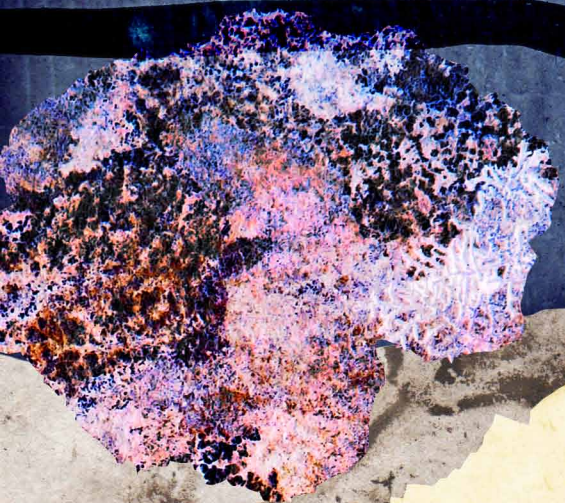
The Graduate School of Education
at The University of Melbourne present

UNESCO Observatory Multi-Disciplinary Journal in the Arts

SPECIAL ISSUE

A/r/tography and the Visual Arts



Volume 3 | Issue 1 | 2013

Guest Editors *Rita L. Irwin*
Anita Sinner

Editor *Lindy Joubert*
Associate Editor *Naomi Berman*
Designer *Rosie Ren*

UNESCO Observatory Multi-Disciplinary Journal in the Arts

Volume 3 | Issue 1 | 2013

ABOUT THE E–JOURNAL

The UNESCO Observatory refereed e-journal is based within the Graduate School of Education at The University of Melbourne, Australia. The journal promotes multi-disciplinary research in the Arts and Education and arose out of a recognised need for knowledge sharing in the field. The publication of diverse arts and cultural experiences within a multi-disciplinary context informs the development of future initiatives in this expanding field. There are many instances where the arts work successfully in collaboration with formerly non-traditional partners such as the sciences and health care, and this peer-reviewed journal aims to publish examples of excellence.

Valuable contributions from international researchers are providing evidence of the impact of the arts on individuals, groups and organisations across all sectors of society. The UNESCO Observatory refereed e-journal is a clearing house of research which can be used to support advocacy processes; to improve practice; influence policy making, and benefit the integration of the arts in formal and non-formal educational systems across communities, regions and countries.

ISSN 1835 - 2776

Published in Australia

Published by
The Graduate School of Education

The University of Melbourne, Parkville,
Victoria 3010.

Special Issue: A/r/tography and the Arts

Guest Editors
Rita L. Irwin | Anita Sinner

THEME

To be engaged in the practice of a/r/tography means to inquire in the world through an ongoing process of art making in any art form and writing not separate or illustrative of each other but interconnected and woven through each other to create relational and/or enhanced meanings. A/r/tographical work are often rendered through the methodological concepts of contiguity, living inquiry, openings, metaphor/metonymy, reverberations and excess, which are enacted and presented/performed when a relational aesthetic inquiry condition is envisioned as embodied understandings and exchanges between art and text, and between and among the broadly conceived identities of artist/researcher/teacher. A/r/tography is inherently about self as artist/researcher/teacher yet it is also social when groups or communities of a/r/tographers come together to engage in shared inquiries, act as critical friends, articulate an evolution of research questions, and present their collective evocative/provocative works to others (see http://m1.cust.educ.ubc.ca/Artography/).

This special issue of Multi-Disciplinary Research in the Arts invites original creative and scholarly inquiry that engages in critical debates and issues regarding a/r/tographical methodologies; are exemplars of critical approaches to a/r/tographical research; and/or extend the boundaries of inquiry-based research. Contributions are welcome from disciplines across the arts, humanities and social sciences and in a wide range of formats including articles, essays, and artistic interludes, which explore diverse forms of the arts from drama, dance, poetry, narrative, music, visual arts, digital media and more.

Engaging A/r/tography to Reveal Countertransference: Enhancing Self-Awareness in Caregiving Professionals

Susana Lauraine McCune MA, CT
Doctoral Student
Antioch University
Seattle

ABSTRACT

A/r/tography is an arts-based method of inquiry that uses artistic and aesthetic means to explore phenomena that influence professional practice. The author proposes that a/r/tography can be used to benefit practitioners in an array of professions by improving awareness of the ways in which their personal experiences inform professional practice. Particular attention is given to using a/r/tography to address the practitioner's feelings toward the care recipient, a dynamic known in psychotherapy as countertransference.

KEYWORDS

Keywords: a/r/tography, arts-based research, countertransference, psychotherapy, caring professions, hospice, death, grief

ACKNOW-LEDGEMENTS

The author wishes to express her appreciation for the meaningful clinical supervision provided by Dr. Mary Wieneke.

ENGAGING A/R/TOGRAPHY TO REVEAL COUNTERTRANSFERENCE

A/R/TOGRAPHY AND ART THERAPY: SIMILARITIES AND DIFFERENCES

A/r/tography has been embraced by artists, researchers, and educators in Canada. I have had the good fortune to visit the University of British Columbia and access their collection of dissertations that use arts-based research. I have found that a/r/tography is not as well known among other professionals, and is less widely understood in the United States. However living in the United States, my engagement with a/r/tography has found a receptive audience in my art therapy community. Perhaps this is because there are similarities in art therapy and a/r/tography. Both value the power of creative processes to explore, reveal, and make manifest previously unformulated (Stern, 2010) aspects of lived experience. Both art therapy and a/r/tography use creative processes to deepen meaning and evoke insight about the most intangible, yet essential and universal, human experiences. These experiences are, as Leavy (2009) observes, "often impossible to access through traditional research practices" (p. 4).

