An Arts-Based Exploration of

Practitioner Vulnerability and the Role of Self-Love in Self-Care Practices

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Abstract

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Therapists and practitioners working in healthcare are often witnesses to the stories, traumas, and imagery of their patients and clients. The role of the professional caregiver requires not only training and skill, but also empathy and compassion. Often, the professional caregiver takes on the function of a container for the stories, images, and traumas of their patients and clients. Therefore, there is a risk of experiencing compassion fatigue, vicarious trauma, and burnout, if proper awareness and precautions are not in place. Art therapists working in medical environments experience the unique relationships that form between professional caregivers and pediatric oncology patients, due, in part, to the nature of the illness and treatment. A particular intensity may develop from being present for many intimate moments in the patients' lives. This paper explores the role of practitioner vulnerability and self-care practices with seven pediatric oncology professionals. Arts-based methods were employed to collect and analyze narrative interviews that informed the final art pieces. The purpose of the resulting essay and creative portfolio video is to support interested professional caregivers in connecting their vulnerability as practitioners with the role of self-love in their self-care practices.

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Dedication

This research project is dedicated to the many children and families affected by childhood cancer who have welcomed me into their lives and into their hearts, and the many practitioners who share my passion and dedication to the field of pediatric oncology. It is an honor and a privilege to journey with you. You inspire me and motivate me with your strength, wisdom, courage, and resiliency. This is the work of love.

Table of Contents

List of Figures

Introduction

The purpose of this arts-based project was to explore the phenomenon of practitioner vulnerability within pediatric oncology, in order to identify the role of self-love in self-care practices. The operational definition of self-love for this research is the offering of empathy, care, compassion, and love to the self. "Self-care" refers to tending to and caring for one's own physical, emotional, mental, and spiritual wellbeing in order to strengthen resiliency and be able to function in the role of professional caregiver. Though the two concepts may appear to be synonymous, I believe that, while self-love may be a component of self-care practices, self-care practices can exist without an element of self-love. Through the arts-based exploration of the particular qualities within the caregiver-patient relationship, my purpose was to explore the experience of practitioner vulnerability and illuminate the role of self-love in self-care practices.

The focus of this study is situated in pediatric oncology for three reasons: first, current literature supports a particularly intense level of care provided in pediatric healthcare; second, as a practicing art therapist, I am familiar with the language and level of care expected in oncology care; and third, I am familiar with the intensity of the long-term relationships that form between professional caregivers and patients. In the context of this project, a professional caregiver includes any pediatric oncology professional who provides care to a patient. A professional caregiver may be a nurse, physician, child life specialist, social worker, art therapist, physical therapist, or other clinical or non-clinical health care professional.

I suggest that there is a dialectic that develops within the therapeutic relationship: (a) enhanced resiliency in maintaining the intense levels of care, and (b) the increased possibility of developing phenomena such as compassion fatigue, vicarious trauma, and burnout. I propose that the use of arts-based self-care practices provides a space for professional caregivers to honor relationships, acknowledge the level of care provided, and tend to their own selves through creative arts expressions (e.g., visual art, creative writing, music and movement).

This study implemented arts-based research methods to collect and analyze data. Arts-based research was defined by McNiff (1998) as a "method of inquiry [that] uses the elements of the creative art therapy experience, including the making of art by the researcher, as ways to understand the significance of what we do within our practice" (p. 13). Artworks provided a means of examining the role of vulnerability within the unique pediatric oncology relationship. As Allen (1995) noted, "art is a way of knowing" and connecting to the soul, and enables the researcher to connect with intuitive natures within the human experience (p. ix). According to Kapitan (2010), "artistic expression as a form of inquiry provides a medium for connecting to the self, while at the same time distances the self in order to see something from a new perspective" (p. 164). My rationale for utilizing an arts-based methodology was to explore the qualitative phenomena of the dynamics I and other caregivers experience within our therapeutic relationships with patients. Arts-based research enables the researcher to remain rooted in art making as a source of inquiry and sharing, and to remain connected to the core practices of the field of art therapy.

As an art therapist working in the field of medical art therapy, specifically pediatric oncology, it became evident to me from personal experience and observation of other oncology professionals, that intense relationships often form between caregiver and patient, due to the longevity of the relationship and the intense impact of the shared experiences surrounding illness and premature death. It is within this context that connection is formed and vulnerability increases [is risked on the part of] for both patient and caregiver. Exploration of the qualities that contribute to the unique relationship between oncology patients and healthcare professionals could contribute to a deeper understanding of the practitioner's vulnerability in the therapeutic relationship. The implication is that there is a need for self-care practices for practitioners, and also, that more effective approaches to self-care practices are required.

Based upon my experience in the field, I believe that the practitioner must offer back to the self similar qualities to those he or she offers to the patient (e.g., empathy, compassion, and love) in order to sustain the role of a caring practitioner. "Clinicians have a responsibility not only to their clients but also to themselves, their work colleagues, their respective professions, and their family and friends not to be adversely affected by their work" (Rohan, 2009, p. 5). For practitioners who work intensely with oncology patients, particularly children, self-love may be one of the key elements that assists helping practitioners in coping with compassion fatigue, vicarious trauma, and burnout.

