

The Interface Between Motherhood and Art Therapist

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Abstract

The Interface Between Motherhood and Art Therapist

Nathalie-Monika Moore, M.A.

I am a mother and an art therapist. This heuristic self-inquiry explored my experience of countertransference issues in a therapeutic alliance with children in a psychiatric ward. Practicum setting and its population initiated a series of questioning concerning the interface between my roles of mother and art therapist that eventually lead to this research paper. My data was collected in the forms of journals, case notes, drawings, dreams, supervision, and self-dialogues. And the essence of meaning was extracted from emerging themes. My findings emphasized the importance of the therapist attending to and working through countertransference issues when personal life changing events affected the therapeutic relationship. I discovered the ways in which the key circumstances in my life as an art therapist and as a mother impacted the therapeutic alliance, more so because my lived experience was related to the population in treatment. Carrying my second child during this study provoked the resurgence of unresolved feelings surrounding my previous pregnancies. I have embodied Moustakas's (1990) six phases metaphorically and literally. The birth of my child and the labour from this study brought forth some unconscious notions into consciousness for the benefit of self-discovery.

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This amazing adventure would not have been possible without the love and support of my husband Benoit Fillion. When I shared with him my dreams of becoming an art therapist, he responded with the following image: Me walking toward the stage to receive my diploma while he sat in the audience with our (yet unborn) children beaming with pride. He helped me believe.

This paper is dedicated to our children Elle-Marie and Benjamin whose birth and life are the greatest gift of all.

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Table of Contents

List of Tables	vii
List of Figures	viii
Introduction.....	1
Methodology	2
Research Questions	2
Assumptions and Biases.....	3
Delimitations and Limitations.....	4
Operational Definitions.....	4
Chapter's Overview	5
Literature Review.....	6
Motherhood and Therapist.....	6
Countertransference Issues.....	14
Theories.....	19
Bowlby's Attachment Theory	20
Winnicott's Good-Enough-Mother	21
Art Therapy	23
Methodology	25
Qualitative Heuristic Research.....	25
The Framework of the Research	26
Participant and Informant.....	27
Relevance to Question.....	28
Moustakas's Processes and Concepts	30
Moustakas' Phases.....	32
Validity and Reliability.....	33
Data Collection and Organising.....	36
Gathering Data	36
Organizing Data	39
Living by Heuristic's 6 Phases.....	43
Processing Inquiry and Pregnancy through 6 Phases.....	43
Processing Data through the 6 Phases.....	49
Parallels within Heuristic	49
Findings.....	52
Emerging Themes	52
Creating the Creative Synthesis	64
Informant.....	67

Conclusion	71
Statement of Findings	71
Theoretical Liaison.....	72
Value to My Career.....	73
Outcome of Assumptions, Limitations, Delimitations.....	74
Recommendations.....	74
Bibliography	76
Appendix A.....	89
Appendix B.....	90
Appendix C.....	91
Appendix D.....	92
Appendix E.....	93

List of Tables

<i>Table 1.</i> The heuristic process applied to the phenomenons.	51
<i>Table 2.</i> The transformation of themes.	52

List of Figures

<i>Figure 1. Pie for dreams.</i>	41
<i>Figure 2. Venting</i>	42
<i>Figure 3. The tree.</i>	45
<i>Figure 4. Stuck #1</i>	56
<i>Figure 5. Stuck #2</i>	57
<i>Figure 6. Stuck #3</i>	57
<i>Figure 7. The hole</i>	58
<i>Figure 8. Mandala</i>	59
<i>Figure 9. Charcoal 8.</i>	60
<i>Figure 10. Charcoal 14.</i>	60
<i>Figure 11. Stars</i>	61
<i>Figure 12. Childhood flower in mandala</i>	62
<i>Figure 13. Woman</i>	66
<i>Figure 14. Bubble gums.</i>	67

THE INTERFACE BETWEEN MOTHERHOOD AND ART THERAPIST

Introduction

In 2003, I became a mother and a few months later I became a part time student in art therapy. Both events were frightening, enlightening, and life dreams. It has been four years of evolving knowledge, devotion to clients and pure love for my family. During this period, I married, gave birth to two wonderful children and completed my masters in Creative Arts Therapies. This is who I am. And it is important to know where I come from and that life circumstances changed the outlook that I had as a therapist. I started to question my role as therapist and mother when first presented with young children in a psychiatric ward during my second year practicum. At the time, my daughter was 3-years-old. This disquieting experience initiated this research and impelled me into the world of children's mental illnesses and their family's upbringing. I found myself constantly scrutinizing and questioning my professional and personal life surroundings. I decided to investigate this platform as the base for my research project. I formulated my question, embraced my final year's practicum and juggled family, school and work. Happily, I became pregnant with my second child and my centre of attention changed once again. Although my pregnancy was not the initial focal point of this research paper it became impossible to ignore its ramifications in my life, home and work situations.

Instigating a practice site as art therapist is part of the academic curriculum. I sought a practicum with a population of children with mental illnesses in a psychiatric ward. The average age was 9 and boys outnumbered girls by 15 to 1. Children were discharged every weekend and returned on the premises for a stay of approximately one month. My previous practicum was with adults with a similar impairment. It is the

children more than mental illness that appealed to me in this practicum. I wanted to gain experience with children. I implemented individual and group art therapy sessions on the ward. The milieu was very receptive to the presence of art therapy and to sharing their knowledge. My opinions and observations were welcomed during staff meetings. I practiced art therapy with these children from September 2006 until April 2007.

Methodology

My question came up before my choice of methodology. The importance of the wording *my experience* propelled me into a heuristic inquiry proposed by Moustakas (1990). He defines it as a form of qualitative inquiry focused on the lived experience of the researcher's intent in exploring a subject to extract deep meaning essential to the phenomenon. Moustakas warns of the involvement of endless hours, total immersion and concentration on one primordial question in the hopes of achieving understanding while risking exposing one's Self and wounds through personal transformation.

Moustakas (1990) elaborated a series of concepts and processes implemented at the core of my research. They are: identifying with the focus of inquiry, self-dialogue, tacit knowing, intuition, indwelling, focusing and, internal frame of reference. To establish consistency and veracity to my quest I applied all 6 phases to guide this enquiry: initial engagement, immersion, incubation, illumination, explication and finally a creative synthesis.

Research Questions

The elaboration of my primary question was the embodiment of the first phase of Moustakas's (1990) *initial engagement*. *What is my experience of countertransferential*

issues in a therapeutic alliance with children as an art therapist and a mother? Happily pregnant with my second child a few weeks after starting practicum raised a subsidiary question: *What impact would the pregnancy have on my quest?*

Assumptions and Biases

I had assumptions regarding my research and my methodology. My investigative assumptions were that both facets of my life, art therapist and mother, influenced one another. Who I am affects the nature of responses elicited during therapy, especially with children. Because I strived at being a good mother to my children, I strived at being a *good-enough-mother* (Winnicott, 1971) to my clients. I also assumed that the interface between my roles would be a one-way system, meaning that the mother would be present in the therapist's office but not the therapist in the mother's living room. I assumed that the emotional roller-coaster of pregnancy would color my experience. Although difficult to admit, I think it is important that I mention the following; I strongly believed that giving birth *naturally* was the measure of a good mother!

The underlying assumptions of heuristic inquiry are that although it is only my experience reported, it could yield collective significance. And truth may be extracted from the understanding of emerging themes. I assumed that I could control the time span of the research and that redaction of this paper would start upon completion of the heuristic process.

My biases were that men do not experience the same struggle with fatherhood as women with motherhood, something embedded in cultural gender roles. I turned forty shortly after the birth of my second child and I believed that age prepares one better for motherhood.

Delimitations and Limitations

This project was delimited by the factor of brief therapy although some children were hospitalized for almost 3 months. The masculine gender and the average age of the children combined with the assessment-diagnosis mandate of the site, delimited the scope of this study. I believed this study to be limited to my interpretation of my experience within its particular context and that my state of pregnancy limited the extent of application to the general population. Nevertheless, parenthood and therapy are hats worn by a vast majority of clinicians and the valuable knowledge of our identity serves many, men and women, pregnant or not.

Operational Definitions

Countertransference: All the reactions the therapist has toward the patient (Gold, 1999).

Heuristic: A process of internal search through which one discovers the nature and meaning of experience and develops methods and procedures for further investigation and analysis (Moustakas, 1990, p. 9).

Therapeutic alliance: A mutual understanding and agreement between patient and therapist concerning the goals of the therapy; a shared commitment to the treatment tasks necessary to achieve these goals, and a sufficient bond of attachment between them to sustain their collaboration in resolving strains that inevitably arise during the course of psychotherapy. (Greenson as cited in Weiner, 1998, p.35)

Chapter's Overview

More and more therapists / authors devoted time and energy on the subject of their life experiences. It is now an acceptable concept to acknowledge that our personal life touches on our professional life, especially in the field of humanities (Gerson, 1996). The crossing point between both roles of mother and art therapist can be explored through countertransference issues compelling us to learn about feelings and encouraging Self growth, hence benefiting our clients.

In this research paper I have fully examined the roles I had as a mother and as an art therapist working with children within the therapeutic boundaries as well as within the frontier of my pregnancy. By inhabiting this dual role it led to the exploration of self-care and the different expressions of disclosure. A therapeutic alliance was propitious to the emergence of transference and countertransference issues, which required from the therapist a good sense of Self. The scope of this paper was limited to the exploration of my countertransference. Bowlby's (1969) theory of attachment and Winnicott's (1971) concept of the *good-enough-mother* provided the theoretical support of this research. The methodology used to complete this qualitative study was based on Moustakas' (1990) heuristic model and as such the different processes, concepts and phases were defined. The gathered data consisted of case notes, journals, artistic creations and dialogue. Data was organised and analysed. Findings through the emergence of themes served as basis for further discussion. To avoid distortion of the understanding of my experience, Moustakas suggested to the reader, not to "fail to seek to understand individual's behaviour and experiences through their perceptions and feelings and the meanings that they attach to their activities" (p. 26).

Literature Review

Motherhood and Therapist

A therapist is foremost a person composed of gender (Harvey and Hansen, 1999), age, status, values and origin. These parameters are the foundation for our reactions which are essential aspects of us as human beings (Gerson, 1996). Everyone is someone before becoming a therapist. The literature demonstrates the importance of knowing who we are and how we react. Gerson reiterates that an analyst's reaction to a patient is no longer viewed as pathology, rather: "Our reactions are essential and necessary aspects of who we are; reacting personally is all we can do. We have no choice but to be who we are, as therapist as well as in our roles" (p. xiv). Those reactions are referred to as countertransference, and a review of the literature is presented further. In the fifties, Fromm-Reichmann (1950) warned therapists to pay attention to their life's events - she coined the term *intercurrent event* (p. 231) - and to examine the repercussions onto their patients' treatment. She contends that illness, divorce, death or pregnancy impacted the therapist and by ricochet, their clients. Many authors / therapists (Barnett, 2005; Basecu, 1996; Chasen, 1996; Crastnopol, 1997; Edgar, 1990; Fenster, Phillips & Rapoport, 1986; Gerson, 1996; Guy, 1989; Green Kibel, 2001; Henderson, 2006; Hurdman, 1999; Korol, 1996; Lee, 1990; Levine, 2007; Maat & Vandersyde, 1995; Marovic, 2002; Schlachet, 1996; Ulman, 2001) started to scrutinize their reactions as well as their patients' reactions following such an *intercurrent event* in their lives. Later, Gerson devoted a book to the now acceptable concept that the therapist is also a person.

Women have entered the field of psychotherapy, a once predominantly male environment, and with them emerged the dual role of the mother and therapist (Scholfield

MacNab, 1995). Susan Scholfield MacNab is a mother and a psychotherapist and she summed up in one sentence the invariable connection between her two roles: "Listening to your patients, yelling at your kids: the interface between psychotherapy and motherhood" (p. 37). She revisits her childhood and questions her parenting style concluding that motherhood is composed of shame and guilt that are also present in her therapeutic role. Despite a mother's efforts to protect and nurture her children, success is not guaranteed. Scholfield MacNab describes the complexities of this interface especially when she realized that she was probably not going to become a *better mother* than those of her patients. Fenster, Phillips and Rapoport (1986) refer to this interface between good mother and good therapist as conflict. It is this unsettled conflict that paints the backdrop for the mother therapist' perpetual feelings of interior struggle between family and professional life. This emotional division might be eased by recognizing this dichotomy. Fenster et al. state that the new mother coming back to work as therapist, hence integrating for the first time her dual role will stop *playing* the role of mother with her children-clients now that she has her own child. They observe:

As the therapist builds up a continuing sense of her own capacity to shift roles successfully, the therapist-mother finds that she is comfortable bringing her increased emotional openness into the treatment process. She is better able to maintain an empathic stance, to tolerate chaos and frustration without feeling excessively frustrated herself. (p. 121)

Fenster et al. amend this statement in the cases of mothers that are back at work and breastfeeding; this exclusive bond is fulfilling but can also be tiring and the mother may

feel drained, more so when the needs of clients and babies are similar in nature. This idea of being on demand may contravene the therapist's sense of self.

Blos jr. (2003) in speaking of the phenomenon that emerges in pregnant woman when faced with the reality and the fantasy of their own upbringing and mother, suggests that only the internal unification of the good and the lacking mother allows free flow of energy. Green Kible (2001) explores this further by adding the healing component of spirituality in order to replenish the nurturing roles of mother and therapist. Chodorow (1978) describes in psychosocial terms where mothering materializes from, in the hopes of elucidating the connection between mothering and woman. But Fenster et al. (1986) insist that the dual role of childrearing and therapist is, in the end, an asset for the woman if the different reintegration stages are properly assimilated. The stages they refer to are: being able to separate from baby while re-establishing working alliance with clients, demonstrating emotional flexibility toward demands of baby's needs and clients' needs, and eventually a greater capacity to shift between roles. This new flexibility can provide a wider experimental frame and enrich the therapist-mother's sense of self. Child rearing allows the therapist/mother a greater understanding of clients' expression of their childhood: being so close to the experience with their own child, the therapist relates directly rather than counting on her own childhood memory. Winnicott (1963) also suggests that we, as parents, can apply what we have learned with our patients. Listening and empathy are primordial in a psychodynamic approach (Rubin, 2002; Weiner, 1998), they are also important for a mother and her children. Listening is not always easy; it takes availability, disposition, and intent (Fenster et al.). Motherhood usually starts with

pregnancy and pregnancy is a limited status, physically as well as psychologically, it is fabricated of boundaries.