At the same time, I see differences between art therapy and a/r/tography. Although a detailed discussion of art therapy is beyond the scope of this article, a brief look at the foundations of art therapy may be helpful. Art therapy encompasses, and art therapists practice across, a spectrum of theoretical and clinical orientations (e.g. Kerr, Hoshino, Sutherland, Parashak, & McCarley; 2008; Malchiodi, 2003; Rubin, 2001). Across these theoretical and clinical approaches art therapists use creative processes in service of the patient's[1] therapeutic goals. Art therapists are trained to make behavioral observations, assess the patient's attitude and approach to creating the artwork, evaluate qualities of the artwork, and make therapeutic appraisals of the subject matter of patients' artwork.

Generally, in art therapy a patient makes art in response to an art therapy "directive." An art therapy directive is a therapeutic intervention the art therapist presents to focus the patient's art-making process on a specific clinical issue. Some art therapy directives are also used as art therapy assessments, are standardized, and have been researched (see for example Gilroy, Tipple, & Brown, 2012). Such directives are used

1. Using the word "patient," I draw on the work of Orange (2006). She points out the Latin origin of the word patient is patior: to suffer, or undergo. Thus, "A patient is one who suffers, who bears what feels unbearable" (p. 15). In relationship to the patient, who is bearing what feels unbearable, the clinician's compassion is thus "a suffering–with, a being together" (p. 15). The author concludes that compassion is "a way of being–with" and is "both process and attitude" (p. 15). Also see McCune (in press).

if they serve the patient's therapeutic goals. An example of a standardized assessment directive that is also widely used therapeutically is the Kinetic Family Drawing (Burns & Kaufman, 1970, 1972). The directive for the Kinetic Family Drawing is: "Draw a picture of everyone in your family, including you, DOING something. Try to draw whole people, not cartoons or stick people. Remember, make everyone DOING something—some kind of action" (Knoff & Prout, 1985, p. 4). Numerous methods have been developed to assess drawings made in response to this assessment/directive (e.g., Burns & Kaufman, 1972; Im, et al., 2010; Knoff & Prout, 1985; Wood, 1985).

At other times art therapists formulate unique art therapy directives to fit the patient's therapeutic needs and goals. An example of an art therapy directive I developed to meet a patient's unique therapeutic goal was a variation of a family drawing: "Draw your family before the divorce." This directive allowed the therapeutic process to meet the patient's therapeutic goals, which included reestablishing better relationships within their family system.

In art therapy, after the patient has created art, the art therapist facilitates the patient's review of their art making process and interpretation of their artwork. Time and space are created for interpretation to unfold in dialogue between therapist and patient.

One way in which a/r/tography and art therapy may be similar is that art therapists sometimes create "response art." In such a process the art therapist allows himself or herself to create art in response to a patient's presenting problem, therapeutic process, artwork, and therapeutic goals. This art making process can reveal to the therapist enriched understanding of the patient's therapeutic issues. This process can also reveal the therapist's countertransference—but creating response art is not necessarily undertaken with this intent.

Art therapy incorporates method, technique, intervention, and at times, standardization and assessment, which are different from the rhizomatically informed a/r/tographic engagement with creative processes for "re-searching the world to enhance understanding" (Irwin et al., 2006, p. 70). The focus of art therapy is the patient's therapeutic process. By contrast, my understanding is a/r/tographic exploration focuses on the practitioner (artist, researcher, teacher, [therapist]) and their lived experience, and uses artistic and aesthetic means to explore phenomena that influence their professional practice. So I propose professionals engage in a/r/tographic inquiry to reveal and address countertransference.

The literature reflects an emergence of using a/r/tography to address countertransference as demonstrated in dissertations by Sibbett, (2004, 2006), Amorous (2009), Deaver (2009), and Weinberg (2009), in addition to the earlier work of Robbins and Erismann (2002 [1992]). Arthur Robbins and Marc Erismann (2002 [1992]) documented their facilitation of a stone sculpting workshop to provide: "a penetrating glimpse of the countertransference conflicts that are inevitable in the therapist-patient relationship" (p. 141). The term a/r/tography appeared in the literature after Robbins's and Erismann's article was first published, yet Robbins and Erismann used creative process to explore therapist issues of countertransference and, if published now, their work may be considered a/r/tography. The article is also included, as Chapter 12, in the book by Author Robbins, entitled: *A Multi-Modal Approach to Creative Art Therapy* (2002). The authors point to the need to integrate creative processes in training programs for therapists:

> *Rarely does the traditional curriculum relate to the subject of therapeutic artistry. More specifically, there is very little attention focused upon the therapist's integration of the creative and therapeutic processes. For the most part, personal therapy is assumed to be sufficient to free the therapist [of countertransference] in his or her work as a psychotherapist. (p. 141)*

Recognizing that countertransference is ever present in the therapeutic encounter, I set out to bring into interplay the theoretical understanding of a/r/tography and psychotherapy, and specifically to reveal deeper understandings of my own countertransference.