This research is relevant to the field of art therapy and psychosocial oncology professionals who seek to better understand the dynamics of the relationships between oncology patient and healthcare professional in relation to self-care practices. Although

this research is situated in oncology, these premises are relevant to art therapy in general. Through the added element of art making in the therapeutic relationship, art therapists often enter a vulnerable space of creating with, being with, and witnessing the stories and art images of clients. This research may serve to support the integration of art therapy services in the work environment, as self-care practices for healthcare practitioners, thus further expanding the career opportunities for practicing art therapists.

Art therapists use a variety of creative modalities as self-care practices. The practice of using art for self-care or for processing clinical experiences is not a new one. Moon (1999), Wadeson (2003), Miller (2007), and Fish (2008) described the use of response art as a way to honor, remember, and make sense of experiences with clients.

I propose that professional caregivers who maintain self-care practices incorporate elements of self-love into their self-care practices. My intention was to implement art therapy as a self-care modality for healthcare professionals in the field of oncology to explore and honor their unique relationships. My purpose was to illuminate the experience of vulnerability and the relationship that develops through the intense shared experiences, in order to help practitioners understand the importance of establishing and maintaining self-care practices.

Purpose and Hypothesis

The broad aim of this research is to support the importance of self-care practices for oncology professionals who are at high emotional risk because of their willingness to be vulnerable within intense therapeutic relationships with oncology patients. It is my belief that, through exploring the qualities that contribute to the caregiver-patient relationship, the phenomenon of practitioner vulnerability will be exposed. The use of

the creative arts and narratives to honor and express the experience of practitioner vulnerability may in turn illuminate the element of (or need for) self-love in self-care practices. Consequently, when practitioners are able to acknowledge the need to care for and tend to the self similarly to the way in which they care for their patients, self-care practices will be sustained and maintained.

Research Questions

My project explored the following questions:

1. What are the unique qualities within the therapeutic relationship that contribute to the intensity of the experience of the oncology caregiver?

2. How does vulnerability contribute to the practitioner's experience within the therapeutic relationship?

3. How do expressive arts interventions in the context of self-care illuminate the role of self-love as an element of self-care for professional caregivers?

Relevance to Practice

Pediatric oncology practitioners provide care not only to the child diagnosed with cancer, but to the child's family and support system as well. Psychosocial support and medical intervention is provided by multidisciplinary teams made up of physicians, nurses, nurse practitioners, child life specialists, therapists, social workers, and chaplains, throughout the course of the child's treatment and years beyond. Due to the nature of oncology care, practitioners are witnesses to the child's experience of pain, loss, disfigurement, and death, as well as experiences of courage, strength, resiliency, and triumph. These experiences enable the relationship between oncology practitioner and patient to form both quickly and intensely. Longevity in the field exposes the practitioner

to numerous relationships and experiences of pain, medical trauma, and loss, which can result in the practitioner experiencing compassion fatigue, vicarious trauma, and burnout.

Workshops and seminars are often provided to educate healthcare practitioners about the signs and symptoms of these care-giving phenomena and the importance of self-care practices. The challenge I have witnessed for myself and other healthcare practitioners is how to maintain and sustain self-care practices. As healthcare practitioners, there are few places we can openly share our stories and experiences, due to the need to both uphold the confidentiality of the patient, as well as the risk of exposing others to the sensitive nature of the experiences we have had (death of young children, witnessing painful medical procedures, and supporting children through relapse or amputation). The use of the creative arts for self-care practices offers opportunities for healthcare practitioners to translate these intimate cancer experiences of pain, loss, death, love, and hope into visual images that can be witnessed, remembered, and honored, with or without the use of verbal language. The art making process and resulting product can serve as vehicles for practitioner healing, and an offering of self-love within the self-care practices of making art.

Chapter 2

Contextual Exposition/Literature Review

The following literature review is intended to situate the content areas of the research questions in current art therapy and oncology professional literature. The literature review supports the use of art therapy as a modality of self-care for health care professionals, as well as the importance of self-care practices as a way to minimize the experience of phenomena such as compassion fatigue, vicarious trauma, and burnout. This literature review will critique current research related to (a) elements within the therapeutic relationship (empathy, love, and compassion); (b) existential qualities within oncology care; (c) witnessing trauma; (d) the role of the therapist as a container; (e) self-awareness and the wounded healer; (f) the phenomena of compassion fatigue, vicarious trauma, and burnout; and (g) self-care in relation to art therapy and oncology.

Elements of Intensity within the Therapeutic Relationship

The therapeutic relationship is an essential component of the experience between caregiver and patient. Stickley and Freshwater (2002) suggested that the therapeutic relationship is a central feature of many health-related disciplines, which includes other medical caregivers, such as nurses, physicians, and various assistants. While the nature of their work may be to provide medical intervention or delivery of services, the relationships that form within the caring, empathic, and compassionate nature of tending to another can be considered a kind of therapeutic relationship as well.