Therapy commonly involves boundaries made of limits in order to create the appropriate frame for the establishment of a therapeutic alliance. Rubin (1998) refers to a “framework for freedom” (p. 140). The concept aims at instilling security and a supportive setting within the therapeutic session in order to establish a therapeutic alliance or a “working alliance” as Weiner (1998, p. 35) prefers to call it. Because Jordan (1995) believes that it fosters a sense of power or authority onto the therapist, she prefers to “state limits rather than set limits” (p. 267). With children, the setting of boundaries through limits is a necessary step since they require structure to evolve securely. In the case of a pregnant therapist, the boundaries transcend the metaphorical concept of walls within the walls of the uterus.

Jane Waldman (2003) is a new mother returning to work as a psychotherapist after a few months at home with her newborn. She asserts that more and more attention is given to the complexities of operating within two different yet similar roles. Waldman compares boundaries to a container: a therapist is in a metaphorical sense a container for the emotional growth of her patient. Containing another life in your womb challenges the boundaries of the therapy, especially when the pregnancy is obvious to the patient. Connection and attachment are not experienced the same way. Waldman describes how her own attunement to her baby’s needs transcended in heightened non-verbal communication upon her return to work with her patients. The boundaries of the pre-verbal communication could be impeded. The expansion or the shrinking of boundaries could help or hinder the therapeutic alliance. Basescu (1996) is also a mother and a

psychotherapist who is intrigued by the complexities in the overlapping of her dual roles.

Her article explores parenthood:

As both a particular example of a personal aspect of the therapist's life, which can become a useful stimulus in the clinical work for patient and therapist and as a unique set of life experiences that shed particular light on clinical issues and the clinical situation. (p. 104)

In a wider spectrum Kottler and Parr (2000) portrays the inseparable dimensions of professional and personal life as family therapist. Boundaries within one's role are evident, but not always apparent. Professional and personal lives impact each other mutually. It has been reported (Palusny and Poznanski, 1971) that a pregnant therapist feels scattered between two worlds; the woman with the baby in her womb, more so in the last trimester when the baby is felt kicking and the therapist with the child-patient.

Motherhood and the therapeutic profession being both caring roles, a woman can easily feel overwhelmed by the different demands of her entourage and put aside her own care (Fenster & al, 1986; Jordan, 1996; Maat & Vandersyde, 1995; Waldman, 2003). Many feelings can crop up from therapeutic work on the therapist depending on the nature of client's issues; anger, fear, guilt, revulsion and possibly hatred to name a few. West (1997) calls for precautions of the possible consequences of these overwhelming feelings on the therapist's life, or worse the lack of any feelings. Constantly nurturing a child in a symbiotic pattern, new mothers need to be re-claimed by their husbands, as Winnicott (1971) says, for the good of the child and of the family. As responsibilities and status change occur, women make little room for leisure time. Bialeschki and Michener (1994) press on women the value of Self care through leisure. West is a play therapist and

she warns mental health workers to care for themselves especially when working with abused children. She offers a variety of suggestions to help them keep equilibrium in their roles as parent, adults and professionals. Supervision, personal therapy, meditation, spiritual growth, play, love and time off are some of her suggestions. Journal writing is another mean of self-care; Baker (1990, 2003) recommends journaling to allow therapists a better level of functioning. She points out the advantages: personal release, professional benefits for the wealth of information that it holds and finally journaling may stand for a warning of emerging distress. In the latter example, the writer can return to previous pages and retrace the source of her stress. Baker (2003) cautions that journal writing does not replace therapy when needed. David Edwards (1993) emphasizes the importance of supervision in the program of student art therapist. Self-care is one of the antidotes to burnout as stressed by Grosch and Olsen (1994), who call attention to the well-known accepted concept of self-care for a better professional growth. Weiss (2004) emphasizes the stressful quality of the profession while offering guidance and tools for life's personal and professional management. Weiss states the following:

As a therapist, you need to create a safe and comfortable environment for those who come to you for help, and you are a big part of that environment. If you are distracted, are fatigued, or have trouble listening to or remembering what your clients tell you because of your own burnout, your clients suffer. If you seem disinterested, overwhelmed, or unhappy, they may not wish to confide in you and burden you further with their problems. (p. xiii)

LeNavenec and Bridges (2005), a nurse and a drama therapist, edited a compilation of connections between nursing care and creative arts therapies. Their

holistic account of care and self-care include many modalities, such as art, drama, music and dance. They report the result of a project consisting of caregivers participating in performance creation in order to prevent burnout by calling attention to self-care. *The Healer as Artist Project's* aim was to take a light-hearted approach toward self-care for caregivers. It revealed that health care professionals benefited from sharing and expressing their worries.

As seen earlier, a properly structured framework is required for the therapeutic alliance to be present. Disruption of the frame invariably affects the relationship, albeit to different degrees. The frame provides structure, safety and predictability for the client in order to examine the personal material. Ulman (2001) describes this retreat: "it allows the therapist the necessary freedom to explore and understand their internal reactions to patient's material" (p. 14). However, this privacy can be uncovered when unwitting exposure occurs, and a sense of vulnerability and loss of balance can derive from it. Ullman goes on describing the effect of countertransference when the therapist is off balance following a privacy breach, especially the pregnant therapist who develops a countertransference blind spot. Supervision is then a valuable place to examine, to understand and to reiterate that the therapist must return to the basis of the client's transference. Self-disclosure is a different phenomenon defined by Myers and Hayes (2006) as: "statements that the therapist makes that reveal something personal about the therapist" (p. 174). Statements can be visual; the office's décor, a picture frame, dress code, personal appearance or verbal declaration in the form of countertransference disclosures. Myers and Hayes studied the effects of disclosure by asking 224 undergrads to view one video where the therapist expressed either self-disclosure,

countertransference disclosure or none at all, within a positive or negative therapeutic alliance setting. The results showed that students rated the therapist as an expert when disclosure was performed in a positive alliance session compared to the negative alliance setting where the therapist was perceived as superficial.

Gold (1999) remarks that in some cases disclosure can bring about successes in the therapeutic process, especially if the issue was appropriate for the client's growth and the ensued discussion provided important material for the process. Hurdman (1999), an art therapist, confirms that her pregnancy allowed certain issues to arise in the artwork of her patients, even though they were unable to express them verbally at the time. She viewed her pregnancy, in some instance, as a diving board for attachment issues. Frost (2005) relays that time has changed and self-disclosure can serve therapy; it may humanize the therapist in the eyes of the patient or group, or it may answer a client's request. In the extreme case, self-disclosure may serve as mutual analysis between patient and therapist. Frost also speaks of the inadvertent self-disclosures such as facts or information picked up by patients in therapist's office, by their attire and so on. A study done by Guy in 1989 examined the events in a therapist's life and the impact on their clients. The results show that the ones in private practice admit their own life events may affect patient care. Surprisingly, older therapists are adamant that their own distress does not affect patient treatment. Considering that stress was the most common distress factor, Guy was perplexed with the results. If the therapist is unaware of unwitting exposure then he cannot properly observe the new countertransference issuing from his life events, and surely treatment results are affected. If therapists choose to disclose, Roberts (2005)

warns them to be cognizant of intent, within the framework and the theoretical models used.

Countertransferential Issues

Judith Gold (1999) affirms that all aspects of a patient's relationships are present in the therapist-patient rapport. She defines transference as the patient's feelings from past relationships transposed onto the therapist and countertransference as all the reactions the therapist has toward the patient, these reactions have conscious and unconscious characteristics. Gold uses a holistic definition of countertransference that evolved considerably from the Freudian's explanation of it as a lack of neutrality of the unconscious defence mechanism of the therapist and as an echo of the client's transference. According to Kernberg (1984) a therapist's character pathology will be present in some aspect of countertransference. Roth (1990) brings attention to countertransference occurring in a group setting, particularly when all members share a similar illness. The therapist may then experience countertransference to the illness, to a patient, or to the group. In consideration of the methodology used in this paper, as mentioned, I shall concentrate on my experience, therefore solely on my countertransferential issues and I shall use Gold's definition of the term.

Derenne (2006), a residential psychiatrist in an anorexia treatment centre was confronted by the aggressiveness of these young women and her overwhelming countertransference regarding her own body. She could relate to the difficulties encountered by her client's parents in setting and keeping boundaries, in turn making her question her future parental skills. Her comments undermine the parallel between the therapist's life experience and practice, they will intertwine and they will have to be

visited. With exploration, observation, sometimes indwelling, countertransference becomes a valuable tool for the therapist. Once countertransference is eliminated from the therapist's concern, she can understand the child's issues. This illustrates the value of this concept; the two-way communication between the unconscious and the conscious of the client and the therapist which can become a highway of opportunities for better perceptiveness. The goal of the therapist is to help the client better understand himself.

Bick (as cited in Haworth, 1964) has this to say about countertransference with children:

The intensity of the child's dependence, of his positive and negative transference, the primitive nature of his phantasies, tends to arouse the analyst's own unconscious anxieties. The violent and concrete projections of the child into the analyst may be difficult to contain. In addition, the child's suffering tends to evoke the analyst's parental feelings, which have to be controlled so that the proper analytic role can be maintained. All these problems tend to obscure the analyst's understanding and to increase in turns his anxiety and guilt about his work. (p. 237)

Children construct the therapist as omnipotent and as a magical parental figure in the hopes of fulfilling their own emotional needs. Rivalry between child clients happens just like between siblings and favouritism is sought upon (Soo, 1989). Soo goes on warning that most therapists involved with children group therapy will have their unresolved childhood repressed feelings awakened. Unless the issued countertransference is dealt with, the group treatment will be impeded. Some aspects of countertransference specific to the pregnant therapist have been relayed in the literature. The feeling of dependency emanating from client-children combined with the unspoken demands on the

unborn baby can impede on the therapist's ability for empathy. The therapist's own sudden dependence on others for support elicits new issues that were not present before the state of pregnancy (Maat and Vandersyde, 1995).

Countertransference can be composed of any emotions; pride, happiness, relief but it is mostly the darker emotions that capture our attention. Counselman (2005) names hate, envy and shame as examples. In 1949, Winnicott wrote a legendary paper on hate in the countertransference stipulating mostly that hate is part of the analyst's work in a subliminal way. Making a comparison to his infamous good-enough-mother", Winnicott wrote about hate, love and latency: "A mother has to be able to tolerate hating her baby without doing anything about it. She cannot express it to him" (p. 74). Working with countertransference requires awareness of its presence, Vannicelli (1989) enumerates three covert and three overt indications of existence of countertransference in a therapeutic relationship. The hidden signs consist of attitude shifting toward the patient; preoccupation with a patient that cannot escape your mind and feelings of exhaustion with hopes of cancelling a session. The explicit warnings are stereotypical responses to the patient regardless of the situation; unsuitable affective responses and finally modification of the previously agreed upon therapeutic contract. In other words whenever the boundaries of the therapeutic alliance are manoeuvred by the therapist, one can suspect countertransference, hence the importance of establishing firsthand the therapeutic frame and abiding by it. Flannery (1995) explores in a paper another kind of emotion present in countertransference: boredom. In hopes of better understanding its meaning for the therapeutic process, Flannery explored the essence of boredom rather

than eschewing it. Scaturro (2005) suggests asking ourselves whether the emerging emotion, in any given session, belongs to the patient or to us and then asks why.

In the life of a therapist, many joyful or sad events, planned or sudden, can occur and change the dynamic of the therapist-patient bond. Inevitably, these happenings create new transference and countertransference within the psychotherapeutic process. As seen, patients assemble a multitude of information about their therapist by observation alone. Patients build their own ideas and it becomes part of the framework. Any changes in the therapist's life can, whether consciously or unconsciously, shape the therapeutic alliance. Gold (1999) insists that with or without intentional disclosure from the therapist, these changing events affect the process in many ways: the therapist's ability might be jeopardized; feelings about the patients or patient's feelings might change. Even undisclosed information about the therapist can shape the therapeutic alliance if, inadvertently, the client uncovered some information. Fenster, Phillips and Rapoport (1986) describe the environment where clients come to expect security and consistency, it is built from variable such as time, duration, disposition and location. In 1963, Winnicott called it the *holding environment*. Fenster et al. (1986) maintain that changes to this environment constitute an intrusion and proper steps must be taken to limit the damage to the therapeutic alliance.

Greenson (as cited in Weiner, 1998) coined the term *working alliance* in the 1960s and Weiner sums up the definition as:

A mutual understanding and agreement between patient and therapist concerning the goals of the therapy; a shared commitment to the treatment tasks necessary to achieve these goals, and a sufficient bond of attachment between them to sustain

their collaboration in resolving strains that inevitably arise during the course of psychotherapy. (p. 35)

In this sense the therapeutic alliance is a necessary part of a successful psychotherapy process but not sufficient on its own (Hervé, Paradis, Legras & Visier, 2005). Weiner explains that the therapeutic alliance is a precursor to transference and countertransference, the commitment of therapist and client is primordial in attaining this goal. This working alliance between therapist and patient resembles a real relationship and that alone can be quite satisfying as it sometimes represents for the client the only significant relationship in his life (Kernberg, 1984). Moreover Myers and Hayes's (2006) study supports the establishment of an alliance before consideration of disclosure from the therapist's part. The term *therapeutic alliance* always refers to the coalition between therapist and patient or therapists and patients in a group setting. But recently a group of French researchers pushed the inner walls of the circle to include a third party; parents of children who are patients in a pedopsychiatric ward. Kabuth, Tychey and Vidailhet (2005) wanted to explore the benefits of establishing a therapeutic alliance with the parents of their patients. The results showed a positive correlation between the establishment and maintenance of the therapeutic alliance with parents, especially mothers, for duration of two years and the social evolution of the children.

When an art therapist is confronted with a child's illness, be it physical or mental; her parenthood affirmation might be met in a confrontational way. Countertransference reaches a different height, when faced with the reality that children can die, even hers can die. She may also be visiting her own death or the child within her. Malchiodi (1999) warns of the importance of having a strong support system for art therapists working in

these situations. The same warning pertains for therapists who have miscarried, lost a child and are working with children or again a childless therapist. Leibowitz (1986) an analyst, took the decision not to have children after having tried unsuccessfully for many years. She relays her experience with patients while she was childless, while trying to conceive and finally after her decision not to adopt. Leibowitz is resolute, the therapist' life experience and its unwinding requires an acute understanding and self-observation in order to minimize the negative impact and to enrich the positive realms on clients. In working with children, a therapist should not avoid looking at her own childhood and at her inner child. Personal therapy helps decipher the different material emanating from the therapeutic alliance in the forms of countertransference. Amazing is the vastness of knowledge acquired from interactions with children. There is something raw about children that is rich and yet makes them vulnerable. A therapist grows as a person from such contact. Lerner (2005) describes a case study with an adolescent within transition to adulthood. Lerner speaks of certain reciprocity of the learning process and he quotes Winnicott's (1971) notion of the necessity to play. In conclusion, Lerner gained a better sense of Self through this therapeutic alliance. Moreover, a better sense of Self helps therapists understand the countertransference issues (Weiner, 1998). And a sense of Self is difficult without conceding to caring for ourselves.