COUNTERTRANSFERENCE[2]

2. *Portions of this section on countertransference are adapted from a forthcoming book chapter (McCune, in press).*

Sigmund Freud (1955[1905]) first identified the psychoanalytic concepts of *transference* and *countertransference* in the early 1900s. *Transference* refers to the phenomenon in which "patients transfer feelings toward persons who were important early in the patient's life" to the therapist (McCune, in press). The American Psychological Association Dictionary of Psychology defines *countertransference* as "the therapist's unconscious reactions to the patient and to the patient's transference" (2006, p. 239). Deeper psychoanalytic understandings of transference and countertransference have emerged since Freud first defined the terms. While an in-depth history of the evolution of psychoanalytic theory is beyond the scope of this article, for this discussion I point out a few noteworthy concepts that have emerged regarding the theory of countertransference since Freud's original identification of the phenomenon.

Heimann (1950) and Little (1951) put forward the understanding that countertransference could be useful therapeutically when seen as the analyst's conscious and unconscious response to the analytic situation. More recently, Schaverien (1999) identified "unanalyzed elements of the analyst's unconscious" as components of countertransference. In this article, Stein's (1985) perspective is used as a basis for my comments. Transference and countertransference, he suggested, can be identified dynamically as the same phenomenon:

> *They both refer to how human beings use one another for unconscious purposes. They differ with respect to who is doing so, not what is being done. Transference in the clinical relationship denotes the patient's displacement and exteriorizing of internal issues onto the clinician; countertransference denotes the reverse. (p. 3)*

Silver (1999) observed that while transference and countertransference exist in all human relationships, transference and countertransference are "most notable and potentially problematic in those relationships involving an imbalance of power" (p. 265) that is "inherent in the power relationship of caring professions …" (p. 267). According to Silver, countertransference arises due to the one-sided duty to care that is inherent in caring professions. Such a one-sided obligation to care can invite misplaced emotional responses and countertransference. These emotional responses must be studied and explored by the practitioner in order to understand countertransference both "doctrinally and personally" (Silver, 1999, p. 272).

While some might disagree with applying the theory of countertransference outside of psychotherapy, several scholars have written about issues of countertransference in

an array of professions, including countertransference in the classroom (Cavanaugh, 2004); qualitative research (Gemignani, 2011); social work (Berzoff and Kita, 2010); mediation (Duffy, 2010); political asylum processing (Meffert, Musalo, McNiel, & Binder, 2010); between correctional officers and prisoners, and forensic clinicians and forensic patients (Zwirn and Owens, 2011); nurse-patient relationships (O'Kelley, 1998); doctor-patient relationships (Stein, 1985); and lawyer-client relationships (Silver, 1999).

Caring professionals must understand basic psychological concepts in order to support their personal and professional development and to improve quality of care. Silver (1999) observed that identifying and understanding countertransference is essential to "both avoid impairment of the therapy, as well as to use countertransference affirmatively in furthering the therapy's progress" (p. 271-272). Only when countertransference is identified and understood can it be used positively to provide the best professional care. Yet in the caring professions, research has revealed a high incidence of unrecognized feelings toward the recipient of care (e.g. Smith, 1984). Neimeyer (2006) observed many caring professionals remain "unaware of the definitional nuances and subtle forms of 'countertransference'" (p. xix). Countertransference is ineffable and even though training programs for caregiving professionals may identify countertransference, they typically do not offer sufficient training in recognizing and working with countertransference as part of their personal and professional development programs.

Identifying transference and countertransference requires attention. Working within a psychoanalytic framework, Parsons identified a particular kind of attending—specialized listening—in order to become conscious of countertransference:

> *It is with regard to countertransference that one most immediately thinks of analysts needing to listen inwardly to themselves. In the classical view of countertransference, aspects of an analyst's psychic make-up are affected by the encounter with a patient in ways that unconsciously obstruct the analyst's understanding. To stop the analysis being impeded, the analyst needs to become conscious of this. (2007, p. 1442)*

I propose that professionals in many disciplines, including teachers, doctors, nurses, attorneys, counselors, and researchers, are engaged in specialized listening––attending to the personal and professional within––as they are simultaneously listening to their students, patients, clients, counselees, and research participants.

THE SELF, THE OTHER, AND COUNTERTRANSFERENCE

Countertransference arises in relationship between a "self" and an "other." Leggo has noted, "there can be no understanding of self-in-relation without attending to the study of the self" (2008, p. 4). Identifying and addressing countertransference requires self-reflection and self-study. A/r/tography is concerned with self-study (Irwin and Springgay, 2008).

In addition to attending to the self and the other, as Leggo observed, one must also attend to the personal and the professional. The personal and the professional are inseparable:

> *There is no need to separate the personal from the professional any more than we can separate the dancer from the dance. The personal and the professional always work together, in tandem, in union, in the way two complimentary angles compose the right angle. (2008, p. 5)*

By employing a wide range of artistic and aesthetic processes, a/r/tography can facilitate professional and personal understanding—facilitating psychological change by allowing unformulated experience, such as unrecognized countertransference, to emerge into conscious awareness and be made manifest through creative expression.