Pediatric oncology practitioners work with the youngest of patients, from newborns through late adolescence. Those caring for pediatric and adolescent patients

often work from a family-centered model in which the whole family is cared for, not just the child. Pediatric healthcare professionals recognize that siblings and parents have important roles in the development and wellbeing of the pediatric patient. In oncology, these caregiving relationships between practitioner and patient can last from months to many years, depending on the prognosis and course of treatment.

Practitioners working with hospitalized children often witness intimate moments in the child's life, both of celebration (developmental milestones, birthdays, graduations, treatment successes) and of devastation (diagnosis, relapse, amputation, death). If a child survives the cancer experience, healthcare practitioners will follow him or her for many years after the end of medical treatment to monitor the risk of long term cognitive, physical, and psychological effects of the cancer treatment. These years of shared medical experiences contribute to the uniqueness and intensity of these relationships. Children and families who have frequent clinic visits and hospital admissions often view their healthcare team as extended family. The healthcare team witnesses the everyday life moments of the families who temporarily live at the hospital, whether that be for weeks, months, or in some cases, years. When a child dies, the practitioner must learn to cope with the loss of the patient while maintaining their clinical practice and the daily work of tending to other young patients.

Empathy.

Rogers (1999) found that when a client felt accepted and understood, healing began. Communicating to another that his or her emotions or experiences are accepted, witnessed, and understood, can be done through words, body language, or even artistic responses. Empathy is a like an emotional echo that enables one to put oneself into

another's place through the perception and experience of the thoughts, feelings, emotions, or beliefs of the other. Through these shared experiences or perceived experiences, connection and relationship may deepen. Empathic body language, such as leaning in toward the other person, a gentle touch on the arm, a nodding of the head, while often a natural and unconscious effort, can provide a sense of comfort or safety (Rogers, 1999).

King-West and Hass-Cohen (2008) explained the experience of an automatic contagious feeling of what someone else is feeling, or a conscious knowledge of what someone is feeling is not enough to be considered an empathic response. The therapist must be able to distinguish between the therapist's self and the client's self; otherwise, the therapist may respond with personal distress and deter attention and focus away from the client's needs. In the medical field, empathy may be an important element within the practitioner-patient relationship when providing medical treatment and care to young children. The empathic relationship will help the practitioner to address the young patient's needs and fears by attuning to the patient's emotional state. If the practitioner is unable to separate the self from the patient self, focus may shift to the practitioner's needs, and the practitioner may not be as effective in performing the procedure or administering medicine.

According to Book (1988), empathy enables the therapist to come to know or comprehend what the patient may be experiencing through the therapist's perception of communications and subtle cues from the patient. The therapist oscillates between being with the patient, thinking about the patient, and being with the patient again. This oscillation elicits an affective state within the therapist in response to his or her perception of the patient's internal state (Book, 1988). The therapist's empathic responses

and attunement can enhance the therapeutic relationship by aligning with the patient and creating a sense of compassion.

Mirror neurons in the brain have recently been discovered as a function of empathy. Mirror neurons are a type of brain cell that responds identically to someone who performs to someone who witnesses that performance of the same action. In the early 1990s, a team of Italian researchers found individual neurons in the brains of macaque monkeys that fired when the monkeys grabbed an object and also when the monkeys watched another primate grab the same object (Winerman, 2005). The discovery of mirror neurons offers evidence for a psychologically based theory of empathy.

Inter-subjectivity is a state that is induced by the sharing of subjective experiences with another person through emotional attunement (Franklin, 2010). Similarly, an artist attunes his or her subject, according to Franklin, by "empathically feeling into the phenomenological object" (p. 160). Emotions may be elicited as a result or response to sensory experiences; however, we cannot access emotions through the senses in the way we come to know the way something smells or tastes. There are ways of knowing that extend beyond what the senses communicate. Allen (1995) wrote about art as a way of knowing through the intuitive and intrinsic creative abilities within us. Perhaps the use of arts-based expression will enhance practitioners' ways of knowing their relationships with their patients through the capacity of the arts to elicit sensory and emotional experiences.

I believe empathy is a key element within the therapeutic relationship, and found myself empathic toward the interviewees as they shared emotional experiences and

stories from within their practice. In one interview, the participant's teary response to her memories elicited tears in me. My tears were genuine, from the felt sense of relating to her expression; while not specifically related to any particular experience of my own that would have shifted focus away from her as the subject of my attention. I have found empathy to be a common quality among oncology practitioners, as its practice provides connection and intimacy within the relationship between patient and practitioner.

Empathy is one way to locate and explore what is emotionally alive in visual imagery (Franklin, 2010, p. 163). Art therapists can uniquely build on inter-subjective understanding by mindfully utilizing art to receive, consolidate, and offer back expressions of deflected affect to their clients (Franklin, 2010). Franklin noted that empathic uses of art were pioneered in art therapy by Kramer and Lachman-Chapin. In addition, art therapists (Fish, 2008; Moon, 1999; Wadeson, 2003) have been using art and response art in session and post- session to make sense of, process, and honor the therapeutic relationships and content shared in session.