Theories

Research demonstrates the overwhelming popularity of attachment theory and Winnicott where issues of relationship with children are concerned.

Bowlby's Attachment Theory

John Bowlby (Bretherton, 1992) was a student of Klein's theory but he countered this paradigm by formulating, in the forties, the importance of the family in the transmission of attachment relation. He claimed by helping parents therapists are helping children. Deprivation and separation from parents, specifically mothers, was the keystone to many children's symptoms. In the context of a therapeutic alliance, dysfunctional attachment relations may be transferred onto the therapist. Considering the attachment is formed in the early years, children are relatively still close to that period and it is a primordial factor for growing up healthy: "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (Bowlby, as cited in Bretherton, 1992, p.7). Bartholomew and Thompson (1995) warn against applying attachment theory to all sphere of psychotherapy but they agree that it informs some characteristics of the therapeutic relationship.

The following is a brief summation of the origin of Bowlby's attachment theory. Bowlby (1969, p. 178) started with four theories: *The theory of Secondary Drive* which is the mother gratifying the physiological needs of the baby. The second is the *Theory of Primary Object Sucking* expressed by the baby's sucking reflex. The third is the predisposition to adhere to another human being and it is called the *Theory of Primary Object Clinging*, and finally the *Theory of Primary Return-to-Womb Craving*. The second and the third theories relating directly to an object have been retained by Bowlby as the basis for his attachment theory. In his view, attachment behaviours manifest to a degree the need to be protected from predators and to insure the survival and the reproduction of

the species; child and mother are never far from one another, both feeling the need to reduce distance. In the presence of a distressing situation, individuals seek proximity to an attachment figure; the bond reinforcing positive response from the attentive caregiver. This secure base allows for exploration, play and social activities.

Between the ages of 6 months to 2 years of age, toddlers learn patterns of attachment behaviours from the various responses they have received from adults. Those “internal working models” (Craik, as cited in Bretherton and Munholland, 1999) are the premise of later interpersonal relationships. According to Bowlby, internal working models or “experienced interactions patterns” (Bretherton, Munholland, 1999, p.89) between toddlers and mothers, for instance, are transmitted between generations. Brumbaugh and Fraley (2006) studied the attachment pattern behaviours in romantic relationships, and their possible transference over time, of 371 participants from a social-cognitive perspective. The data implies that internal working models of attachment are transferred from one relationship to another but Brumbaugh and Fraley were unable to determine the cognitive components. On the other hand, authors Bartholomew and Thompson (1995) caution the wide therapeutic application of attachment theory in social relational behaviour for it is only one apparatus of the large realm of relationships.

Winnicott's Good-Enough-Mother

Winnicott (1971) coined the term *good-enough-mother* to emphasize the importance of proper childcare in the early years of one's life specifically in terms of the mother serving as her child's external ego. The good-enough-mother involved in therapy with children, trying to offer the necessary blank screen for the client to transpose on, trying to offer a form of ego substitution, trying to repair.

Winnicott (1971) brought forward the psychoanalytic theory of the transitional object. Mother and child live, in the first weeks of life, a symbiotic relationship. The child feels thirst and the breast appears almost like magic, to the point that baby believes in his own omnipotence. It is the mother's role to slowly detach herself, once comfort and security have been solidly established, and start providing feedings at regular times rather than upon immediate demand. Disillusion brought on by mother's behaviour frustrates baby who is forced to consider the breast as an object outside of his powers. He then transfers to a transitional object, he may self-comfort when mother is absent from his sight. This transfer is only possible if mother has been able to create the illusion of baby's powers, in other words if she has responded promptly to his demands, and whether she was successful at establishing a sense of reality. Although the transitional object is physically an external object – a teddy bear for example – baby believes it to be part of himself. Unlike Melanie Klein's (as cited in Winnicott, 1971) internal object is not a possession of the child but rather a concept. The child's capacity to create an external object out of an integrated phenomenon is the basis for play and creativity. As seen previously with Bowlby (1969), this notion enables the conception of "internal working models" that offer a window into the organisation of relationships in individuals.

In a paper written in 1962, Winnicott explains the effect of failure of the environment to provide adequately in the early stages of infant; such failure affects the maturity of the ego and possibly the child's mental health. He speaks of the possibilities of repair by the analyst and he uses the term failure in order to succeed. He means that in order to repair he needs to rebuild the illusion of power in the patient and then to fail the patient's expectations as to recreate the transitional object to finally build new internal

working models. Winnicott's (1971) goal is to demystify the role of psychoanalysis by clearly understanding the development of internal schemes and by recreating the basis for their occurrence. Following this idea Winnicott (1967) demonstrates the effect of mirror-role of mother with baby; baby looks in mother's smiling face and equipped with his omnipotence believes that what he sees is himself. Winnicott (1967) transposes this in psychotherapy: "Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings. It is a complex derivative of the face that reflects what is there to be seen" (p. 32). The good-enough-mother is also on hand in the therapist's family. In other words, feelings and reactions expand into all spheres of our lives.

Art Therapy

Everything mentioned so far applies to art therapy, with the artwork itself offering another component. Children can transfer their feelings on the artwork, hence the necessity for the therapist to resolve his countertransference. Moustakas (as cited in Malchiodi, 1998) clearly expresses this when talking about the relationship between therapist and child:

A place where the normal child is able to release tensions and frustrations that accumulate in the course of daily living, to have materials and an adult entirely to himself, without any concern with sharing, being cooperative, being considerate, polite or mannerly. He can feel his feelings and express his thoughts all the way knowing that he is accepted and revered unconditionally. (p. 32)

Concerning pregnancy, Maat and Vandersyde (1995) highlight the value for the art therapist to recognise the altering countertransference in parallel to the three terms of

expectancy. They also claim that art therapy is an appropriate tool for children to explore their concerns toward the pregnancy, while Swan-Foster (1989) demonstrates that art therapy is valuable for pregnant woman through self portrait and the transformation of their fears through imagery.

Methodology

Qualitative Heuristic Research

The methodology followed in the research and writing of this paper was the qualitative heuristic method. Qualitative genre emphasized exploratory research within a context favouring the experience of the participants living the investigated phenomenon (Marshall and Rossman, 2006). Defined by Linesch (1995) qualitative research is:

A set of inquiry processes that offer rigorous but open-ended opportunities to explore human experiences in depth. By avoiding the reductive tendencies of quantification, qualitative approaches respect the complexity of human experience and allow for the emergence of meaning and understanding. (p. 261)

A form of qualitative research – heuristic, is “a passionate and discerning personal involvement in problem solving, an effort to know the essence of some aspect of life through the internal pathways of the self” (Douglass and Moustakas, 1985, p. 39). Moustakas (1990) with the input of his students developed the methodology and continued improving its structure from 1961 to 1990, inspired by a variety of theorists such as Maslow and Rogers. Douglas and Moustakas stipulated that heuristic is: “An approach to human science research” (p. 39), basing it, in some way, in humanistic approach. Garai (as cited in Ruben, 2001) described the basic principles of humanistic psychology through which some correlations can be made with Moustakas’s heuristic approach, such as the importance of the person as a whole, self-realizations and fulfillment. Although these are applied as the study of the person as a whole and self-realizations are the person’s goal, it provides links with self-search, self-dialogue and

self-discovery (Moustakas). Commitment is a common denominator in both approaches, one for the commitment to the whole person and the other for its commitment to the exploration of the question. Douglas and Moustakas contrasted the heuristic inquiry with the phenomenological model. Heuristic emphasizes on the relationships between researcher as a whole person and her quest for essential meanings carrying personal significance presented with the help of tacit knowledge in a creative synthesis. Phenomenological research promoted detachment between researcher and the subject. The meaning was extracted from the experience rather than from the person in experience.

The Framework of the Research

The time span of this study ranged from September 2006 through February 2008. Data was collected during training period from fall 2006 until spring 2007. The practicum site was the psychiatric ward of a hospital for children under the ages of 12. Children were required to live on the facilities from Monday to Friday, for a minimum stay of four weeks. The mandate of the hospital was one of assessment and diagnosis. Patients had a wide variety of diagnoses such as attachment disorder, pervasive developmental disorder and paranoia. The admission process consisted of an interview between the psychiatrist and the child with his parents or tutors, in the presence of the staff. The family situation was explored and the child's imminent admission was discussed. The multi-disciplinary team was comprised of pedo-psychiatrist, nurse, psychologist, speech therapist, occupational therapist, special educator, psycho-educator, social worker and for the first time art therapist. Appointments were set to meet with different specialists and the child was taken over within a framed and contained environment. The staff met weekly to

share thoughts, impressions and findings on each child on the ward. The department offered the employees group supervision headed by a neuro-psychologist. This setting also provided a platform for exchange between the staff to discuss countertransferential issues and to detect similarities or divergences regarding a situation. I also benefited from individual and group academic supervision as well as one-on-one sessions with the neuro-psychologist. My role was to observe and assess each child individually and in group art therapy, to participate in meetings and to write up reports presented to parents.

Participant and Informant

Moustakas (1990) argued the requirements of direct and active participation of the researcher; therefore I am simultaneously the researcher and the participant. It is my experience of the phenomenon under study. Moustakas stated that a wider pool of participants investigating the same phenomenon offers rich and varied meaning. I believed that for the intention and the requirements of this study, my single inquiry of the interface between motherhood and art therapy can provide significant knowledge and understanding. I also did not feel that other participants would have added anything to my own experience as I was going through the process. As Sela-Smith (2002, p. 71) pointed out: “co participants might add an unwelcome diversion”. I believed as well, like Sela-Smith that the implication of other participants dissipates the internal meaning of the search. Nonetheless, I asked a nurse from my practicum site to play the role of informant to discuss with her my findings and to explore her experience of countertransference, with the intention of increasing the validity of the research as presented by Moustakas. Cameron, Kapur, and Campbell (2005) expressed beautifully the therapeutic potential of the psychiatric nurse in establishing therapeutic alliances. The authors hypothesized that

an object-relations approach between nurse and patients could tap into the potential unused therapeutic capacity of the psychiatric nurse. Cameron et al.'s article certainly expressed the value of the psychiatric nurse / client relationship and the significance of treating transference and countertransference issues with a psychotherapeutic approach rather than the familiar medical approach. The nurses' identity is at stake, and their training does not always lead to this alternative position. Duff and Bryon (2005) similarly conveyed the importance of bringing, in a pediatric setting, a less medical more psychological quality to the team. Because I feel I have been privileged to experience this contemporary approach at my practicum setting I have chosen an informant from the hospital.

Relevance to Question

It was apparent from the beginning that I was leaning toward heuristic research. The wheels started turning when I first visited the practicum site where I encountered a heartbreaking young girl of approximately the same age as my own daughter. I was taken aback and felt a wave of conflicting emotions; the mother in me wanted to take her in my arms, but at the same time, I wanted to run home to protect my daughter. The art therapist in me wanted to kneel down and offer her crayons while hoping to console her. It was my first confrontation between two parts of my life: the mother and the art therapist. Prior to this experience both roles amicably walked side by side. The uneasiness I felt made me aware the situation with children might be different from my first practicum with adults and I wondered in what manner. I was thinking of my own young child and felt emotional about working with ailing children. I wondered how I would react and what would I do with these new emotions. Without knowing, at the time, I was following

Moustakas' (1990) concept: "From the beginning and throughout an investigation, heuristic research involves self-search, self-dialogue, and self-discovery; the research question and the methodology flow out of inner awareness, meaning, and inspiration" (p. 11). I began, like Moustakas, with my life experience as the territory for my question: *What is my experience of countertransferential issues in a therapeutic alliance with children as an art therapist and a mother?* This autobiographical question set the table for an intimate meeting with my Self.

The internal desire to understand my quest emerged from my apprehension of practicing art therapy in this setting. I was weighing my capacity to leave my home experience at home and my work experience at work. I wanted to protect my family as well as hold my clients. I drew strength from inside and was guided by my internal set of references. Being a mother was new, so was being an art therapist. I started the practicum constantly sentient of my reactions, wondering still how I could handle both, while adapting very well to the team and the site. I then joyfully learned of my pregnancy and worried some more, wanting protection for my unborn child. The family cell grew within my body, invariably propelling me inward. I was literally living and feeling my question. I paid close attention to all my emotions and tried to decipher whether they emerged from my pregnant state, my interactions with clients or my daughter. I was looking for answers inside of myself that now also belonged to another soul. Inevitably being pregnant with a second child during my practicum raised a subsidiary question: *What impact would the pregnancy have on my quest?* Believing that surely this life inside of me would color my experience of the phenomenon explored, is an assumption that I strongly held.

My questions embodied the necessary qualities for heuristic research as mentioned in Moustakas (1990) such as seeking to reveal the spirit of a qualitative phenomenon while totally immersing oneself in the process without trying to oversee the outcome. Data was collected throughout practicum year on the pedo-psychiatric ward of the hospital as well as in-school setting and at home. The data followed as well, the heuristic phases, consequently a list of themes emerged from the funnelled information. I assembled a questionnaire in the form of open conversation for the informant, ensued a general interview guide (Patton, 1980) outlining my experienced themes. The dialogues between myself and the nurse served two purposes: establishing validity and comparing our internal frame of references. Another section details the data, its organisation and analysis. The following chapter describes the heuristic process and concepts experienced in this research.

Moustakas's Processes and Concepts

The concepts and processes employed for illuminating a quest in heuristic research (Moustakas, 1990) are: Identifying with the focus of inquiry, Self-dialogue, Tacit knowing, Intuition, Indwelling, Focusing and The internal frame of reference. These did not necessarily occur in sequence and they envelop the heuristic model every step of the way.

Identification with the Focus of Inquiry - The question aroused from the researcher's mind, inspired by her life, her surroundings and it then becomes part of her. She embodied the question to reach a greater understanding of its different facets. The quest is experienced, lived and analysed through her.