Countertransference can be elusive. Since existing education and supervision regarding countertransference among caregiving professionals (i.e. physicians, nurses, and psychotherapists) is often insufficient (e.g. Neimeyer, 2006; Smith, 1984), I engaged in a/r/tography to better understand how countertransference can influence professional practice.

As a doctoral student in clinical psychology I have provided psychological care at hospice during end-of-life care, at death, and through bereavement. As a researcher, I have investigated issues related to end-of-life choices, end-of-life care, and grief. In these roles I have experienced intense emotional responses to both my clinical patients and research participants. Furthermore, I have come to realize that "my personal experiences inform––perhaps helping, and hindering––my clinical practice" (McCune, 2012).

I engaged in a/r/tographical inquiry with the primary objective of using creative processes to improve professional practice by revealing deeper understanding of countertransference—particularly around end of life, death, and bereavement. I aimed to generate creative works that would present new understandings of countertransference to the larger community of caregiving professionals. I intended that a primary artistic work resulting from my a/r/tographic engagement would take the form of a published work (such as this article) to reveal the value of caregiving professionals using a/r/tography to better understand their countertransference. In what follows, I present a case study, an exemplar of my countertransference in a clinical encounter. Telling this story here is the primary synthesis of my a/r/tographic exploration thus far, a process of inquiry that I continue to engage.

A MOTHER'S PAIN

I was busy with paperwork in the hospice office when my phone rang. The receptionist said a person was in the reception area that wanted help with grief. I said I would be right there, and walked to the reception area. I introduced myself to a woman whom I will call Andrea. She appeared to be about 40 years old. We walked to a counseling room. As we sat face to face, Andrea said:

> *"My son died a few months ago. I am visiting here from out of town. My parents live in the area. I came here because my parents thought you might be able to help me help my other son with his brother's death."*

In hindsight, I recognize that the anxious tension typically underlying first meetings was missing. Andrea went straight to the heart and soul of what motivated her to come into hospice.

The immediacy with which Andrea told me about the death of her son, whom I will call Ryan, and her desire to help her surviving son, whom I will call Daniel, prompted me to think about my training in grief counseling. My clinical experience has demonstrated and research has shown that people who have survived the death of a loved one are often foreclosed in talking about their experience (DeSpelder and Strickland, 2005; Neimeyer, 2000; Becvar, 2003). So, when offered an opportunity to share their experience in a safe, non-judgmental environment, they welcome the chance. At this point in our session, I felt oriented to my theoretical training and very much in control as the therapist.

I asked Andrea, "How did Ryan die?"

"He had brain cancer." Andrea said.

I asked, "How long has it been since he died?"

"About six months," she said.

The literature informs us that the death of a child is one of the most difficult deaths to grieve (e.g., Stroebe, Hansson, Stroebe, Schut, 2004, p. 14; Rubin and Malkinson, 2004, p. 221), although of course surviving the death of a loved one is never easy. Feeling secure in my theoretical training, I then asked,

"How old was Ryan when he died?"

"Eighteen months."

I felt as if a moderate-sized earthquake shook me in my chair. Unyielding to the force, I continued.

"How old is Daniel?" I asked.

Andrea answered, "Almost five."

I felt dizzy and weak; I fought the urge to hyperventilate. I felt as if I was melting. Andrea's and Daniel's experiences were also the story of my life. When I was almost five years old, my younger brother died in my arms. But I could not think about that. I could not allow myself to be overwhelmed by my personal history in this moment. I recognized that as a professional, my focus needed to stay with Andrea, and so I brought my attention back to her.

At the same time, conviction and determination burst forward like a fire from somewhere within me. My body and mind burned with what I knew I knew–– memories of my brother's death were mixed with training in psychology and grief counseling. But I quickly reminded myself that Andrea was sitting across from me, and I determined that I should say nothing about what I was experiencing.

I remember the rest of our time together from several points of view: looking up through the eyes of a small person, the five-year-old within; looking down on us in the room, as if I were outside of myself hovering up high in a corner of the room; observing from behind the face of my fifty-year-old self sitting in the therapist's chair; and seeing through my mother's eyes––watching, listening, hoping I would not do harm, and hoping I might help Andrea and Daniel. Holding on to my training and my yearning to help, I kept going.

"What are your concerns about Daniel?" I asked.

She explained, "He is doing what they say is common. He doesn't want to go to bed. He is afraid to go to sleep. And he is wetting his bed. They tell me that is common, but he was through that stage, and now he has regressed back into bedwetting."

Andrea had clearly done her homework. She understood the theoretical and developmental aspects of Daniel's grief response commonly seen in young people. But now I was not functioning in theory. I repressed an urge to tell Andrea that I had been a child of five when my brother died. I feared that if I allowed myself to focus on or speak about my experience, I might be overcome with the emotions I felt when my brother died. I could not let myself be five years old. I needed to keep my clinical persona functional even though, in real time inside, I was falling apart. But falling apart was not an option.

I remember gathering my determination. Grasping for the support of conversation, I feebly affirmed,

"What you are telling me makes sense." Then I asked, "Was Daniel involved in Ryan's death?"

"Yes. He was there when Ryan died. I made certain he was as involved as possible. He was there at Ryan's death, and at the funeral. Was I wrong? Did I do the wrong thing by exposing Daniel to these things? Is that why Daniel is regressing now? Because I didn't do it right?"