Franklin (2010) explored an understanding of empathic art interventions through the lenses of attachment theory, recent neuroscience research on mirror neuron systems, and mindfulness-based meditation. He found that the use of his personal art making helped him attune to the art therapy group he was working with, as well as make sense of and reflect back the emotional center of the group's communication. The group consisted of seven adolescent males diagnosed with clinical depression, who were residing on a locked inpatient unit. Over the course of five weeks, Franklin made a conscious effort to assess the core themes of the group. Once he identified the core theme, he would then locate within his own self-awareness empathic imagery that he would present in visual

form as a springboard for conversations within the group. Group members commented that they felt that Franklin understood their situations, and that the visual responses greatly helped them reflect and experience their own feelings. Franklin's example provides much to consider for facilitators who might use visual responses to connect with group members, while also deepening the dialogue and facilitating group cohesion and communication. It seems that an important element in Franklin's ability to facilitate this group utilizing empathic imagery is his own self-awareness as an art therapist, and ability to separate his experience from the client experience.

The use of art to facilitate, develop, and explore empathic relationships with patients was employed by Bruce Moon (1999) in his work with adolescents. Moon emphasized the benefits of responsive art making for art therapists, in that art making both facilitates the establishment of empathic relationships and serves as an expressive outlet for the art therapist's strong feelings that are often stimulated in the clinical context. He believed responsive art making could be a catalyst for creative interpretive dialogue with patients.

Of the benefits Moon described, the use of art as an expressive outlet for the art therapist's powerful feelings suggests a valuable use of art for other practitioners who may need an outlet for self-expression. Through my experiences working as part of a multi-disciplinary team in pediatric oncology, I have witnessed practitioners develop deep connections with their patients as a result of shared emotional and intimate experiences related to oncology care. These relationships may be difficult to articulate in words, and perhaps art can provide an opportunity for other practitioners to be able to know and honor them, through the creative and intuitive processes of art making.

I agree with Moon (1999) that, as art therapists, we cannot avoid being moved by our patients. I have experienced the deep connections that occur by being with and witnessing another person during painful, challenging, and emotional experiences of cancer treatment. As an art therapist working with young children diagnosed with cancer, I could not imagine being disconnected from my emotional self. However, it is important to manage the feelings that are stirred within, or we become at risk for phenomena such as compassion fatigue or vicarious trauma. As art therapists, we are in relationship not only with the patient, but his or her images, as well. Moon supports and advocates for the use of personal art making by the art therapist to manage intense feelings in a healthy and authentic manner.

If we, as practitioners, are willing to journey with our patients on their creative path to healing and self-awareness, then so must we journey on our own creative paths of self-healing and self-awareness. Perhaps practitioners of other disciplines must also find avenues to protect themselves from the vulnerability of caring deeply for and with their patients. The elements that contribute to a high level of care, that provide both patient and caregiver with a high level of satisfaction, are potentially the same elements that contribute to caregivers' risk of experiencing compassion fatigue, vicarious trauma, and burnout.

Love.

The challenge of defining love is that it is a phenomenon that is intangible and uniquely experienced by each individual. Weinstein (2007) wrote that, until the last decade, the role of love in psychotherapy and medical treatment has been largely ignored. "Love does, however, seem to underlie such terms as empathy, compassion, acceptance,

joining, reflecting, positive feedback, holding and containing environments, meeting maturational needs, corrective emotional experience, and so forth" (p. 304). Weinstein offered two case studies to illustrate how positive countertransference may be used therapeutically to help patients move towards healthy self-esteem, self-care, and a more benevolent and loving relatedness.

I support his belief that love is a healing force or energy that keeps us connected to life, to health, and to relationship. Perhaps love is an element that allows us to return each day to be authentically present for the next patient. Weinstein (2007) was clear in communicating that the therapist does not have the power to cure through these feelings of love or connectedness. However, this love for another human being, and the therapist's professional commitment to the relationship, may provide opportunities for the patient to say and feel everything that he or she needs to say and feel. Weinstein described love as the "backdrop for the analyst's caring and nonjudgmental attitude" (p. 304). This caring and nonjudgmental attitude facilitates openness within the therapeutic relationship that may be especially important in relationships with pediatric patients and their families, because they become dependent upon the care and trust of their medical and multidisciplinary teams.

Children who experience the diagnosis of cancer are often subjected to potentially harmful and devastating treatment options. These young patients and their families are uprooted from life as they knew it, and submerged in a new way of life that includes frequent hospital and clinic visits, medicines with complex names and upsetting side effects, such as nausea, hair loss, and weight gain or loss. They not only lose a sense of their life before cancer, they also lose a sense of independence, control, and privacy. The

caring and nonjudgmental attitude of the practitioner can elicit a sense of safety and trust as the young patient and family adapt to the cancer experience. I suggest that the expressions of love, compassion, and empathy contribute to the openness and authenticity that develops within the practitioner and patient relationship.

