action. Like all the other respondents, his learning involves going out into the world with what he has learned even if he can't name it.

> [T]hen he ultimately left [the respondent's home state] and he went to the Mayo Clinic [in Minnesota] and I got a letter from him saying, "I can't even begin to tell you how my practice has changed as a result of having the infant developmental specialist. Randy has taught me that babies are precious and that when I hold a baby, I have to be thinking of the baby, to be thinking that [to] that parent that's the most important thing in that's parents life and that every action and every interaction for that baby is contributing to that baby's overall well being and that parent-child relationship and if I model good interactions with the child I'm modeling them for the parent as well." [Randy] created an opportunity for him to get a better understanding of what it's like to have a relationship with the child. (Movement 2)

VII Limitations of the Study: Practical and Theoretical

The limitations of the study are discussed in terms of the practical and theoretical domains. In the practical domain, the sample was derived from one institution that trained professionals across epistemologies. Researching a sample from one training program provided a way to isolate an experience and look at it in depth. The sample, while small numerically, included 79% of the allied health professionals and nurses who attended the program during the research period but was limited to one set of professionals who underwent the transition to broad, intrapersonal transdisciplinary practice . A larger and more varied sample might have changed, confirmed or altered the tenor of the emergent findings and conclusions of the study.

The number of interviews also turned out to be another limitation. The respondents were interviewed just once. No follow-up interviews were planned. While this limitation was planned based on the needs for efficiency for the researcher and the respondents as presented by McCracken (1988), follow-up interviews could have explored emergent themes such as the peak experiences that were not anticipated or closer examination of intrapersonal transdisciplinarity, the inner experience of working with two epistemologically different process (Pfirman & Martin, 2009).

A third limitation was created by the goal of the study which was to create a coherent narrative of a group experience. Meeting this goal limited the narrative common factors which emerged during the process of becoming a transdisciplinary a practitioner which included the antecedent and post-graduate experiences that bracketed the training process. This study's goal was realized but it precluded the exploration of individual factors that might have shed more light on the transition to transdisciplinary work. Some individual processes, despite the limitations, were touched upon. For example, one of the respondents was aware that her reaction to a busy working mother was a countertransference reaction related to her own experience as a child among nine siblings who was effectively raised by a nanny. There was sufficient material for this exploration but no justification within the study's goal. Other explorations of individualized features examples of personal features that were not presented showed how the desire to nurture, being a local practitioner, and one individual's sense of space could be organized from their responses.

The theoretical limitations can be considered in terms of the single interviews in to emergent findings. It was not anticipated that the transition to transdisciplinary education could be predicated on the validation and sharing of one's own work. Instead, the ability to share was

the block. Sharing was successfully completed in the case of learning the psychological way of thinking. Sharing was unsuccessful when it came to the acceptance of the ideas of abuse and trauma. There could have been more delving into the poor response to what was discovered to be confused ideas about socioeconomic status and parenting.

Another unanticipated finding was the presence of what Kuhn (1996, p. 85) calls gestalt switching, the dramatic switch in theoretical perspective. The presence of gestalt switching was a key finding that could not have been anticipated as Kuhn was not consulted until the data analysis was nearing completion. In fact, Moustakas' conceptualization (1990, 99-103) adequately explained the peak experiences but Kuhn's ideas address some of the epistemological concerns on the study that relate to understanding scientific theory. Still the lack of preparation and follow-up for this finding led to limitations in the exploration of the switch despite presence, in some cases, of graded experiences of gestalt switches that suggest that gestalt switches appear in varying degrees. Second interviews would have allowed this emergent feature of transdisciplinary preparation and learning to be explored in a more refined way.

VIII Future Research: Practical and Theoretical

Sample size and scope also play a role in possibilities for future research. Two other populations exist for further research. One is the Infant-Parent Training Institute run by the Boston Jewish Board of Family and Children's Services. The second training program that focuses on IMH is Adelphi University's Institute for Parenting's Post Graduate Training Program in Parent-Infant Mental Health. Future research in areas that were underexplored or emergent in this study could be expanded to include graduates of these two programs to create a larger and broader sample to acquire more data.