As my 50-year-old therapist-self, what should I say? As my five-year-old self, what could I say? To my mother, what would I say? From up high in the corner of the room, looking down on these two people, what might I say?

I remember that sorting through these perspectives felt as if I were sorting through a deck of cards, looking for the card that held *the right* answer as I was dissolving into nothingness. And the wish to deliver the most help I could to Andrea and Daniel continued to be strong within me.

While sitting with Andrea, I remembered my mother fighting other family members to make sure I was present when selecting my brother's casket, at the funeral, and at his burial. I realize through recollecting my story here that because my mother included me, as a clinician I hold on to the opinion that in most cases, including children is the best way through the death of a loved one. Perhaps, from some theoretical perspectives, in that moment with Andrea I should have been able to separate my personal experience from my professional experience. But I could not.

At the same time that my memories competed for my awareness, I realized my focus was far away from Andrea. Again reaching for an anchor of stability in approaching Andrea and Daniel—and from personal conviction—in response to Andrea's question about including Daniel in Ryan's death and funeral I said,

"What you have accomplished is amazing."

With a sense of relief she responded:

"I tried very hard to do this the best way. Do you think I did?"

"Yes." We paused to integrate what had been said.

Then I asked,

"Shall we talk about helping Daniel?"

"Yes," Andrea said.

Through my reflective process, I have realized that at this point in our session I had gathered the information I needed from Andrea, the information a psychologist would label "the presenting problem." Next, I prepared to help Andrea so she could in turn support and guide Daniel. In order to do so, I drew on two disparate histories within me. From my professional adult self, I acted from my psychology and grief training. At the same time, I responded from my terrified five-year-old self who had lived through an event similar to Daniel's experience, having also been present for my younger brother's death. Both perspectives informed what I said next: "Daniel may be afraid to go to bed because he might be afraid he will go to sleep and never wake up, that he will die."

"Oh, I see," Andrea said with relief and realization. This explanation seemed to make sense to her. "I see how that could be the case. What should I do?"

"Perhaps you can gently speak in language he understands and let him know that yes, Ryan died, but it is unusual for a child in a family to die. Help him to see that most people go to sleep at night and wake up the next morning. This is especially important for Daniel to understand regarding himself, you, and his father. You may need to have these conversations several times, over time, as Daniel grows through each developmental stage. There are also age-appropriate books you can read together that help young people acknowledge and process the death of a loved one."

"I see. I can do that,"

Andrea said with a new sense of sureness. She appeared relieved to have an explanation for Daniel's fears and suggestions about ways she could help him. She thanked me. Our time together felt complete. With both of us holding back tears barely perceptible beneath the surface, we hugged and said goodbye.

As I walked back to my desk, I realized I was shaking. I was in more of an altered state than I had previously realized. I felt as if I was disintegrating. In retrospect, I would say I was in shock.

But why? I had not just come through a trauma. I had not been in war or disaster. I had talked with a mother seeking help for her son who had witnessed the death of his brother. I think that talking with Andrea had catapulted me back to my brother's death. I was flooded with a jumble of feelings about Andrea, Daniel, and my mother. In addition to being overwhelmed with my feelings about their experiences, I was also flooded with my own feelings about, and re-experience of, my brother's death.

Within the week, I discussed the case with my clinical supervisor. But over the next few weeks I continued to wonder about Andrea and Daniel. I replayed our encounter over and over in my mind, second-guessing everything I had said. Was I guilty, although unintentionally, of hurting Andrea? How would Daniel grow older in the shadow of his brother's death? Given the residual beliefs, opinions, and feelings that I have come to hold from my brother's death, had my therapeutic responses unknowingly hindered Daniel's future developmental trajectory?

Despite years of personal psychotherapy that addressed my brother's death, and my professional diligence in bringing this case to my clinical supervisor, I was lacking insight into how my professional duty with Andrea had impacted me personally. I continued to suffer from on-going self-criticism, self-doubt, and depression. I had been catapulted into re-processing events I thought were behind me. I was a wreck, and I did not understand why. I insufficiently understood my countertransference. So I have engaged in a/r/tography to understand.

REVEALING COUNTERTRANSFERENCE WITH A/R/TOGRAPHY

In this a/r/tographic inquiry I reviewed case notes and process notes I had written about my clinical work with Andrea. I gathered relevant personal artifacts, ordered my brother's death certificate, and collected obituaries and newspaper articles about his death. I documented the factual similarities between Andrea's case and my personal experience including ages of each person, causes of death, and who was present at the deaths. In so doing, I realized:

At the time of Ryan's death Andrea was forty years old.

At the time of my brother's death my Mother was 39 years old.

At the time of Ryan's death Daniel was between four and five years old.

At the time of my brother's death I was almost five years old.

Daniel and I both witnessed our brothers' deaths.

Seeing these age similarities stunned me then, and they stun me still...

The visual modalities of my a/r/tographic inquiry included creating a photographic timeline of my life, with particular emphasis on my family during the period from my birth until a year after my brother died. I also created kinesthetic collages, wherein elements were not secured in a stationary place but simply arranged in relationship to each other. Kinesthetic collages enabled me, and continue to enable me, to shift elements of the collages in relationship to each other: to move, add, and subtract components as my questions and revelations change. These visual creations incorporated official documents such as birth and death certificates along with photographs of gravesites, and photographs of family members who are deceased and who are still living. Photographs of these artworks are not included here for reasons of confidentiality.