Adams (2006) discussed the connections between love, openness, and authenticity within relationships: "In being loved, we become more open. In being more open, we become more authentic. In being authentic, we become more loving and creative. Love, open awareness and authentic existence are intimately interrelated" (p. 10). Adams' exploration of the key qualities of psycho-spiritual health determined that these qualities of love, openness, and authenticity arise independently of each other, but also as aspects of each other, which adds to the complexity in understanding their role in relation to health and development. Adams argued that, when we love authentically, we go beyond our egocentric nature and open ourselves to the present experience. Within this authentic space it becomes clear that both suffering and beauty, two great existential elements of the human condition, evoke a loving response (p. 31). Through the act of creative art making, these existential themes of suffering and beauty, as well as themes of pain and love, may be honored with authenticity and openness.

Moon (2003) explored the role of love in the context of art therapy, defining it as, "the will to attend, to be with, one's self and the self of others" (p. 143). His definition resonates with my belief in the presence of love within the therapeutic relationship. He continued, "it is impossible to be genuinely attentive to another if you are not being attentive to yourself" (p. 143). By replacing the word *attentive* with *love*, it could be inferred by Moon's description that it is impossible to genuinely love another if you do

not love yourself. It is my belief that as practitioners in care-giving roles, we must maintain a practice of loving and tending to our own selves in order to be most effective, authentic, and present to those we care for. In the process of caring for, tending to, and loving others, we must not forget to offer the same care, attentiveness, and love to ourselves. Moon (2009) also described the creation of art as an act of love. It therefore follows that the creation of art for the self or for the other is an act of love toward the self or the other. This concept supports my assertion that in order to best care for others one must care for the self. The integration of arts-based self-care practices could provide opportunities for healthcare practitioners to tend to the self through creative and artistic expression.

Self-Awareness and the Wounded Healer

The archetype of the wounded healer has been expressed throughout history in religious symbolism, mythology, and healing in shamanistic societies (Stone, 2008, p. 48). "The identity of the wounded healer flowed from the awareness of and attention to one's own pain and fear, which the wounded healer allows to be tended to by another. One's awareness of brokenness and mortality becomes a powerful tool when tending to the pain of another" (Corso, 2012, p. 449). Oncology professionals, as is true with other healthcare professionals, are often witnesses to the suffering of others (e.g. diagnosis of life threatening illness, side effects of treatment, physical pain, and death).

A wounded healer relates to the practitioner's willingness to go inward, and experience one's own mortality and brokenness as an avenue to heal the patient and the self (Corso, 2012; Tafoya & Kouris, 2003). According to Corso, nurses and other health care practitioners often experience a strong connection between who they are and what

they do. Self-awareness can ground the practitioner in the moment, allowing the practitioner to attune to the patient while being mindful of the self. Self-awareness enables the practitioner who has a strong connection between who they are and what they do to keep a slight distance and separation from internalizing their role as a caregiver from who they are as a person. Self-awareness allows the practitioner to offer empathy and compassion without enmeshment of the emotions and relationship.

Self-awareness in how we present ourselves to others, as well as how we see ourselves, is important when relating to and caring for others. Zikorus (2007), a nurse, wrote about her personal experiences and the importance and significance of presence in the therapeutic relationship. She recognized that within the therapeutic relationship, when the caregiver enters into the patient's emotional and psychological state of being, he or she contributes to the quality of the energy of that space.

Bardot (2008), an art therapist, shared a case example of her work with a young boy grieving the loss of his grandmother. Her work with this young child demonstrated the resiliency and growth that can happen as a result of moments of pain and suffering. She believed that, with support, children could often become caring, empathic, and wise young people, having endured their loss in a positive manner. Bardot emphasized the importance of the therapist's self-awareness, and reflected on her own woundedness in relation to death and loss. She shared her personal experiences of art making and supervision to become more resilient as an art therapist, and as one who witnesses traumatic stories and images of loss. Bardot's example supports the need for exploration of the practitioner's vulnerability within the therapeutic relationship, and how the presence of self-love supports self-care practices.

The practitioner working in field of pediatric oncology is often faced with exploring existential concerns of the human condition related to death, freedom, isolation, and meaning. Existentialists believe that suffering, anguish, and struggles are essential to life and universally experienced (Moon, 2009), as well as the emotional opposites, which may embrace joy, love, and awe. In the field of pediatric oncology, patients and practitioners are confronted almost daily with the realities of existence, that death is a part of life, that people have choice, ultimately we are all alone, and that there is a desire to make meaning of this life. Practitioners who have taken time to make sense of their own understandings and beliefs related to life and death and pain and love will be better able to journey with their patients, as their patients begin to examine these same concerns. Art can provide a necessary space for practitioners and patients to examine these concerns that may be too complex for words. The arts create opportunities to be vulnerable in the exploration of these concerns as we explore, struggle, and search for our own understandings as practitioners.

Brown (2012), a social worker, wrote that it takes courage to be vulnerable. She described the field of social work as "all about leaning into the discomfort of ambiguity and uncertainty, and holding open an empathic space so people can find their own way" (p. 8). This description of social work can apply to experiences of many oncology professionals, whose relationships with their patients are uncertain, due to the course of the disease. It is within these intense relationships that connections are formed and vulnerability is heightened.