Self-Dialogue - Moreover, the researcher dialogued with the investigated question. To understand a phenomenon, one should start within the core of her personality. Allowing questioning in all its forms and entertaining a mental conversation back and forth with the object of interest represented the task. Honesty, self-inquiry, openness and a desire to learn were the beginning qualities of this concept.

Tacit Knowing – It embraced the power of revelation. All the other concepts flew from this base of heuristic knowledge. According to Douglass and Moustakas (1985) “tacit knowing operates behind the scenes, giving birth to the hunches and vague, formless insights that characterize heuristic discovery” (p. 49). Polanyi (1967) devoted his time to this concept by defining its elements as *subsidiary* for what is seen and describable and *focal* for those that are unseen and invisible while requiring focus for their understanding.

Intuition - Is inferred from the concept above. “Through intuition I reach beyond the scope of my usual perceptual abilities and discover knowledge and meaning unexpectedly and implicitly” (Douglass & Moustakas, 1985, p. 50). In 1990, Moustakas added in its description of *intuition* the analogy with a bridge. *Intuition* is the bridge between the subsidiary, describable, implicit knowledge and the unseen tacit knowledge. The researcher was guided by *intuition* in her quest for patterns of meanings.

Indwelling - This conscious concept demanded of the researcher an inward regard, a quest beyond the subsidiary and focal elements to extract deeper meaning. Its emphasis lied within the parameters and details of the experience. *Indwelling* was a turning point in the explication phase, although sometimes painful, the researcher’s bare honesty was primordial in this concept.

Focusing - Was achieved with the help of creating space inside one's mind in order to extract the most meanings, feelings and thoughts somewhat hidden under the clutter. The results of this concept were manifested by changes, interior as well as behavioural.

Internal Frame of Reference - The previous concepts above referred to tacit, describable, intuitive or unseen knowledge with the help of dialogue, self-searching, *focusing* and *indwelling*. None of this was possible without the basic *internal frame of reference of the researcher*.

Moustakas' Phases

In order to guide the researcher through the process of heuristic methodology, Moustakas (1990) elaborated the following six phases. Each segment is underlined by one or more of the concepts detailed earlier.

Initial Engagement - The *initial engagement* was the part that called out to the researcher. It implied interest, curiosity, passion for a subject, an event compelling the investigator to search inward for a personal answer with social ramifications. With discipline and commitment, the researcher embarked on this autobiographical experience of finding meaning to her formulated question.

Immersion - The next step called *immersion* spoke for itself. The subject plunged completely into the pool of sensation of the question, her thoughts were absorbed while gathering all possible elements through dialogue, intuition, and people. The researcher was alerted to anything that came in the form of energy.

Incubation - Was the period of retreat. The researcher refrained from consciously thinking about the question while busying herself with other issues. Nonetheless, the

question continued to grow in the form of tacit knowing to allow new angles of the phenomenon to arise. It was like forgetting about a problem for a while and discovering a few days later that the answer was there all along.

Illumination - While incubation resided in the unconscious, *illumination* was a conscious state. It was the breach in the dark that brought new light to the idea. The transformation allowed for awareness of a distorted concept or of new sets of characteristics. Moustakas (1990) spoke with experience when he stated: “in illumination, it is just such missed, misunderstood, or distorted realities that make their appearance and add something essential to the truth of an experience” (p. 39).

Explication - A table of contents emerged, concepts and themes became clear. This was the *explication* period. The researcher looked inside at her feelings, emotions and thoughts trying to explain the different concepts presented to her. She must decipher what was now conscious and make room for this new meaning.

Creative Synthesis - Finally, the *creative synthesis* was expressed in different forms ranging from dialogue to artistic expression. This conclusive phase was challenging because it required a thorough assimilation of the understanding as well as its transformation into creativity. The researcher prepared for this phase by entering in a state of relaxation, solitude.

Validity and Reliability

Validity and reliability are terms inherent to quantitative research. The appeal of the heuristic method resided in the freedom of the exploration and the lack of constraints regarding the provability of hypotheses (Douglas & Moustakas, 1985; Fenner, 1996;

Frick, 1990; Sela-Smith, 2002). The researcher was invited to examine her Self, to be intuitive, to allow the surge of tacit knowing and to validate her personal frame of reference in the search of essential meanings of a common human experience. Douglas and Moustakas believed that heuristic inquiry was a valid form of research:

The validity of heuristic research is inherent, insofar as it pursues the truth, to the extent that it is conducted through authentic self-processes, and to the degree that after repeated examinations of the data, the same essences are revealed with the same degree of plausibility (p. 44).

In 1990, Moustakas held the same discourse regarding validity by insisting especially on the subjectivity of the researcher in *going again and again* to verify the data and by sharing and confirming the meaning with participants. I have dialogued with the nurse specifically for this purpose. The validity of this qualitative form of research was intrinsic to the search of the truth by the person in the experience and it must be authentic to the self-experience. Through repeated examinations of the data, the same quintessence must emerge (Douglas & Moustakas, 1985). Polanyi (1967) pointed out the researcher's responsibility in evaluating the validity of the research by means of the inquiry process. Moustakas mostly made reference to internal validity (Lincoln and Guba, 1985) by establishing a systematic way of collecting data as followed in the next section.

Patton (2002), Lincoln and Guba (1985) transformed the terminology to adapt it to qualitative research; credibility, transferability, dependability and confirmability. I have applied these notions as defined by Marshall and Rossman (2006). Credibility was provided by the in-depth descriptions of Moustakas (1990) processes along with its complexities imbedded in the collected data. I believed this study to be transferable to

other art therapist encountering motherhood as a life changing event; the themes would differ but the meaning yielded collective understanding. Furthermore a record of all the data permitted systematic verification. Dependability required of the researcher an account of change within the universe studied. Moustakas method aimed for change. I believed my interpretations of emerging themes would make sense to another reader, therefore affirming confirmability.

The choice of this methodology reflected the question inhabiting my mind and also established internal validity. The rigor and the focus in following each step toward the emergent Self validated the preference of this methodology.

Data Collection and Organising

Gathering Data

The gathering of data started immediately with the immersion into the question with wide open eyes, heart and feelings (Moustakas, 1990). Anything can constitute data. I was consciously attentive to all facets of my life and not only when I was therapeutically involved with children-clients. It was during art therapy sessions with the children that countertransference manifested itself however its roots and its ramifications were present in everyday life. The question of countertransference was also explored unconsciously and manifested itself in my dreams and journal writings.

Following is a list of everything that constituted data for this study from the manner it was collected, assembled, and later organised in order to retrieve themes and garner knowledge. Data was gathered from self-dialogue, journals, drawings, dream writings, case notes, and supervision reports. Like Moustakas (1990) said: "Heuristic inquiry requires that one be open, receptive, and attuned to all facets of one's experience of a phenomenon, allowing comprehension and compassion to mingle and recognizing the place and unity of intellect, emotion, and spirit" (p. 16).

Baker (1990) was adamant: Journaling allows primitive-process to be dealt with as an ego support, it provides a container, and it offers the possibility of being with the Self in the here and now. I kept a journal sporadically for most of my life. At practicum after my sessions of art therapy with the children, I sat down and took a moment to journal. My intention was to write spontaneously (Moustakas, 1990), honestly and deeply as Baker suggests. Spontaneous writings came naturally only after many weeks of

practice. Initially I tried to make sense, to understand rather than letting the flow of thoughts invade the paper (Rainer, 1978). I followed Julia Cameron (1992)'s book on *journal writing to unleash your creativity*, she encourages unstructured writing exercises and offers techniques to complete the process in a timely fashion. Spontaneous writing encourages a wider variety of input even though it is arduous to get inherent message.

Case notes pertaining to countertransference issues were also observed; specific sections in my case notes allowed immediate jotting down of perceived countertransference during sessions. This procedure facilitated later expansion on the noted feeling, further elaboration or immersion were possible in the journal or drawing engagements.

Reading Sela-Smith (2002) prompted me into paying attention to my dreams by having a pencil and paper by my bedside. And these were later glued into my journal. It also happened that journaling prompted the memory of a dream, usually an old dream. Sometimes I did not write the dream but simply sketched it or drew the feeling of it.

Collecting drawings as data came naturally for an art therapist. Yet I initially forced myself to draw after each session with clients, but realised that I was impeding on the natural process. Eventually I picked up crayons whenever I felt like it, whether alone or with my daughter but I refrained from drawing in the presence of clients, for ethical reasons and by professional choice. My focus had to be on the children and not on my research. This was when the inquiry rested in the unconscious. I remained open to any outcome; "freedom in discovery is a necessary feature of heuristic research" (Douglas & Moustakas, 1985, p. 44). My first idea prompted me to create mandalas on a regular basis

but this also turned out to be an imposition rather than free expression. I thought that mandalas would add a relaxing component to the experience and set the frame for disclosure. It takes time to learn to let the question guide you and not to project your intentions and ideas on it. In those moments of doubt I would return to Moustakas (1990): “The initial data is within me; the challenge is to discover and explicate its nature. In the process, I am not only lifting out the essential meanings of an experience, but I am actively awakening and transforming my own self” (p. 13). I was learning to let go and not to control everything. Drawings were collected in a portfolio, sometimes accompanied by words.

Weekly group supervision discussions at my practicum site also constituted data when relevant to the phenomenon in question because my contribution was transcribed and elaborated upon in my journal. Bi-weekly supervision as part of the scholastic curriculum provided a platform to share my concerns with a qualified art therapist. Most sessions concluded with a few pages in my journal to better grasp and to allow burgeoning thoughts. In line with Douglas and Moustakas (1985), I believe that the emerging data is autobiographical, original and representative of the experienced notion of countertransference as a mother and art therapist.

Upon reception of an e-mail confirming an appointment with the psychiatric head nurse to discuss possibility of enrolling in practicum for one year, self-dialogue started. The questions, the apprehensions, the excitement of the unknown already inhabited my thoughts. This initial awareness of a challenging life experience constituted the first steps of heuristic inquiry. I continued to allow self-dialogue since it was practically impossible to ignore, and I jotted down some of the thoughts, questions, and comments even when

they seemed inconsequential - no censorship. Soon enough I used a notebook in order to collect everything in the same place. Self-dialogue mostly occurred when my mind was idle, when I was physically preoccupied with something else and not intellectually solicited. For example; sleeping, driving and lately, walking on the treadmill trying to shed the baby weight.

Organizing Data

When I found I was pregnant I made the decision to hand in this research paper before giving birth. It was an unrealistic goal for many reasons: I had forgotten what being pregnant felt like and as it turned out, I was exhausted. Time was needed to live the heuristic process through and I could not simply decide I was done until I really was. Heuristic research guides you and not the other way around. Moustakas (1990) warns us:

The heuristic research process is not one that can be hurried or timed by the clock or calendar. It demands the total presence, honesty, maturity, and integrity of a researcher who not only strongly desires to know and understand but is willing to commit endless hours of sustained immersion and focused concentration on one central question, to risk the opening of wounds and passionate concerns, and to undergo the personal transformation that exists as a possibility in every heuristic journey. (p. 14)

Analysing data took place almost as soon as I started collecting it. Douglas and Moustakas (1985, p. 51) used the words *focusing* and *differentiating* as tools used during the acquisition phase to determine the value and the direction to give to the data. The aim

of this word exercise was not to limit the quality of the emerging data; rather it served as a perception booster allowing the researcher to manoeuvre freely within the experience.

When trying to understand through immersion the collective data, I soon realised that I needed a technique to help me decode it. Of course the heuristic method was used but I applied it in the form of a diagram. I followed my intuition and ripped all the pages out of my portfolio and spread them on the floor. I was starting my *initial engagement* with the data. I now had a bird's eye view of my experience. I immersed myself in this vastitude of paper. Still, it needed organizing therefore I compiled every document by sources of data; all the dreams recollection together, drawings in one pile, case notes in another, one word thoughts or ideas separated from journal entries and finally comments from supervision sessions. I looked at those piles for a while without touching them and went on to write other sections of this paper, this was the *incubation* phase. The next step consisted in separating a huge Bristol carton into six sections corresponding to each pile. I *immersed* again. For example, I would write the main idea from each paper from the dream pile into the appropriate square on the carton. The task proved to be difficult when it came to the journaling stack; extracting the main idea from a mountain of disorganised free-flow thoughts demands concentration. Although my goal was to make sense of the data, at this point I was careful not to lose the essence of the meaning while purifying the data, sometimes more than one idea was extracted from the same journal entry. I went from a bird's eye view to a map of the data.

Looking at those six squares I was able to put into categories patterns, not themes yet as of the core idea, like the pieces of a pie. This was *illumination*. For example in the dream circle I had nine pieces of pie, containing some of the following ideas: falling /

tripping, kittens, running, unprepared for meeting, birth, and daughter (Figure 1). I identified the nucleus as *anxious*. So I drew circles and attributed a converging theme in the center of each circle – *explication*. This new diagram offered a perspective of the phenomenon explored. At this point I assumed I would be relieved of discovering the different themes, but I did not feel satisfied: “I am missing something” I thought. Therefore I entered *incubation* once again. I was really frustrated and took it out on my husband; I was starting to doubt the process. I concentrated on proof reading other sections of my paper. I put aside my diagrams and charts and I took out my crayons (Figure 2). I worked things out with my husband, I cleared the air, and I slept.

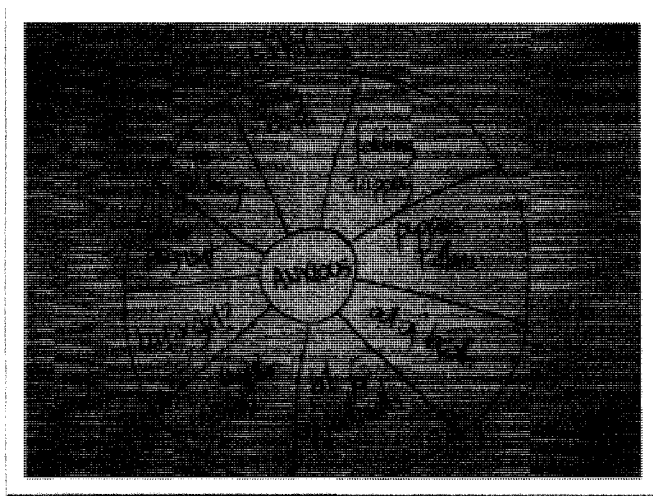


Figure 1. Pie for dreams.