I also engaged in free writing and writing poetry. Free writing and writing poetry allowed implicit understanding to come forward into my consciousness.

When writing poetry and in free writing, the writer is encouraged to suspend the lexicon, grammar, and rules of language required in writing prose and formal writing, such as is required in writing case notes and process notes. Writing in these ways opened vistas in my memory beyond what I could access through case notes and process notes. These approaches to writing enabled what had remained unformulated to emerge into awareness. Free writing allowed me to give language to my process during the session with Andrea and allowed me to discover and articulate the impact of the clinical encounter that had remained with me—although beyond awareness—during the months that followed. Free writing made this article possible.

Approaching writing freely also allowed me to give expression to previously concealed grief that lived deep within about my brother's death:

> *Death brought about an ungraspable emptiness or nothingess—which I term the missingness—that stayed with the living left behind, in a world where the missing Other's Being ceased to be....I had just watched my brother die, yet I could not grasp his absence, nor could I grasp the nothingness left behind when he, the Other, ceased to be while I continued to be... (also see McCune, 2012).*

REVELATIONS

Through the combination of phenomenological, hermeneutic, and artistic exploration comprising a/r/tography, I experienced the ability to halt my self-criticism and freely allow strong emotional reactions––positive and negative, unconscious and semi-conscious––to reveal themselves. While my creative processes enabled deeper understanding and new interpretations of my professional relationship with Andrea, the most stunning discoveries were about my connections with my mother.

Through Andrea, I had begun to see my mother anew, both as we were at the time my brother––her son––died and over the next 42 years until her death. My new perspective came with newly realized grief that I had been holding for my mother from the time my bother died through the course of our lives together. This grief, which had been stimulated by my encounter with Andrea, had remained mostly unconscious until I engaged in self-reflection through a/r/tography. A/r/tography revealed that the meeting of my personal and professional experiences in my encounter with Andrea was a major underlying source of the depression that had developed following our session.

I WILL NEVER KNOW

A/r/tographic engagement with my personal and professional experiences brought forward questions of countertransference that arose from my work with Andrea. What is the origin of my opinion that in most cases children "should" be included in the death experiences and burial rituals of loved ones? Is this opinion mine or my mother's? Is this opinion present because of my professional training or a result of my personal experience, or both? Because of this opinion, might I be helping others, or unintentionally harming others?

I will never know if I helped or harmed Andrea and Daniel. Andrea seemed relieved. She may have been relieved, in part, because I did not issue a diagnosis for Daniel's

"sleep disorders" and "Enuresis," or bedwetting (American Psychiatric Association, 2000). Such a diagnosis could have pathologized Daniel's behavior and burdened Andrea with self-blame for bad mothering. Perhaps my not issuing a diagnosis released her from the stigma that can accompany a diagnosis, released her from fear that she had acted badly as a mother, and relieved her from worry that Daniel's behavior was inappropriate. Instead, I sought to bring my psychological training and developmental knowledge along with my personal experience to her, and in doing so, hopefully normalized her experience and Daniel's behavior. I also perceived relief, as she felt free to read books together with Daniel and talk openly with him about people dying and living. Andrea was now aware of specific strategies that could support Daniel in his grief, strategies that are part of a larger range of age-appropriate activities in which she could engage with Daniel at his current age, and throughout his life. I sensed a freedom she felt in receiving "permission" to continue to talk about life and death with Daniel as he grows through each developmental phase throughout his future life. But I will never know.

DEEPENING UNDERSTANDINGS

Using a/r/tography to reflect on my work with Andrea has helped me live with the paradox and uncertainty that was engendered in our meeting. Without the aesthetic inquiry of a/r/tography, I could not have allowed myself to confront and understand the ways in which my personal feelings informed my professional practice with Andrea. Furthermore, only through writing this article, which I consider a major part of my ongoing a/r/tographic process, did I realize I could not separate myself from my mother's perspective and indescribable grief when I was five years old, nor throughout our lives until she died when I was 46 years old. Through this a/r/tographic study I have realized, in psychological language, that perhaps as a result of my brother's death, I was not able to individuate from my mother and her grief.

Through a/r/tographic inquiry was I able to push back my self-criticism, which was paralyzing, enough to allow my feelings about failing my mother to emerge. In doing so I have realized I failed my mother because while cognitively I knew my brother's death devastated our family, until sitting with Andrea and reengaging with old photographs of my mother, I hadn't been able to see so explicitly the impact of my brother's death on my mother. I felt, and still feel, guilty for not being able to have better supported her. I wish I could go back in time and be a better daughter for her—a better daughter at five years old, if I could––but certainly a better daughter later in my life before she died. I also wish I could thank her for all she did well, especially for making sure I was able to participate in funeral and burial rituals for my brother. I would also like to thank her for talking with me about my brother's death at the time it happened and continuing to do so throughout our lives together. All she did well continues to inform my professional practice.