Hardy (2001) examined the role of countertransference through the use of case examples from his work in hospice. He asked,

> How then do we as art therapists continue to cope, and not just cope, but continue to interact with our patients in a vigorous and creative way? How can we operate among all this loss without ourselves becoming defended? The truth is, perhaps, that to some extent, we cannot. (p. 26)

Hardy suggested that more active engagement with countertransference that emerges from the challenging relationship would enhance practitioners' efforts in this field, and enable art therapists to retain their own creativity and versatility in the face of challenge. Hardy concluded that it is important to acknowledge that art therapy work is difficult to sustain, and that only by paying attention to our own needs can we more truly listen to the needs of our clients. While I support Hardy's belief that we need to more actively acknowledge that the work of the art therapist is difficult and complex, I do not agree that we necessarily become defended from our experiences.

I propose that a component of what may be missing in self-care practices is the acknowledgement of the role of self-love. By offering love and care to oneself, we can then honor and acknowledge our limitations as humans, thus making us vulnerable in our humanness. Perhaps by activating an element of self-love in self-care practices, practitioners will be able to love themselves through their successes and failures, their challenges and rewards, and repeated exposure to the pain and suffering of those they care for.

Compassion Fatigue, Vicarious Traumatization, and Burn Out

Compassion fatigue, vicarious traumatization, and burnout are three separate phenomena that are often used interchangeably to describe the risks practitioners may face as a result of the role and responsibilities of being a caregiver. *Compassion fatigue,* as defined by Figley (as cited in Berzoff & Kita, 2010), refers to the reactions that emerge from the therapist's over-exposure to client suffering. Compassion fatigue emerges suddenly and without warning, and usually includes a sense of helplessness and confusion (Potter et al., 2010). In contrast, *burnout* is cumulative stress from the demands of daily life, and can be described as a state of physical, emotional, and mental exhaustion caused by the depletion of one's ability to cope with one's environment (Potter et al., 2010). Another key concept to define is *vicarious trauma,* which refers to an identification with a traumatized client that causes a transformation in the therapist's inner experience, as the result of empathic engagement with the client's trauma material (Sinclair & Hamill, 2007).

Potter et al. (2010) conducted a quality-improvement evaluation of inpatient and outpatient oncology healthcare professionals within a large Midwestern cancer center. The results of this evaluation showed that staff on inpatient units had the highest percentage of high-risk compassion satisfaction scores, while the scores for compassion fatigue were relatively equal among inpatient and outpatient staff. Staff on inpatient units tends to care for patients who are in need of more critical care than those who are visiting an outpatient center for chemotherapy or transfusions. In addition, staff with 11-20 years of professional experience also had the highest percentage of high-risk compassion fatigue, followed by those with 6-10 years of experience. Although the study had a small

sample size, and the evaluation was conducted within only one hospital system, a program at this site has since been developed to train staff facilitators to assist nurses in gaining the skills needed to reduce their own compassion fatigue and burnout.

Compassion fatigue and burnout may produce similar symptoms; however, the root of burnout is often associated with environmental factors, in contrast to compassion fatigue, which is often relational in nature. Berzoff and Kita (2010) explored compassion fatigue and countertransference, arguing that they are two separate concepts that serve separate functions and require different kinds of solutions. Therapists who experience compassion fatigue absorb the emotional weight of their clients' experiences in ways that can negatively impact both their professional identities and their personal lives. In contrast, countertransference is seen as resulting from interpersonal or intrapsychic dynamics with a client that are both inevitable and essential for meaningful change to occur (Berzoff and Kita, 2010, p. 349). Countertransference can be a valuable tool for the practitioner to gain empathic access to the world of the client.

The literature on compassion fatigue suggests self-care practices as a remedy, including ways to soothe the self, such as meditation, yoga, spirituality, or connecting with nature; laughing and crying; tending to the need for relaxation, diet and exercise; leading a more balanced life, and maintaining social supports. Group support is also mentioned as helpful in sharing and education (Linley & Joseph, 2007; Nelson-Gardell & Harris, 2003; Neumann & Gamble, 1995).

The authors emphasize that compassion doesn't always lead to fatigue, and shared the belief that there are gifts in compassion, such as resiliency, the capacity of the mind to survive, and creativity of the human spirit to make meaning in difficult life events, that

compel us to do this work and keep us engaged in it. On the other hand, the necessary responses to countertransference are in understanding and exploring the interpersonal roots of the therapist's reaction to the client through self-reflection, self-analysis, supervision, or psychotherapy (Berzoff & Kita, 2010, p. 347).