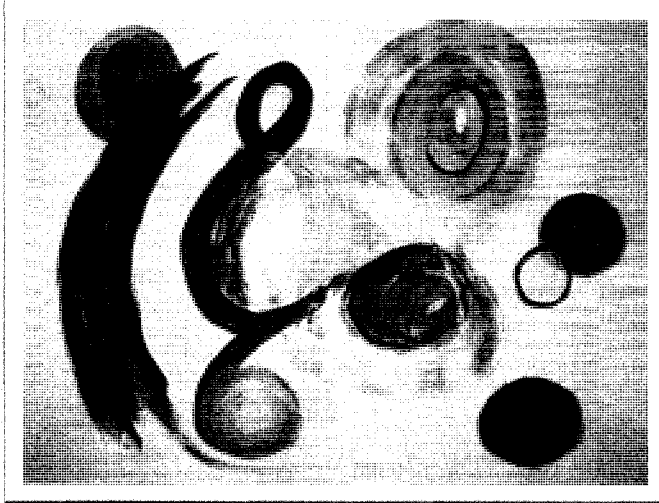


Figure 2. Venting.

The next day, I made a column of my initial data piles represented now by a circle. Next to it, another column with the themes extracted from these circles. And it hit me. *Indwelling* required that I look inside the themes, that I followed clues, consciously. A third column presented itself to me and I saw it, just like *illumination* said. Suddenly it was clear, I was satisfied I had gone to the end, I had “a synthesis of fragmented knowledge, an altogether new discovery of something that has been present for some time yet beyond immediate awareness” (Moustakas, 1990, p. 30). I had reached *explication* and because it represented an important phase, I have detailed the themes and meaning in a subsequent paragraph. I enjoyed this moment very much and I understood that I had work to do, to assimilate all this new (to my conscious) information. Again I left it aside and waited until *intuition* guided me before completing the last task: *creative synthesis*.

Living by Heuristic's 6 Phases

The phases of the heuristic process described by Moustakas (1990) are presented in order and I have experienced them mostly in the same sequence. At this point I would like to point out that some of the steps were recurrent as if in a loop; *immersion*, *incubation* and *illumination* were repeated at different level more than once. This strategy allowed for deeper understanding. It felt as if I was stripping old furniture, arduous work. I often felt or hoped that I was done but I could see paint still, and I would reason myself that it would be best if I peeled off another coat. Revealing the essence of the wood grain provided a higher level of satisfaction, of work well done through persistence.

Processing Inquiry and Pregnancy through 6 Phases

Initial Engagement - This phase started before I knew anything about heuristic research. Immediately after approval of practicing art therapy in a psychiatric setting with children, the questions started to haunt my mind. The relative similarities in age of my daughter and these children called out to the mother in me. Could this happen to her? Can I contaminate my healthy family life? I did not know why or how but the wheels started turning. I engaged into *self-dialogue*: Why is this disturbing me? What lies behind these worries? Can I continue at this site? I knew – *tacit knowing* – there were something big there but I did not understand its implication. And it did not go away, it gnawed at me. I wanted and needed to understand. *Intuitively*, I knew that this line of questioning was important for me to see through, it was a life project. I sifted it for a long time, and then two things happened: I found the question and learned of my pregnancy – *internal frame of reference*. Just like Moustakas (1990, p. 27) said:

The engagement or encountering of a question that holds personal power is a process that requires inner receptiveness, a willingness to enter fully into the theme, and to discover from within the spectrum of life experiences that will clarify and expand knowledge of the topic and illuminate the terms of the question.

I was thrilled to carry this life within me and even more *focused* on the apprehension of practicum because being pregnant raised new concerns. Deep inside I knew I was pregnant before the test showed positive, this *tacit knowledge* based on physical manifestations such as exhaustion and womanly instinct is a particular phenomenon. The tree with deep roots represents the first drawing I made at practicum, it spoke of life and rooting, I did not know of my pregnant state then (Figure 3). The possible danger that I felt for my daughter before, were imminent for the child in my womb. Safety was now primordial and not a simple matter of bringing the children-client's issues at home. More *self-dialogue* ensued accompanied by *self-discoveries*: Priorities were shifting, my daughter, this baby and the clients. One of the things I discovered early on in my practicum was the appropriation of the children-client. My husband drew my attention to the words I used when speaking of the children at the hospital. I stopped referring to them as "my children". I am their therapist, not their mother, he reminded me, I am mother to my own children and that is all. This self-discovery alleviated much weight off my shoulders; the pronoun carried a hefty emotional resonance. Once I assimilated this new approach I was better able to perform my art therapist's tasks and really be a good-enough-mother to these children (Winnicott, 1971).

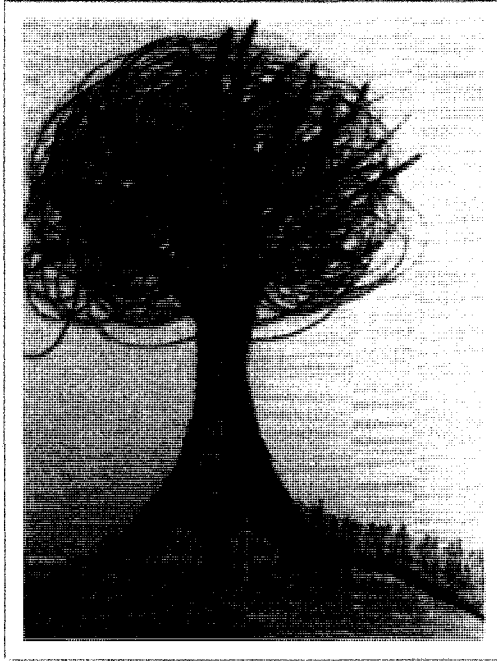


Figure 3. The tree.

Immersion - My last school semester was well on its way and my pregnancy was in its second trimester. I was collecting data at practicum, at school and at home. I posted my research question on my computer screen; invariably it was within my sight every day. I discussed my topic with anyone asking what my project was about, all my school papers were related in some way to this area of study. Preparing the literature review, reading theories and authors' opinion on the subject was the perfect form of *immersion*; the intellectual stimulation propelled me into the subject matter. Although gathering data became a second nature, I was not trying to make sense of it. Yet I constantly thought about it. "Virtually anything connected with the question becomes raw material for immersion, for staying with it, and for maintaining a sustained focus and concentration" (Moustakas, 1990, p. 28). When countertransference occurred, I made note of it. I either

knew where it came from – *subsidiary knowledge* □ or I pursued the issue further in journaling and supervision. It stayed in my head until I had absorbed the concept revealed by the experience □ *indwelling*. My pregnancy showed a lot more, staff and students commented and inquired on my well-being but none of the children openly acknowledged the transformation. My daughter acquainted herself with the statute of *big sister*, and she marvelled at the sight of my belly carrying her sibling, she was hoping for a sister. We were adamant; the sex would remain a surprise. Countertransference was particularly prevalent at this period. I was often suddenly irritated by the children's attitude or overwhelmed, torn or even bored. Some of these feelings had to do, I suspect now, with my state but also with issues of countertransference. This phase of Moustakas was flooded with data and I felt as if I was barely keeping my head out of the water, going with the flow, coping as best I could.

Incubation - School and practicum were ending. It meant termination with the clients and the practicum setting as well as with classmates and teachers. I had completed the academic section of my curriculum. I was flooded with term papers. I put a halt to journaling, drawing and supervision. In my mind, my research occupied the back burner. Moustakas (1990) describes this phase as a detachment period from the research and the question under study; he adds that knowledge is transposed to a different level because growth continues to exist in the form of *tacit knowing*. In other words, while the researcher is busy with the question she is not preoccupied with the answer. Once *incubation* occurs and the question is set aside, once the researcher's mind busy with other details, then *tacit knowledge* is possible and *illumination* may occur. This period set the stage for the emerging themes that will be revealed in the following section. My

pregnancy entered the last trimester and with more time on my hands I finally felt connected with my baby, I communicated and caressed my belly and my daughter also interacted more with the baby to come. For the first time in many months I took long baths and walks by myself. Moustakas (1990) wrote: “the heuristic researcher through the incubation process gives birth to a new understanding or perspective that reveals additional qualities of the phenomenon or a vision of unity” (p. 29).

Illumination - This is the breakthrough phase. Meaning comes to the researcher’s awareness by clusters of themes. This natural process depends on the researcher’s receptiveness to her *intuition* and *tacit knowledge*. Finally I gave birth to a big baby boy. Later I concentrated on the data. And the data followed the same heuristic phases as the research itself had. My pregnancy also followed the same phases. Identifying this parallel was the beginning and the base of the *illumination* process. It brought new meaning to the progression and the specifics of my experience as a pregnant mother and art therapist. Different themes emerged, connections were made, relief also from finally understanding the virtue of this inquiry and the joy of finally discovering that I had been carrying a baby boy.

Explication - The essence of meaning is found in many layers which need to be uncovered. I had to dwell within and interrogate my beliefs, feelings and thoughts - *focusing*. *Indwelling* and *focusing* were necessary to extract as much understanding out of these layers of information. Moustakas (1990) describes the action of *indwelling* as a conscious process of searching inward for a profound understanding and meaning of a theme. *Focusing* demands space inside the researcher’s mind to concentrate fully on the themes’ constituents. First I took time to make acquaintance with this new baby, to

familiarize my family and myself to this new life in our lives. I received a wonderful *explication* for who was in this huge belly I had been carrying. I saw, felt and heard more answers than I dreamed of when I looked in the eyes of my baby. This was the culmination point of a lifetime. Eventually, I took another deep look at the different diagrams made from the data collected earlier. I had more room this time in my head and in my body for the exploration of all the facts. I met with an informant who practices as a nurse at the practicum setting. Together we exchanged in open dialogue about the themes that were uncovered. The method of interviewing was an in-depth interview, more like a conversation than a structured questionnaire. This type of exchange where the participant chooses the direction of the conversation in order to expose his own perspective on the matter is called the *emic perspective* and it serves as an assumption of qualitative research (Marshall and Rossman, 2006). I was interested in the nurses' comments and views, because at this stage of data analysis and explication, I wanted to compare my findings, increase the validity of the research experience. We had one meeting that lasted two hours and the encounter was recorded. My objective was to make her feel as comfortable as possible and to indulge her views as widely significant. Some of the passages were transcribed verbatim.

Creative Synthesis - Easier said than done. "Once the researcher has mastered knowledge of the material that illuminates and explicates the question, the researcher is challenged to put together the components and core themes into a creative synthesis" (Moustakas, 1990, p. 24). Intuitively, I always visualised a painting in my head, an image of woman and child in an abstract form. It would not leave me but I never took the time to put it down on canvas. At this stage of writing I still have not completed the creative synthesis

of my research. I had put aside the heuristic process. I found the themes and their explication, and the process proved to be enlightening and empowering. In the meantime, my baby was 8-months-old and adjusting to family life (or is it us that adjust to him?). I was trying to slowly wean him; it was difficult for both of us. The smiling toddler laughing out loud at his sister's mimics while we, the parents, proudly gazed at each other was a wonderful creative synthesis.

Processing Data through the 6 Phases

A non-statistical method of data analysis was followed according to the heuristic method. Moustakas (1990) guides the researcher through the following steps:

- 1- Gathering all the data: case material, journal, drawings, dream writings, dialogue.
- 2- Understanding through immersion of all the data, re-reading, re-observing of drawings, searching for themes (immersion).
- 3- In order to get a fresh outlook on the data, it is necessary to leave it and return to it later (incubation). Identifying themes and qualities rising from the data. Circling of my experience.
- 4- Return to data to verify concordance between themes and actual data depiction.
- 5- Understanding of the experience through illumination.
- 6- Looking for meaning (explication).
- 7- Creative synthesis: writing and writing.

Parallels within Heuristic

The previous section presented the evolution of my research project and pregnancy as experienced through the six phases of the heuristic methodology as

identified by Moustakas (1990). My research intentionally followed the heuristic process unlike my pregnancy which seemed to have followed the same steps naturally. This realization proved to be quite interesting; I truly lived the heuristic process from my womb. This *illumination* was the strongest form of *tacit knowing* emerging out of this experience. I knew this methodology was for me but I never imagined the scope of the experience extending this far beyond the initial question. I felt somewhere inside - *tacit knowing* - that this type of methodology appealed to my personality and lifestyle. The data also followed the six heuristic phases. During the *illumination* phase, I analysed the data according to the same six steps. The *initial engagement* consisted in spreading all my documents on the floor and getting acquainted with this information. Reading, re-reading my journals, notes and dreams depictions as well as browsing through my drawings consisted of the *immersion* phase. I was literally covered with papers and frantically needed to organise them. I had not decided in advance how to assemble them, other than gathering the data in a journal. *Tacit knowing* guided the sorting process. I kept asking myself how I could make sense of this information. *Intuitively* I started to tally each entry in different sections, *focusing* on the essence of each tab. Exhausted I left this clutter to rest and concentrated on writing another section of this research paper. *Incubation* was working its magic; diagram and charts were forming in my head even though I had left the data aside. I was starting to understand. I came back to it and created the charts, I made parallels and the essential qualities of themes were taking form in front of my eyes. This was the fourth phase: *illumination*. *Explication* of the data happened in part when I interviewed the nurse and we compared our experiences. There was a lot of *indwelling* on my part. And finally, a drawing of wheels was created out of all this data

taking the form of a creative synthesis. Moustakas uses this methodology to explore a phenomenon. The phenomena that I explored are my experience of countertransference issues in a therapeutic alliance with children as an art therapist and a mother, my pregnancy and the data. The following chart (Table 1) exposes the parallels of these three phenomena.

Process Phenomenon	Initial engagement	Immersion	Incubation	Illumination	Explication	Creative synthesis
Research	Question Practicum starts	School year Gathering data	End of school End of practicum Termination	Looking at data Emerging themes	Understanding themes Informant Organising	Painting
Pregnancy	Announcement 1 st trimester	Coping 2 nd trimester	Focus on baby 3 rd trimester	Birth Joy Adaptation	Discovering baby	Weaning Family is whole
Data	Spread it on floor	Reading Remembering Connecting with feeling	Writing other sections Reading leisurely	Charts Diagrams Parallels Extracting	Comparing with informant	Charts - Pics

Table 1. The heuristic process applied to the phenomenons.

Findings

The heuristic process is lengthy and demands ubiquity from the art therapist. The emerging themes shed some light on issues of countertransference present in my role as art therapist while emanating from my role as mother.

Emerging Themes

I explained earlier the procedure through which I uncovered the different themes, six in total, and in this section I will describe what I understood from this journey. First I would like to expose the columns that helped decipher the themes from the data (Table 2).