This encounter with Andrea did not feel random. An element of synchronicity seemed to be at work. I make meaning of our work together through the hope that experiencing the trauma of my brother's death, and receiving the gifts my mother gave me in the wake of his death, may have allowed me to help others with uncannily similar circumstances, thus providing a reason for and giving meaning to events that have otherwise seemed incomprehensible and random. I hope that through my life experience—living beyond my brother—I was able to offer the gifts I received

to others—gifts that include an invitation to engage with each other after the death of a family member at the time of the death, and throughout the rest of their lives together.

Throughout this a/r/tographic inquiry I endeavored to expand the boundaries of my awareness and expression. I endeavored to find new meanings in recent echoes of personal catastrophe that happened long ago, revealing just a few understandings about why it is critical to help caregiving professionals realize how unconscious processes can affect professional capacity. I credit the rhizomatic relations and aesthetic forms of a/r/tography for the ability to suspend self-criticism and freely undertake self-study through a variety of creative modalities, in order to better understand the unresolved feelings that connect professional and personal experiences in countertransference. My a/r/tographic journey inspired this poem, which anchors my deepening understanding of my identities as self/other, daughter/sister, creator/created, researcher/researched, teacher/learner, and clinician/patient within—all of which inform my work as a therapist:

Entreaty to Self as Therapist

May I always-
Hold all creation in reverential esteem.
Retain awe for the hidden grand design.
Consider potential of variables.
Possess sufficient magical thinking to withstand turbulent storms.
Bear in mind each are more than dilemmas presented.
Respect pain.
Revere agony.
Honor my tears and
Hold in highest regard darkness and light in tears of the Other.
Trust and validate.
Midwife transcendence.
Birth strength.
Question. Always.
Seek, find, and deliver insight.
Select words as pearls.

REFERENCES

American Psychiatric Association. (2000). Eunuresis. In *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed., pp. 118-212). Washington, DC: Author.

Amorous, I. (2009). *A death educator explores personal issues of grief and loss in an arts-based intuitive inquiry.* (Master's thesis). Prescott College, Prescott, AZ. Available from ProQuest Dissertations and Theses database. (UMI No. 1473506), Prescott College, Prescott, AZ.

Becvar, D. S. (2003). *In the presence of grief.* New York: Guilford Press.

Berzoff, J., & Kita, E. (2010). Compassion fatigue and countertransference: Two different concepts. *Clinical Social Work Journal*, 38(3), 341-349.

Burns, R. C., & Kaufman, S. H. (1972). *Actions, styles, and symbols in Kinetic Family Drawings (K-F-D): An interpretive manual.* New York, NY: Brunner/Mazel.

Burns, R. C., & Kaufman, S. H. (1970). *Kinetic Family Drawing (K-F-D): An introduction to understanding children through kinetic drawings.* New York, NY: Brunner/Mazel.

Cavanaugh, S. L. (2004). Upsetting desires in the classroom: School sex scandals and the pedagogy of the femme fatale. *Psychoanalysis, Culture and Society*, 9(3), 315-332.

Countertransference. (2006). In G. R. VandenBos (Ed.), *APA Dictionary of Psychology* (p. 239). Washington, DC: American Psychological Association.

Deaver, S. P. (2009). Reflective visual journaling during art therapy and counseling internships. (Doctoral dissertation). Old Dominion, Norfolk, Virginia. Available from ProQuest Dissertations and Theses database. (UMI No. 3356758)

DeSpelder, L. A., & Strickland, A., L. (2005). *The Last Dance: Encountering death and dying.* New York: McGraw-Hill.

Duffy, J. (2010). Empathy, neutrality and emotional intelligence: A balancing act for the emotional Einstein. *University of Technology Law and Justice Journal*, 10(1), 44-61.

Freud, S. (1955). Fragment of an analysis of a case of hysteria. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 1-122). London: Hogarth Press. (Original work published 1905)

Gemignani, M. (2011). Between researcher and researched: An introduction to countertransference in qualitative inquiry. *Qualitative Inquiry*, 17(8), 701-708.

Gilroy, A., Tipple, R., & Brown, C. (Eds.). (2012). *Assessment in art therapy.* New York: Routledge.

Heimann, P. (1950). On countertransference. *International Journal of Psychoanalysis*, 31, 84-92.

Im, Y., Oh, S., Chung, M., Yu, J., Lee, H., Chang, J., & Park, D. (2010). A KFD web database system with an object-based image retrieval for family art therapy assessments. *The Arts in Psychotherapy*, 37(3), 163-171.

Irwin, R. L., Beer, R., Springgay, S., Grauer, K., Xiong, G., & Bickel, B. (2006). The rhizomatic relations of a/r/tography. *Studies in Art Education*, 70-88.

Irwin, R. L., & Sprinngay, S. (2008). A/r/tography as practice-based research. In S. Springgay, R. L. Irwin, C. Leggo, & P. Gouzouasis (Eds.), *Being with A/r/tography* (pp. xix-xxxiii). Rotterdam, The Netherlands: Sense Publishers.

Kerr, C., Hoshino, J., Sutherland, J., Parashak, S. T., & McCarley, L. L. (Eds.). (2008). *Family art therapy: Foundations and practice*. New York, NY: Routledge.

Knoff, H. M., & Prout, H. T. (1985*). Kinetic Drawing System for family and school: A handbook*. Los Angeles, CA: Western Psychological Services.