Bush (2009) explored compassion fatigue, and, like other writers, distinguished between compassion fatigue, vicarious traumatization, and burnout, in relation to oncology nursing, and explored who is at risk. "A risk for oncology nurses, and other nurse caregivers…is that after prolonged exposure to trauma and loss, the caregivers begin to integrate the emotions, fears, and grief of their patients, ultimately increasing their own stress and emotional pain" (p. 25). All caregivers are at risk for emotional exhaustion from their work, and the level or degree to which they experience the exhaustion can be related to work environment, coping skills, work load, and role ambiguity, among other factors. Stress and coping theories often propose that it is not the stressors themselves, but how the individual responds to the stressors that influences stress and coping responses (Bush, 2009).

Bush (2009) noted that there is a need for caregivers to find balance in the empathic engagement on the spectrum between over-involvement with patients, and the other extreme of emotional distance that leads to burnout. Bush reflected that perhaps oncology nurses learn about courage and resiliency from many of their patients who transform their adversity into a challenge, and who find hope in what may be hopeless situations. Bush emphasized that learning forgiveness and self-love is inherent in healing and preventing compassion fatigue. One must be gentle, kind, and patient with oneself, and treat oneself with the empathy and compassion that one gives to others (p. 27). This

literature supports the theory that in order to best tend to or offer love to others, one must tend to and offer love to the self.

Medland, Howard-Ruben, and Whitaker (2004) developed a one-day *Circle of Care Retreat* (p. 50) to identify specific concerns relevant to improving the psychosocial wellness and skills of staff members. The *Circle of Care Retreat* addressed the human side of caring for patients with cancer by nurturing the spirit of the interdisciplinary oncology team. This retreat was offered to all members of the oncology care team, from doctors and nurses to social workers, therapists, and housekeeping staff. Services offered to the team members included stress management sessions, self-care behavior coaching, skill building, and individual counseling for those who had a high risk for burnout. Those involved in the *Circle of Care Retreat* shared personal patient stories, admissions of vulnerability, and expressions of loss and sadness.

More than 150 staff members participated in the retreat, which was held away from the clinical area in a more relaxed setting on the hospital campus. Participants engaged in a variety of activities, including an art therapy session called "All Gifts Differing," which gave participants an opportunity to reflect on the unique gifts they bring to the oncology department (Medland, Howard-Ruben, & Whitaker, 2004, p. 51). Participants were also asked the question, "Did you choose oncology, or did oncology choose you?" (p. 51). This question was posed to invite participants to share their unique story of how they came to work in oncology.

Follow-up evaluations were to be distributed through human resources to evaluate the rate of staff turnover, staff psychosocial wellness, and coping strategies. As a result of the retreat, alumni from the *Circle of Care* formed a council to strategize how to

further implement self-care strategies in the work place (Medland, Howard-Ruben, & Whitaker, 2004, p. 52). One of the self-care practices implemented was to create a ritual on the oncology unit to recognize the loss of a patient. The retreat enhanced group cohesion, collaboration, and communication. The authors recognized that further research is needed to better identify those at the highest risk for burnout.

The literature reviewed describes the similarities and differences between vicarious trauma, compassion fatigue, and burnout, to assist caregivers in identifying the symptoms, knowing the differences, and how to prevent or heal from these phenomena. The concepts of self-care and caring for the caregiver are referenced throughout nursing, creative arts, and health care literature. While it appears that self-care practices are recognized as contributing to the wellness of healthcare staff, I believe an exploration of the experience of vulnerability in the therapeutic relationship will contribute to an understanding of the role of self-love in self-care practices.

Self-care

While much of the literature describes self-care and the need for self-care practices for caregivers, few sources offer an agreed upon definition of self-care (Richards, Campenni, & Muse-Burke, 2010). My project broadly defines self-care as consisting of the positive things one can do to care for, tend to, or support the self, as well as revitalize energy and strengthen resiliency. This definition is based upon Moore, Bledsoe, Perry, and Robinson (2011), who wrote that self-care enhances well-being, and involves purposeful and continuous efforts that are undertaken to ensure that all dimensions of the self receive the attention that is needed to make a person best able to assist others.

Recent research has suggested that self-care practices can alleviate and perhaps prevent the phenomena of compassion fatigue, burnout, empathy fatigue, and vicarious traumatization, to which healthcare professionals are so vulnerable; however, more research is needed to identify barriers to maintaining self-care practices. While my project did not examine the barriers to self-care practices, I believe that self-love may have a role in maintaining and sustaining self-care practices. Perhaps if practitioners can offer themselves a bit of what they offer to their patients, they will be better able to maintain their self-care practices.

Richards, Campenni, and Muse-Burke (2010) studied the relationship between mental health professionals' self-care practices and general wellbeing by investigating the indirect effects of self-awareness and mindfulness. The authors defined self-awareness as knowledge of one's thoughts, emotions, and behaviors, and they defined mindfulness as awareness of and attention to oneself and one's surroundings. They identified four areas of self-care: physical, psychological, spiritual, and emotional support. Tending to physical self-care includes exercise, movement, household activities, and other daily functioning, whereas psychological self-care includes seeking one's own personal counseling. Spiritual self-care incorporates one's sense of purpose and meaning in life, and may include spiritual or religious beliefs and practices, and/or meditation. The support aspect of self-care can also be considered social, as it includes personal and professional support systems.