Original piles of data	Converging theme extracted from circle	Final themes
Supervision	Me	Consciousness
Case notes	Inner-child / Pregnancy	Birth
Dreams	Anxiety	Unconscious
Drawings	Pregnant / Holding	Container
Journal	Countertransference	Shadow
One word thoughts	Guilt / Ambivalence	Torn

Table 2. The transformation of themes.

Consciousness - was a theme derived from the pile of observations issued from supervision sessions. I benefited from four different sources of supervision: bi-monthly individual meetings with my academic supervisor, alternating with bi-monthly individual sessions with the hospital affiliated neuro-psychologist. I also participated in group supervision in University and on practicum site with the ward's staff. Supervision was throughout my practicum the most valuable tool in my bag and I used it well. I always

prepared a list of issues, questions or a specific case that I wanted to discuss. Sometimes the discussion did not follow my list because something came up that turned out to be more important. In other words I planned to elucidate an idea but my supervisor brought to the surface some unexpected topic. I felt as if I needed to uncover the real issue and my list only served as guideline. Today, I could call this intuition. For example, my supervisor and I were discussing a surprising individual art therapy session with a nine year old boy. During my conversation with the boy, he spontaneously hugged me and I was taken aback. I reported this episode to my supervisor, hoping to discuss the reason and the consequences of this demonstration of affection. Rather, my supervisor asked me to observe my reaction, my countertransference rather than the child's action; it seemed that I was recalcitrant to such an outburst of affection. It surprised me. She had brought my attention to something that was not on my list and this happened more than once. Although I was pregnant and possibly worried that the boy would unintentionally harm my baby, I was startled by the possibility that I had difficulties being the recipient of affection. And of course, this concept needed further introspection.

Supervision was a valuable source of guidance especially concerning the unfolding of art therapy sessions with children. But in keeping with the methodology used here, I am referring to topics that concerned my experience as an art therapist rather than specificities of children's issues. During the first 3 months of practicum, due to scheduling constraints, I was not privy to the initial encounter between parents, child and hospital staff. I read the file, spoke with staff and met the child, but only encountered parents at the final report. The first time I was able to attend the initial interview; I felt a huge surge of countertransference with the mother present. In supervision it became a

pivotal topic. As a mother, as a woman, as an art therapist and as a pregnant woman, the feelings, the judgements, the empathy, the rage, the disappointment that invaded me were sometimes difficult to bear. And supervision provided guidance, affirmation and perspectives.

The second column above refers to “me” because supervision was a window with a view on me. I realised that it brought to consciousness facets of me that were unknown or untouched until then, such as my rapport to affection and my idealism regarding motherhood. Exposing who we are to ourselves is a pre-requisite to becoming a therapist. One cannot ask of another what one has not done for oneself.

Birth - I specifically paid attention to my countertransference while in sessions with children and I wrote them down in my case notes. That is when I was aware of it. As seen countertransference happens all the time; we either recognise its origin from having experienced it before, or we recognise it as such and explore it later, or the countertransference goes unnoticed, for the time being. When I looked at the pieces of pie that make up the circle of countertransference retrieved from my case notes, it seemed to me that it was either related to my pregnancy or to my inner-child. Birth represents the encircling theme.

When I was four months pregnant, in the final session with the same 9-year-old boy mentioned earlier, he invited me to make something out of plasticine as he was working the dough. “What would you like me to make?” I said, and he replied: “I don’t know... make an animal, why don’t you make a stork”. I was blown away. I read about the phenomenon of open channels between the unconscious of the therapist and client

within a therapeutic alliance, but I had never witnessed it. I was ecstatic to think that at the unconscious level he was referring to my pregnancy, something he was not consciously aware of. This was an example of my countertransference, because I was pregnant, I believed the stork referred to the child I was carrying. This was the first and only time that my state was the subject of an art therapy session and I did not recognise it as countertransference, therefore I did not deal with the child's concern. I should have mentally distinguished the feeling of awe as a reference to my state, put it aside to better dwell upon it later, and address the child's concern with the stork. Maybe he was referring to his birth, to his mother. I will never know, caught up as I was in my countertransference.

Being "Stuck" - At this point of redaction, I experienced resistance. I was stuck. I could not write anymore. Instead I alphabetised my biography. I was disappointed because I assumed the mental work should be done prior to writing and I was now at a standstill. I met with my advisor. She pointed out the relevance of "being stuck" in my quest for the truth, and suggested that I look into it. She also added that it might be painful. This was *incubation* again, followed eventually by *illumination*. I was stuck in this paper, my daughter was stuck in my womb - my first pregnancy necessitated an emergency cesarian - my baby boy was stuck on my breast, he refused the bottle. And I suspect my inner child was also stuck. This personified the most difficult *indwelling* I have experienced. What was holding me back? Fundamentally I believed that a good mother should conceive and give birth naturally, and should breastfeed her baby. Where did that come from? Pre-natal classes and their idealistic notions, my mother, society, maybe all these answers were good. One thing was certain, this idealism was strongly embedded in my

psyche – *internal frame of reference*. With not meeting these criteria came a huge bag of guilt. I had many clues over the last four years since my daughter's birth, but I have dismissed them as unimportant and now they were back in my face. Look at it. When I held my daughter in my arms for the first time, I said: "I know this is my baby but I don't feel like I have given birth". She was healthy, gorgeous and the pride of my life. I was left with a feeling of ineptness, incompleteness, still pregnant. I was back at the incubation phase for now.

I went back to my drawing table and in a 2 day period produced these three drawings (Figure 4, 5 and 6). From an open scratchy motion to arcs, I ended in a circle. This was the cycle. I was whole again and rich (color gold).



Figure 4. Stuck #1.

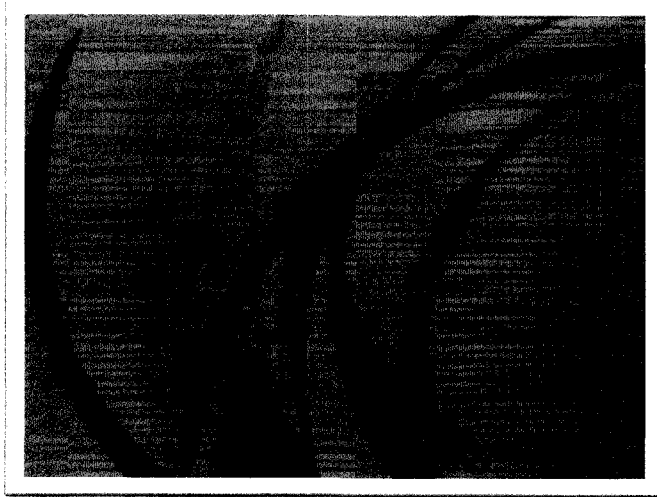


Figure 5. Stuck #2.

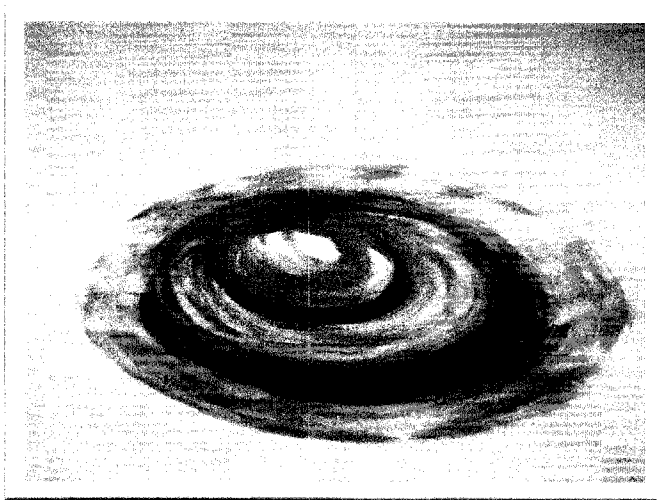


Figure 6. Stuck #3.

Unconscious - Most of my dreams related to being pregnant, giving birth or being late for some engagement. Time was often a factor and I associated it with anxiety because I was out of breath in keeping with my schedule. My body was slower and it was very difficult to listen to the clues when so much needed to be done. Since I was not hearing the

warnings to slow down, my dreams were taking care of it. I eventually reduced my schedule and made time for yoga classes for pregnant woman. Marotta and Valente (2005) presented a study on the benefits of yoga for the well-being of psychotherapist, both personally and professionally. They claimed that yoga encourages self-awareness and reduces burnout. It was difficult to sort out my priorities at the time. "I'm spinning in circle, I feel dizzy, I'm afraid to fall in the hole" I wrote of a dream one morning. Later that day, I drew the image and I knew I needed to slow down (Figure 7). During explication I later realised that the image might actually be referring to the birthing process and the shadow. I remember thinking that if I did not do it for myself; I had to do it for my baby. I was startled by this affirmation as if I was not important enough to be on the front burner. I absolutely needed to care for myself first before attending to others. Was the hole referring to the birthing process? My unconscious was letting me know through my dreams of the importance of taking care of myself.

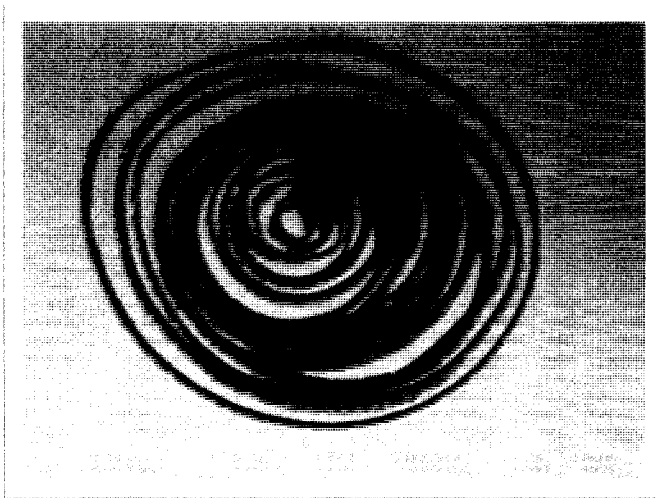


Figure 7. The hole.

Container - My first intention was to draw only mandalas but in keeping with the receptivity required by the heuristic process, I remained open to all possible drawings (Figure 8). Nonetheless the circle was a recurring form. My womb, my family, holding, life cycle are ideas referring to the circle. The container emerged as the overall theme as I am containing my child, my family, and my clients. I made a series of charcoal drawings in a quick motion. They are composed of spheres, circles or arcs (Figures 9 and 10). To me it is the evolving process of my different roles, my pregnancies. Much later I produced a similar painting in color, possibly a beginning of acceptance (Figure 11).

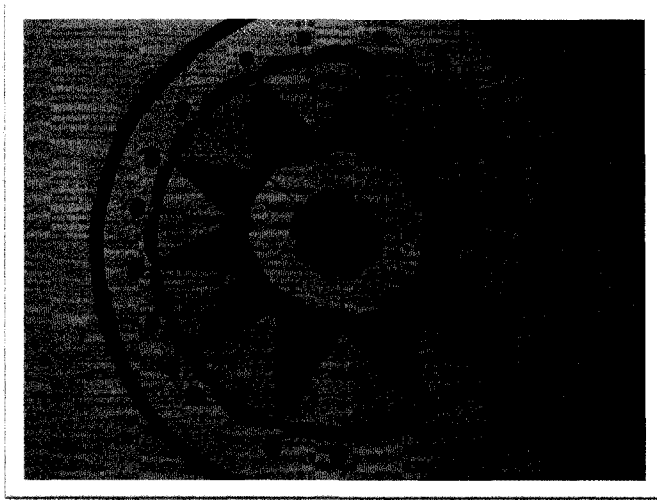


Figure 8. Mandala.

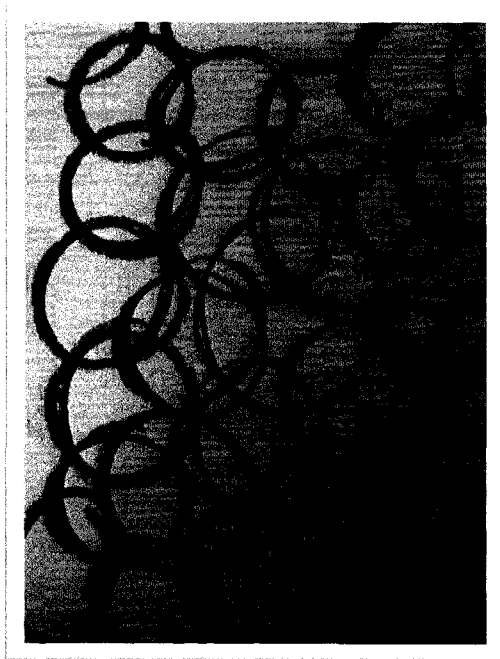


Figure 9. Charcoal 8.

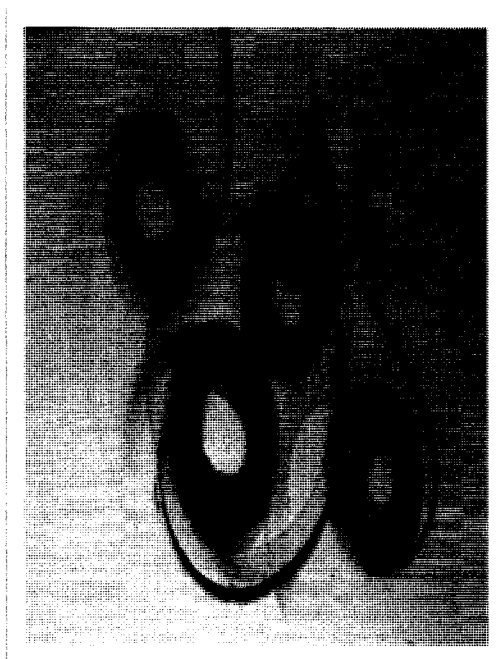


Figure 10. Charcoal 14.

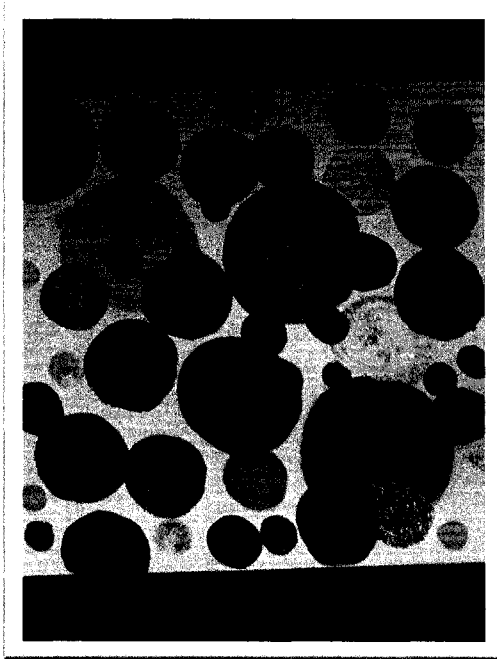


Figure 11. Stars.