An application of the findings would be to present the findings in digest form to the faculty of the three programs that train allied health professionals. The findings could operationalized into testable hypotheses. An important hypothesis test would be one that might determine the silence experienced by the respondents at the initial phases of education could be shortened or eliminated by intentional effort on the part of the faculty. Another important test would be to see if there could be greater acceptance of the idea of trauma, abuse with greater discussion of socioeconomic factors associated with practice.

From the theoretical viewpoint, two avenues of research have some compelling features. One is the idea of intrapersonal transdisciplinarity that was briefly mentioned in a chapter by Pfirman and Martin (2009) and expanded, in another chapter, by Fuller (2009) but only in terms of single theory transdisciplinary methods whose conclusions are somewhat determined by the outlook of the theory which he called deviant transdisciplinarity. Deviant transdisciplinarity was given a complete discussion in terms of single theories that claimed to encompass disparate views by one person. The concern in this study has to do with dual epistemologies or paradigms being managed by one person. The respondents in this study are most likely bound to working between the epistemologies of realistic and anti-realistic science for the near future. The idea of blending of psychological approaches to occupational and speech therapy has already been raised by Mattingly (1994) and Hinckley (2008) in the respective allied health disciplines but not fully explored from the point of view of practitioners by both these authors. More recently, a conference session for dietitians working with eating disordered adolescents entitled *A Listening Ear: Does It Turn a Dietitian into a Therapist?* presents one more example of how some dietetics practitioners are managing to cross epistemological divides. The talk addresses the

discomfort that dietitians feel while working with eating disordered patients as they are placed in counseling or therapeutic roles beyond their training.

Working under dual paradigms was considered by Kuhn to be a transitional phase within a given discipline as paradigms shift within that discipline (Masterman, 2004, p. 74). However, managing dual paradigms will remain permanent situation for the practitioners in the study and those like them who travail between competing epistemologies and, further, have apply the Principle of Complementarity. For the time being, no resolution of the mind-body problem appears likely. Examples of work across disciplines were presented but it would have been even more revealing if questions could have lead the discussion to other aspects of dual paradigm work.

As more workers formally and informally are released into the role of intrapersonal transdisciplinary worker, professional dilemmas can be examined from a theoretical perspective. With an enlarged pool of respondents, the ideas of gestalt or paradigm shifts can be explored to see if the dramatic experiences reported by the respondents in this study are fundamental to the becoming transdisciplinary. For Kuhn, only a few pioneering scientists undergo the experience of gestalt switching (Kuhn, 1996, Chap. VIII). After the new paradigm is proposed, the discipline undergoes a process of acceptance or rejection that is less astounding for the individuals within the discipline. For the individuals in our study, the gestalt shift recurs within individuals frequently as they somehow arrive at the sudden conclusion that some psychological force impels at least some part the physical problem they are treating. Cognizing this experience, the respondents go on to develop a cosmopolitan role by expanding their practice into psychology. One important difference between Kuhn's pioneers and the respondents and any others undergo this shift in viewpoint to include realistic with anti-realistic science have a place

to which they can turn. The peak experiences and the less powerful experiences reported by the respondents are of a different order from the ones described by Kuhn because the respondents and the people like them can enter an existing paradigm of psychology or, more broadly, anti-realistic thinking with its own teachers, theories and traditions. The respondents have to discover for themselves, not invent a new world.

II. Future Research: Practical and Theoretical

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Appendix: The Study Guide

Introduction

The purpose of this interview is to gather information about your experience as a trainee and a graduate of the Institute for Infants, Children and Families' program for early intervention practitioners. Specifically, the goal is to study the impact of this program on practitioners like yourself who were originally trained in the allied health professions and nursing and, later, pursued training in infant mental health. The results of the study will contribute to knowledge

about multi-disciplinary approaches to infant mental health and help the Institute evaluate its own program.

The interview will take between 60 to 90 minutes. Data gathered will be incorporated into my Ph.D. dissertation in Social Welfare at the Graduate Center of the City University of New York. For both evaluative and knowledge-building purposes, your responses will be completely confidential and your identity will be protected. Though you have already signed and agreed to participate in this interview or focus group, you still have the option to refuse to answer any question.