Leavy, P. (2009). Social research and the creative arts: An introduction. In P. Leavy (Ed.), *Method meets art: Arts-based research practice* (pp. 1-24). New York, NY: Guilford Press.

Leggo, C. (2008). Autobiography: Researching our lives and living our research. In S. Springgay, R. L. Irwin, C. Leggo, & P. Gouzouasis (Eds.), *Being with a/r/tography* (pp. 3-23). Sense Publishers: Rotterdam, The Netherlands.

Little, M. (1951). Countertransference and the patient's response to it. *International Journal of Psychoanalysis*, 32, 32-40.

Malchiodi, C. A. (Ed.). (2003). *Handbook of art therapy*. New York: Guilford Press.

McCune, S. L. (2012). Living beyond the Other. *Pastoral Psychology*. Retrieved from http://link.springer.com/article/10.1007%2Fs11089-012-0466-8?LI=true#page-1 doi:10.1007/s11089-012-0466-8

McCune, S. L. (in press). Worlds of Connection: Applying an Interdisciplinary Relational Model of Care© to Advance Care Planning. In L. Rogne & S. L. McCune (Eds.), *Advance Care Planning: Communicating About Matters of Life and Death*. New York: Springer.

Meffert, S. M., Musalo, K., McNiel, D. E., & Binder, R. (2010). The role of mental health professionals in political asylum processing. *Journal of the American Academy of Psychiatry and the Law Outline*, 38(4), 479-489.

Neimeyer, R. A. (2006). Series Editor's Foreword. In R. S. Katz & T. A. Johnson (Eds.), *When professionals weep* (pp. xix-xx). New York, NY: Routledge.

Neimeyer, R. A. (Ed.). (2000). *Meaning reconstruction and the experience of loss.* Washington, DC: American Psychological Association.

O'Kelly, G. (1998). Countertransference in the nurse-patient relationship: A review of the literature. *Journal of Advanced Nursing*, 28(2), 391-397.

Orange, D. M. (2006). For whom the bell tolls: Context, complexity and compassion in psychoanalysis. *International Journal of Psychoanalytic Self Psychology*, 1(1), 5-21.

Parsons, M. (2007). Raiding the inarticulate: The internal analytic setting and listening beyond countertransference. *International Journal of Psychoanalysis*, 88(6), 1441-1456.

Robbins, A., & Erismann, M. (1992). Developing therapeutic artistry: A joint countertransference supervisory seminar/stone sculpting workshop. *The Arts in Psychotherapy*, 19, 367-377. (Orig. pub. 1992).

Robbins, A., & Erismann, M. (2002). Developing therapeutic artistry: A joint countertransference supervisory seminar/stone sculpting workshop. In A. Robbins (Ed.), *A multi-modal approach to create art therapy* (pp. 141-139). Philadelphia: Jessica Kingsley Publishers. (Original work published 1992).

Rubin, J. A. (Ed.). (2001). *Approaches to art therapy* (2 ed.). New York, NY: Brunner-Routledge.

Rubin, S. S., & Malkinson, R. (2004). Parental response to child loss across the life cycle: Clinical and research perspectives. In M. S. Stroebe, R. O. Hansson, W. Stroebe & H. Schut (Eds.), *Handbook of bereavement research* (pp. 219–240). Washington, DC: American Psychological Association.

Schaverien, J. (1999). Art within analysis: Scapegoat, transference and transformation. *Journal of Analytical Psychology*, 44(4), 479-510.

Sibbett, C. (2006). *Liminality, cancer and art therapy: An autoethnographic exploration––Living with the tiger.* (Doctoral dissertation C829089), Queen's University Belfast (United Kingdom), Northern Ireland.

Sibbett, C. (2004). *Liminality: Living and practicing at the threshold*. Paper presented at the 3rd Global Conference Making Sense of: Health, Illness and Disease, St. Catherine's College, Oxford.

Silver, M. (1999). Love, hate and other emotional interference in the lawyer/client relationship. *Clinical Law Review*, 6, 259-260.

Smith, R. C. (1984). Teaching interviewing skills to medical students: the issue of 'countertransference'. *Academic Medicine*, 59(7), 582-588.

Stein, H. F. (1985). *The psycho-dynamics of medical practice: Unconscious factors in patient care*. Berkeley, CA: University of California Press.

Stern, D. B. (2010). *Partners in thought: Working with unformulated experience, dissociation, and enactment*. New York: Routledge.

Stroebe, M. S., Hansson, R. O., Stroebe, W., & Schut, H. (2004). Introduction: Concepts and issues in contemporary research on bereavement. In M. S. Stroebe, R. O. Hansson, W. Stroebe & H. Schut (Eds.), *Handbook of bereavement research* (pp. 3–21). Washington, DC: American Psychological Association.

Weinberg, B. (2009). *Visual and verbal narratives of women who identify themselves as lifelong learners.* (Doctor of Education). University of Toronto, Toronto, Canada. Available from ProQuest Dissertations and Theses database. (UMI No. 60886)

Wood, B. (1985). Proximity and hierarchy: Orthogonal dimensions of family interconnectedness. *Family Process*, 24(4), 487-507.

Zwirn, I., & Owens, H. (2011). Commentary: Boundary violations in the correctional versus therapeutic setting: Are the standards the same? *Journal of the American Academy of Psychiatry and the Law*, 39, 164-165.