Shadow - I wrote in my journal my newly discovered countertransference as well as issues I knew to be carrying and working on. For example, one day I drew a flower inside a mandala and I remembered that I used to draw flowers like that as a child (Figure 12). From there I tried to understanding how the children felt, staying in the hospital for months for an invisible illness. I wrote in my journal:

Je dessinais ce genre de fleur quand j'avais huit ans. Des fois j'essaie de me rappeler ce que c'était d'avoir huit ans. Comment je me sentirais si c'était moi, ici, pendant trois mois? Comment qu'on se sent à huit ans dans un hôpital avec des problèmes qu'on ne comprend pas trop bien? Le sentiment d'abandon doit être intolérable.

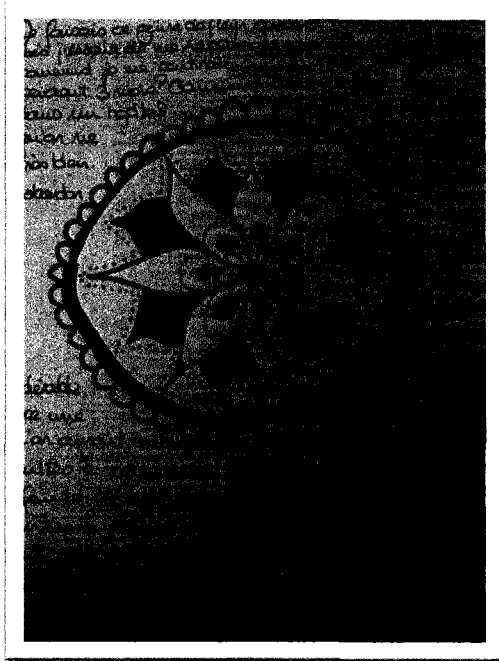


Figure 12. Childhood flower in mandala.

I named the feeling of abandonment although none of the children have ever made reference to it in my presence. Surely I spoke for myself here, my own guilt of abandoning my children at the daycare as if abandonment represented the shadow of being contained, held. Shadow was the resulting theme in return for the container.

When I encountered resistance in the writing of this paper as mentioned in the “stuck” section, I remembered something important to which I had not made reference to. I considered this incident as part of the shadow theme also. For the 9 months of my pregnancy I needed to make an important decision regarding the delivery of this baby. After a first cesarian I really wanted to experience a natural delivery. I believed it to be the epitome of the *good-enough-mother* and I wanted to mend the feeling of dissatisfaction I experienced with my first delivery. To accomplish this dual goal I had to

sign a waiver understanding the risk of ongoing a natural delivery after having had a cesarian. The dilemma was excruciating; my desire as a mother against the safety of my unborn child. I waited until the last weeks when my doctor told me the same conditions were present in this pregnancy as with my first child. I opted for a cesarian and verbalised my hopes of meeting my baby in the same manner as a vaginal delivery. And the experience proved to be fantastic, I knew what to expect and I was prepared and comfortable with my decision. I saw my little boy right away and he was at my breast within minutes. Of course I know I am a good mother, having taken the right decision for the health of my baby and surely mine, but I still hoped. No, I did not hope because I will not have more children but I must admit that I would have liked to live the experience naturally. This decision taking danced around my head, like a shadow, for the duration of this research and the heuristic process.

Another fact unconsciously omitted is my miscarriage in early 2006. Although it happened early in the pregnancy, the pain for my husband and I was very palpable. I surmounted it by journaling and drawing but there was always a residue of pain, the grief was undetected. My second child put a balm on it but I now understood its presence in this *shadow*. I was certainly grateful for Laura Seftel's book (2006) *Grief Unseen: Healing pregnancy loss through the arts*. She starts with the caution for women to give themselves permission to grieve. Whether 6 weeks or 6 months pregnant, the loss needs grieving.

Torn - was the final encompassing theme derived from *guilt* and *ambivalence*. *Torn* was my *internal frame of reference*. It actually represented the pivotal point of this research regarding my roles as a mother and as an art therapist. I was ambivalent about a situation,

mostly because I felt guilty if I bent in one direction at the cost of the other, I was torn. For example, I needed to start weaning my baby so a babysitter could watch him while I wrote this paper. He refused all forms of container. I felt guilty for removing one breastfeeding a day. I was torn between satisfying my baby's needs and the requirements of my paper. The day I made the decision that the transition was necessary and healthy for him as well as for me, it was an opportunity to slowly let go of the symbiotic relationship, my baby took the bottle on that day. For a long time I was torn between taking care of my daughter at home and pursuing my studies. That one was resolved once I decided that my dreams were important and that I served as a role model for my daughter. Once I took a stand and moved out of the unbalanced scale, I stopped being torn but it seemed to have been my course of action. Green kibel (2001), a mother and child therapist recalls an instance of strong countertransference when she spoke sharply to a young girl in therapy. Green Kible states:

What sort of spiritual position can allow one to tolerate being the hated, untrustworthy mother? (...) It requires acceptance of playing one part in a larger whole, of facing up to one's own destructive impulses, and of letting go of taking the rejection personally. It takes a renunciation of the impulse to judge myself. It takes a sense of proportion and balance. (p. 91)

Creating the Creative Synthesis

The creative synthesis is the last phase of Moustakas' (1990, p. 32) heuristic inquiry and I have only completed it as I wrote this section because I was stuck and like Moustakas says: "knowledge of the data and a period of solitude and meditation focusing on the topic and question are the essential preparatory steps for the inspiration that

eventually enables a creative synthesis". I experienced the heuristic process as a whole but I dissected it into three levels: the phenomenon inquired (motherhood and therapist), its data and my pregnancy. The empowerment granted through this phase was phenomenal, yet disturbing. The synthesis in a visual form permitted greater absorption of the many ramifications. A mini phase of incubation was lived here for the time needed inward.

The occasion finally provided itself for the exteriority of the internal image. I with my baby in arms, at the breast, my daughter at my side gaining autonomy and the inner white space representing the foetus who chose otherwise (Figure 13). In exteriorising this image I granted myself the opportunity to grieve and to dwell into the powers I have been given as a woman. Wealthy, extremely rich is how I now felt.

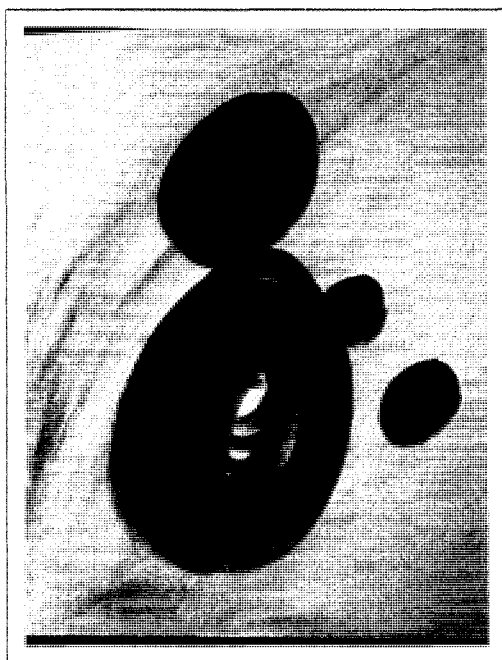


Figure 13. Woman.

Unsurprisingly I then painted a formation of six circles (Figure 14). This form has been present throughout my research, whether in the organisation of the data, in the mandalas or in the cycle of life. Each disc held a theme and a color. During the process I laboured on the emphasis of a border, the black rings contained and limited the forms. It seemed important to honour the emerging themes full of the essence of my journey. For a moment I was compelled to include them all in a big sphere as if absorbed in one unit. But, no, these were parts of me, just like motherhood and therapist are parts of who I am and I did not feel the need to agglomerate everything in a puree. Understanding their presence and the ability to recognise them as countertransference in future situations is the key to becoming an art therapist. The realisation provided me with a sense of peace and a greater understanding of my power for happiness.

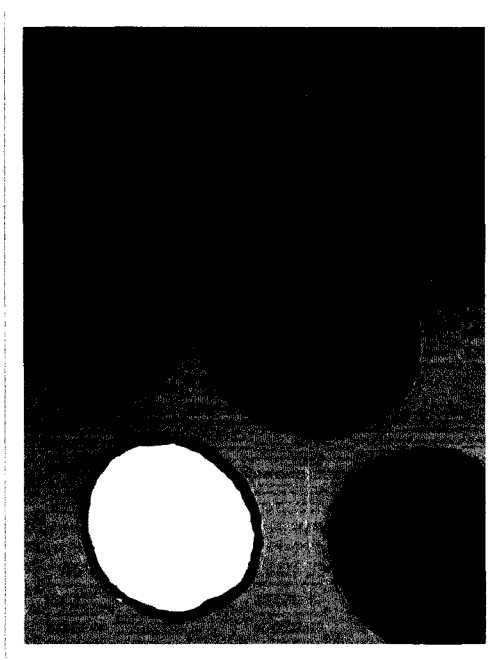


Figure 14. Bubble gums.

The sight of my four year old smiling daughter hugging her baby brother with pride while my husband and I held hands and absorbed the miracles of love was the ultimate creative synthesis. Powerful! There is no more need to be torn between my roles, I know in my heart to be offering the best of me to the ones I love. My space is filled with love, satisfaction and the power to take a stand, guilt has been dismissed from my life. It certainly will not be part of the heritage I will leave for my children.

Informant

An informant is a person that has had a similar experience as the one the researcher is exploring and is willing to share her understanding of the issue. I had asked a nurse's participation in April of 2007 when I was working as an intern on the psychiatric ward for children. She accepted and kept her promise of contributing to my work. We met once for her signatures on the consent forms and another time for our exchange based on an interview informal questionnaire which was recorded. She also agreed to answer questions over the phone when the situation required her to. Finally I solicited her feedback when I showed her what was written about her. Dialoguing with an informant increased validity.

The nurse has been working on the psychiatric ward for two years now where the stability of the nursing staff is precarious, especially in the evenings. These constant changes added to the stress and to the workload as she was required to train a new nurse on a regular basis. Prior to this post she garnered nine years of experience in the

emergency unit. She is affianced and does not have children. Very little information was provided on her to protect her anonymity.

In a café we talked about the hospital and the changes since I terminated practicum and I inquired about her well-being. My aim was to put her at ease. She confided her hopes of conceiving in the near future as well as her disappointment that it has not happened yet. The questionnaire only served as a guide; I was following the conversation and letting her have the podium. I shared with her some of my feelings experienced on the ward; she concurred and added her take on it. Jourard (as cited in Moustakas, 1990, p. 47) "has shown that self-disclosure elicits self-disclosure". The nurse defines countertransference as: "*Les sentiments que je ressens en réponse à un enfant*". She described a recent experience of countertransference with a boy presenting an attachment issue. Her difficulty emerged from her role capacity. She wanted to establish a healthy pattern of attachment with the boy but he oscillated between rejection and closeness. The nurse described her fear for the child when the time would come for him to leave the hospital, if she obliged his demands the rupture would be more difficult for him, yet she also believed that a healthy attachment, even if ephemeral, could be beneficial. "*C'est pas moi sa mère, au niveau thérapeutique, y'a un malaise*" she says. Acknowledging countertransference and talking about it, is what she considered the most helpful. She said since her arrival in that department her mind never stopped working, self-talk continued on at home, she could not escape it. We exchanged on our rapport with the parents and I divulged my experience with a mother with whom I felt a surge of negative emotions. The nurse believed that her hopes of bearing a child changed her way of addressing certain situations with the patients. She felt the need to be reassured in her

actions, as if her maternal capacity in her professional role was affected by her physical difficulty to procreate. There was a sense of unfairness, she would care for her baby; she would provide what was required, she exclaimed. When asked if she meant that she would do everything to protect her baby from mental illness she acquiesced. She said she needed to be reassured a lot more since her desire for motherhood. We also discussed discipline and we agreed on the artificiality of the milieu, the problems with division between the shifts. She relayed trying to adapt her intervention plan according to the child's needs and her capacity to ensure the child will respect them, all within the requirements of the departments. Nevertheless she expressed her uneasiness and her quavering self-assurance. Finally on the topic of therapeutic alliance, she alleged the facility of bonding with the child when the contact with the parents has been successful and rewarding. In this example, she empathized with the mother, talking about the difficulties she must have encountered when being rejected by her son in this manner.

I concluded that the nurse and I have experienced similarities within countertransference in regards to the therapeutic alliance, the holding environment and the quest for motherhood. Following are some of the exposed parallels.

The relationship between parents and nurse depended on the positive or negative countertransference and this influenced the quality of the therapeutic alliance with the child. Kabuth, De Tychev, and Vidailhet (2005) studied for the first time the therapeutic alliance between therapists and the parents of their patients. The association proved to be beneficial to the overall experience of hospitalisation but not specifically to the reduction of symptomatology. In the first half of practicum I met parents only during the deposition of the final reports, in the second half I met them at admission as well as at departure. I

noticed a big difference when I encountered parents from the onset and initially I preferred not to be tainted by this encounter. I needed to learn to bypass my countertransference, my judgements and my opinions, in the hopes of offering a blank screen to the child.

The hospital erected very strict guidelines to ensure safety and order for the staff and the patients. The environment dictated plain rules and discipline was well enforced. The child learned quickly within the limits and gained a sense of security conducive to appropriate behaviours. The nurse maintained the need to adapt these rules to the child's problematic and to lessen separation between shifts. Mainly she expressed her difficulty in enforcing this discipline when she did not foresee the benefits for the child. I also experienced difficulty applying these rules within the art therapy frame. For example when an eight-year old boy started to scream and demonstrated aggressiveness during an art therapy session, I encouraged him to rip and tear recycled paper. The structured chaos attracted the staff wanting to make sure everything was under control and they pressed me for explanation after the session. The boy had been drawing monsters as self-portraits and he claimed to be a bad boy. With this intervention I successfully demonstrated to him my unconditional acceptance of who he was. Of course other children heard of this event and the staffs reported heightened manifestations of unruly behaviours within the next day. At the immediate moment I needed to take sides and I leaned toward the therapeutic benefits of one child over the extra workload of my coworkers, a sometimes difficult stance to uphold.