Demographic Information
The first series of questions are demographic and will help me put your information into a personal and group context. Answering the questions will just take a few minutes.

ID Code ____

Name ___________________________________ Date of Birth__/__/__
Gender M/F Racial/ethnic identification_______
Profession at time of registration ______________________
Years in profession at time of registration ___________________
Current title _______________________ Per cent of time spent in direct practice______
Other related trainings ____________ Last completed degree

Year Completed Institute Program Frequency of Supervision
Maintains relationship with Institute Y/N
How is it maintained?

____

Have you published anything on your new practice? Y/N
Number and type of publications:
Would you provide a list of presentations and publications Y/N
Have you spoken in any professional forums about your new practice? Y/N
Number ______

Transdisciplinary Practice Questions

1- There are probably many reasons why people enrolled at the Institute. Looking back, what were the motivations and incidents that led you to register at the Institute?

Probes: What about any important…..

a. Prior experiences
b. Prior training
c. How did you hear about the Institute?

2- When you came to the Institute as biomedically trained professional, you had to learn a body of psychological knowledge. In remembering your first months at the Institute, what struck you early classroom and reading learning experiences?

Probes

a. What were your initial experiences of supervision?
b. Describe your initial attempts at integrated care.
c. What was it like learning psychological principles?
c. What was a surprise?
d. What was a difficult?
e. What was familiar?

3- As someone trained in a physical discipline, how did your experience of working psychologically develop over time?

Probes

a. What were your early experiences of transference and countertransference?
b. How did your experience of parents' emotional needs develop?
c. How did your sense of child development change? Give examples.

4- I am interested in examples of how you began to include infant mental health practices in your work. Can you describe some incidents of how you began to work with relationships in the context of your physical practice?

Probes

a. What were the signal positive cases?
b. How did you manage any difficulties?
c. What was your experience with supervision as your IMN practice developed?
d. How does IMH it affect your practice?

5- Supervision sessions provide insight into practice. What can you say about how your experience of supervision over time?

Probes

a. How did supervision initially affect your practice? Can you give me an example?
b. What were the initial effects on your sense of yourself as a professional?
c. What kinds of learning relations did you have with the supervisor?
d. What kinds of notable enlightening, threatening or difficult experiences did you have with parents or children?

6- Since you were trained to work with the body, how has your training at the Institute altered the way you previously worked?

Probes

a. What is no longer or less of an obstacle? Could you tell me about a couple of cases?

b. What is your experience of the parents after graduating? For example, …
c. What, if anything, is harder now? Any interesting cases that are tough now?

7- Infant mental health principles mean engaging the families in ways that are more sophisticated than in your original training in professional school. Would you describe how you work with problems rooted in the parent that affect your ability to remediate the delay?

Probes
a. Such as the loss grief- cycle?
b. Disordered attachment?
c. Extreme family problems and the desire to call ACS

8- Now that you've been practicing with infant mental health for some time, please describe how your ways of discovering and managing physical-psychological interplay of developmental delays.

Probes
a. What are the tip-offs that let you know when physical care for the child is not sufficient and you need to consciously use IMH ports of entry?
b. What has happened when you could not come up with an immediate solution?
c. What is it like finding a psychological solution to a new, physical problem? Any notable cases?

9- How would you describe your professional relations with other health care providers from your original and other disciplines now that you have psychological training?

Probes
a. Would you describe some cooperative experiences?
b. Would you describe some uncooperative experience?

10- As we begin to sum up, how would you describe your training and practice as a transdisciplinary therapist to an interested colleague?

Probes
a. What in your professional practice justifies your original expectations of the training met or not met?
b. To what kind experiences would make you recommend the Institute to a colleague?
c. In what kind of cases has the training helped your career?
d. What kind of cases has the training been a detriment?

11- Thanks for being so informative and open. Before we end, are there any other thoughts and or special stories you would really want to tell others that somehow sum up the effect of the training on your practice or personal life?

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