The nurse noticed a change in her behaviour since trying to conceive a child. She acknowledged needing reassurance in her role as a nurse regarding her therapeutic

actions with the boy presenting an attachment syndrome. As if her trouble with fecundity affected her self-assurance as a mother and as a nurse. This analogy was what prompted my research in the first place, wondering whether my roles as therapist and mother influenced one another.

Conclusion

Statement of Findings

This research paper has been an inquiry into my quest to explore the interface between motherhood and art therapist. The heuristic approach brought forward an honest, personal, mature and passionate contribution of a pregnant mother's pursuit for truth based on her internal frame of reference explored within the context of a psychiatric setting with children.

The collection of data took the forms of case notes, journaling, dreams, drawings, supervision and word-thoughts. Its organisation and distilled analysis permitted the emergence of six themes holding the essence of meaning. Their depiction shed light on the primary question meant to elucidate my experience of countertransference issues as a mother and an art therapist in a therapeutic alliance with children. As well as the secondary question concerning the possible impact of my pregnancy on this experience. These themes are: consciousness, birth, unconscious, container, shadow and torn. Consciousness brought to the surface my concerns with demonstration of affections and countertransference towards the parents of the children, especially the mothers. It led to next theme of birth, invariably connected to my pregnancies and my wounded inner child. The unconscious theme rang the alarm to care for myself and to apply what I

already did for others, which was the fourth theme: container. Containing my clients, the baby in my womb, and my daughter comprised the foundations of art therapy and motherhood. My unresolved grief from miscarrying and the difficulties accepting the circumstances of my deliveries have been unearthed by the shadow. Although seemingly negative, the shadow was powerful; its projection into the consciousness carried the promise of healing. Finally torn was the underlying theme that served like a foundation propelling the other subject matter. Removing guilt from my life, taking action, caring for myself, accepting the outcome of my children's birth and relinquishing to the happiness emanating from their presence in my life represented the concrete work needing to be done. Pregnancy did more than impact the experience of countertransference, it served as a springboard for unresolved issues surrounding the passage to motherhood.

This journey of the art therapist's use of the Self has proven to be difficult but rewarding and enlightening. The creative synthesis representing the last phase of Moustakas' (1990) heuristic process provided the opportunity to assemble and comprehend the phenomenons explored.

Theoretical Liaison

Winnicott (1971) used the terminology *good-enough-mother* from the child's point of view and not from the mother's perspective. He claimed that mothers either can provide the necessary elements for the development of the child's ego, or mothers cannot. I believe the implications of being a good enough mother took roots in Winnicott's theory but the ramifications far exceeded his expectations. Women struggled with their roles and within their roles. Art therapists may very well play the role of the good-enough-mother with their clients without being mothers themselves. But the art therapist who has faced

motherhood and its realms of self-doubt should first, clear the stage before playing this very important role introduced by Winnicott.

Bowlby's (1988) internal working model can be reworked in therapy if needed. Within the secure base (holding or container) provided by the therapist and an empathic ear, together, the therapist and client can reset a relationship pattern. This relationship was construed by the patient's history but also by the therapist's contribution. The contribution to the relationship was based in some way on what the therapist experienced in her childhood. Emphasizing once more the need for awareness of her own countertransference, the therapist must know what she brought to the therapeutic relationship, surprises may disrupt the alliance. Colman and Colman (as cited in Maat and Vandersyde, 1995) strongly believed that accepting one's pregnancy and implications was directly proportional to the effectiveness of dealing with transference and countertransference issues. Indeed, this research inquiry will concretely serve me as an art therapist and as a mother who has finally shed the weight of her pregnancies, metaphorically and literally.

Value to My Career

Knowing more about my countertransferential issues and having dealt with them freed the therapeutic potential. Understanding that life changing events like pregnancies or less joyful circumstances, transformed the art therapist and required introspection to better decipher the changes, added value to my Self confidence. I will surely recognise future life changing events and expect new countertransference. During this heuristic process of almost two years I often entertained the desire to quit. This was how difficult it felt at times. It made me realize and better understand the challenges we ask of our clients

and I hope to accompany them to prevail. This new knowledge may help me spot early clinical drop-outs.

Outcome of Assumptions, Limitations, Delimitations

Assuming that both roles influenced one another has proven to be accurate; I cannot separate the mother from the art therapist although I understand the position required by each role. The interface between mother and good enough mother may be transposed on the interface between motherhood and art therapist. Being pregnant certainly added qualities to the depth of this inquiry. The assumption that good mothers give birth naturally has proven to be a significant underlying current.

Although limited to my own interpretation of meaning from the emerging themes, I believe they yield collective resonance, and other woman in the same context may recognise themselves. The delimitation of brief therapy was valuable because it provided a large spectrum of children creating many instances for countertransference to surface. Although brief, therapeutic alliance was possible and laid the grounds for countertransference.

Recommendations

I recommend heuristic inquiry to art therapist in training. The assiduity, honesty and introspection required for the completion of the process carries transferability into the therapeutic work with clients. I press the importance for art therapists to speak of their experience of life changing events for the benefit of the community and to dispute the prejudices that therapist cannot help others if themselves experience problems. It is not *if* they experience problems that counts but *how* they experience and resolve them while

protecting the therapeutic potential. Further studies are needed on how art therapists resolve countertransference issues when in therapeutic relation with a population which presents problematic personal material already experienced by the art therapist. This could be a descriptive quantitative research. A protocol of open ended questions could be tallied by researchers looking into the art therapists' choice of coping mechanisms in the presence of countertransferential material. The data could consist of a list of triggers of countertransference, the different coping strategies as well as the possible analogies between the population and the art therapists' personal situation. The results would help art therapists tap into potentially disturbing countertransference by raising their awareness and knowledge of coping strategies within a particular situation.

Most of my countertransference concerned motherly issues, heightened by my state of pregnancy. Allotting specific time to review countertransference in drawings or journaling provided an outlet and comfort from an otherwise turbulent art therapy session. I agree with Linesch's (1995) study on art therapy research when she concludes that art therapists consider research to be a personal process oriented venture that needs more studies to overcome resistance and enrich the field of art therapy.

I turn the page on this wonderful journey and shall continue to embody the good-enough-mother in therapy and to be the best good mother as can be to my children.

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Appendix A

Formulaire de Consentement

Pour la participation à la recherche menée par Nathalie-Monika Moore

Étudiante à la maîtrise en art-thérapie du département de Thérapie par les arts à l'Université

Concordia

J'accepte de participer au travail de recherche effectué par Nathalie-Monika Moore, étudiante au programme de maîtrise en art-thérapie, au département de Thérapies par les arts de l'Université Concordia. Je comprends que le but de cette recherche est l'exploration du contretransfert de l'art thérapeute. J'ai reçu et lu le document « Information relative au consentement ».

Je donne à la chercheuse la permission de photographier et utiliser le matériel produit au cours des rencontres individuelles et de groupe d'art thérapie. Les photographies des œuvres seront publiées dans un travail de recherche réalisé en vue de l'obtention du diplôme de maîtrise en art-thérapie. Le travail de recherche sera conservé à la bibliothèque de l'Université Concordia ainsi qu'au centre de documentation du département des Thérapies par les arts. Je comprends que les informations recueillies sont confidentielles et que mon nom ne sera pas dévoilé.

J'accepte de participer aux rencontres ci-haut mentionnées. Je sais que ma participation est volontaire, que je peux cesser de participer à n'importe quel moment, sans que cela me nuise ou me porte préjudice.

Nom du participant : _____

Nom du parent : _____

Signature du parent : _____

Date : _____

Appendix B

Information relative au consentement

Pour la participation à la recherche menée par Nathalie-Monika Moore

Étudiante à la maîtrise en art-thérapie du département de Thérapie par les arts à l'Université Concordia

Projet : Le contretransfert de l'art thérapeute et de la mère

Chercheuse : Nathalie-Monika Moore

Superviseure : Madame Louise Lacroix, MA, art thérapeute

Nature et objectifs de l'étude

L'Étude pour laquelle je demande votre participation servira à un travail de recherche en vue de l'obtention du diplôme de maîtrise en art-thérapie au département de Thérapies par les Arts de l'Université Concordia. Cette recherche permettra d'analyser le contre-transfert de la chercheuse en tant que mère et art thérapeute avec des clients enfants. Je définie le contre-transfert en tant que sentiments ressenties par l'art thérapeute lors des sessions d'art thérapie.

Déroulement de l'étude

Le projet s'étendra sur la durée du stage, soit de septembre 2006 à mars 2007.

Risque, effets secondaires et désagréments

La présente recherche ne comporte aucun risque. Dans le cadre du stage, la chercheuse est supervisée par une neuro-psychologue de l'établissement ainsi que par un professeur en art-thérapie de l'Université Concordia.

Confidentialité

Tous les renseignements fournis sur votre enfant au cours de l'étude demeureront strictement confidentiels. Aucune publication ou communication scientifique résultant de cette étude ne renfermera quoi que ce soit permettant de l'identifier. Son nom ne sera pas dévoilé, ainsi que toute autre information géographique ou situationnelle pouvant révéler son identité.

Participation volontaire et retrait de l'étude

La participation de votre enfant demeure volontaire. Vous pourrez le retirez des sessions d'art thérapies ou annuler votre consentement à tout moment d'ici la fin de la recherche. Vous n'aurez aucune conséquence sur les services offerts.

Personne à contacter

Si vous avez des questions ou pour de plus amples informations concernant vos droits en tant que participant à une recherche, il est possible de contacter Adela Reid, au bureau de recherche :

Adela Reid, Compliance Officer
Office of Research, GM-1000, Université Concordia
514-848-7481

Appendix C

Formulaire de Consentement - Informatrice

Pour la participation à la recherche menée par Nathalie-Monika Moore

Étudiante à la maîtrise en art-thérapie du département de Thérapie par les arts à l'Université Concordia

J'accepte de participer au travail de recherche effectué par Nathalie-Monika Moore, étudiante au programme de maîtrise en art-thérapie, au département de Thérapies par les arts de l'Université Concordia. Je comprends que le but de cette recherche est l'exploration du contretransfert de l'art thérapeute et que j'agirai en tant qu'informatrice. J'ai reçu et lu le document « Information relative au consentement ».

Je donne à la chercheuse la permission de photographier, d'enregistrer et d'utiliser le matériel produit au cours de nos rencontres individuelles. Il est possible que mes commentaires s'inscrivent sous forme de verbatim dans le travail final de la chercheuse. Les photographies des œuvres seront publiées dans un travail de recherche réalisé en vue de l'obtention du diplôme de maîtrise en art-thérapie. Le travail de recherche sera conservé à la bibliothèque de l'Université Concordia ainsi qu'au centre de documentation du département des Thérapies par les arts. Je comprends que les informations recueillies sont confidentielles et que mon nom ne sera pas dévoilé.

J'accepte de participer aux rencontres ci-haut mentionnées. Je sais que ma participation est volontaire, que je peux cesser de participer à n'importe quel moment, sans que cela me nuise ou me porte préjudice.

Nom du participant : _____

Signature du participant : _____

Date : _____

Appendix D

Information Relative au Consentement de l'Informatrice

Pour la participation à la recherche menée par Nathalie-Monika Moore

Étudiante à la maîtrise en art-thérapie du département de Thérapie par les arts à l'Université Concordia

Projet : Le contretransfert de l'art thérapeute et de la mère

Chercheuse : Nathalie-Monika Moore

Superviseure : Madame Louise Lacroix, MA, art thérapeute

Nature et objectifs de l'étude

L'Étude pour laquelle je demande votre participation servira à un travail de recherche en vue de l'obtention du diplôme de maîtrise en art-thérapie au département de Thérapies par les Arts de l'Université Concordia. Cette recherche permettra d'analyser le contre-transfert de la chercheuse en tant que mère et art thérapeute avec des clients enfants. Je définie le contre-transfert en tant que sentiments ressenties par l'art thérapeute lors des sessions d'art thérapie. En tant qu'informatrice j'échangerai avec vous sous forme de dialogue ouvert vos sentiments par rapport à des thèmes précis dans le but d'ajouter de la validité à ma recherche.

Déroulement de l'étude

Le projet portera sur la durée du stage, soit de septembre 2006 à mars 2007 et votre participation s'échelonnera jusqu'à la rédaction du travail de recherche en mars 2008 .

Risque, effets secondaires et désagréments

La présente recherche ne comporte aucun risque. Dans le cadre du stage, la chercheuse est supervisée par une neuro-psychologue de l'établissement ainsi que par un professeur en art-thérapie de l'Université Concordia.

Confidentialité

Tous les renseignements fournis à votre sujet au cours de l'étude demeureront strictement confidentiels. Aucune publication ou communication scientifique résultant de cette étude ne renfermera quoi que ce soit permettant de vous identifier. Votre nom ne sera pas dévoilé, ainsi que toute autre information géographique ou situationnelle pouvant révéler votre identité. Je référerai, dans ma recherche, à vos commentaires en tant qu'infirmière sans plus.

Participation volontaire et retrait de l'étude

Votre participation demeure volontaire. Vous pourrez refuser de dialoguer ou d'annuler votre consentement à tout moment d'ici la fin de la recherche. Il n'en découlera aucune conséquence.

Personne à contacter

Si vous avez des questions ou pour de plus amples informations concernant vos droits en tant que participant à une recherche, il est possible de contacter Adela Reid, au bureau de recherche :

Adela Reid, Compliance Officer
Office of Research, GM-1000, Université Concordia
514-848-7481

Appendix E

Entrevue Avec Infirmière

J'étudie mon expérience de contre-transfert en tant que mère et art thérapeute dans des situations thérapeutiques avec des enfants.

Une étude heuristique est un compte rendu unique et essentiel du sens même de la personne qui vit l'expérience.

- Qu'est-ce que tu entends par « contre-transfert » (CT)?
- As-tu un exemple qui te vient en tête d'une expérience de CT que tu as vécue?
- Tu vis ça par rapport à qui?
- Quelles émotions ou pensées ressens-tu dans ces moments là?
- As-tu des manifestations physiologiques?
- À quoi sert le CT pour toi?
- Tu fais quoi avec?
- Ton travail te permet-il de vivre et d'assimiler l'expérience de CT?
- Peux-tu identifier des situations qui provoquent du CT chez toi?
- Est-ce que devenir mère va changer quelque chose à ton CT?
- Qu'est-ce que tu penses de la discipline dans le milieu?