The researchers found a significant and positive correlation between self-awareness and mindfulness (Richards, Campenni, & Muse-Burke, 2010), which suggests that when self-awareness increases so does mindfulness. The participation in self-care

activities also may relate to enhanced well-being without necessarily requiring a state of mindfulness. Self-care frequency and self-care importance were also significantly and positively correlated, suggesting that the more frequent participation in self-care activities, the more perceived importance (Richards, Campenni, & Muse-Burke, 2010).

Self-awareness may be significantly correlated with self-care, but not frequency of self-care practices (Richards, Campenni, & Muse-Burke, 2010). This finding could suggest that self-awareness is not a necessary component in self-care activities. Further research could explore the relationship between self-awareness and consistency of self-care practices in mental health professionals.

Self-care practices should be attainable so that they are implemented consistently. Murrant (2000), in her work in hospice, found that self-care strategies for caregivers are essential to the effective functioning of hospice and the longevity of individuals working or volunteering in palliative care. These caregivers often neglect their own self-care and struggle to leave their patient care (Murrant 2000; Repar & Patton, 2007). Murrant found that caregivers are willing to make the commitment to caring for the clients; however, they are less willing to commit to self-care, for fear of being viewed as selfish.

Murrant (2000) initiated the development of *Creativity and Self-Care for Caregivers* within a hospice center. Her workshop incorporated art, writing, and music. The goal was to provide an opportunity for caregivers to explore journal writing, art therapy, and music therapy as forms of self-care. Participants were divided into three smaller groups and each small group rotated through all three two-hour modalities during the course of one day. From the evaluations of 75 participants in the program, all were positive and indicated that participants had gained valuable insights. No one modality

was evaluated as more useful than another. Participants found that the nurturing, nonjudgmental, supportive environment of the workshop was beneficial, and appreciated the opportunity to take time for themselves. Participants also indicated that they appreciated sharing these experiences with other caregivers. A follow-up phone survey was conducted two years after the initial workshop to evaluate whether participants continued a level of self-care after the workshop. Of the 75 participants, 34 responded that they were better able to care for themselves after the workshop.

As a result of this workshop and evaluation, the hospice has since offered additional caregiver programs. This type of workshop allowed for an immediate integration of the body, mind, emotions, and spirit, and provided a holistic experience for the participants (Murrant, 2000). Program outcomes offered evidence that expression through the arts and creative play can increase caregivers' awareness of the importance of self-care. Murrant indicated that further research is needed to quantify these findings and determine the long-term effects of self-care.

Art therapy and self-care.

Nursing, social work, and expressive arts literature support the use of art therapy as a self-care practice for caregivers. Zammit (2001) examined art therapy as a healing and transformative modality for one of her patients; she was interested in exploring the link between the physical and nonphysical—the body, mind, and spirit—in one person's self-healing of a medically incurable illness.

The participant's artworks revealed eight major categories: people, animals, symbols, colors, numbers, archetypes, thematic motifs, and spiritual references. The participant then interpreted her artwork by associating the imagery to the eight categories.

Overall, one of the most important contributions of the study was that the participant's art and healing process demonstrated the inseparable nature of body/mind/spirit. Although Zammit (2001) focused on the patient's experience with art therapy in relation to illness and healing, it supports the notion that art making provides an opportunity for individuals to be active participants in their own healing. This notion supports my interest in assisting healthcare professionals to become active participants in their professional health and wellbeing through sustainable self-care practices.

Salzano, Lindemann, and Tronsky (2013) used quantitative measures to study the effectiveness of a collaborative art-making task on reducing burnout and increasing social support in a group of hospice caregivers. Participants in the study consisted of a non-randomized sample of ten social workers and ten members of the arts department at a hospice care facility. Each participant was randomly assigned to a dyad, and each dyad was directed to work together with his or her partner to create a quilt panel that expressed what it meant to be a part of a hospice team. The panels were then joined together to create a large quilt. The results confirmed the hypothesis that the art-making intervention would cause a statistically significant decrease in participant burnout scores. The results also suggested that the collaborative act of creating with colleagues could be an effective means of reducing staff stress in a palliative care setting.

When comparing the differences in burnout reduction across the two departments, it appeared that the art interventions used in the study were more beneficial for the social workers than for the members in the arts department. Salzano, Lindemann, and Tronsky (2013) suggested two possible reasons for this: that the control conditions for the social workers might be inherently more stressful than the control conditions of the arts

department members, and that because members of the arts department already used the relaxing qualities of art-making with patients and families, they may have been less affected by the art interventions.

This study provided quantitative evidence in support of existing qualitative research on the benefit of collaborative art interventions with hospice staff. In hospices and other medical institutions there is value in utilizing professional art therapists to provide staff with opportunities for art making as a means to manage and prevent burnout. Salzano, Lindemann, and Tronsky (2013) proposed that it is beneficial to preemptively manage burnout levels in order to maintain staff wellness and the highest possible quality of caregiving. When caregivers take the time to care for themselves, they not only decrease their levels of burnout, but also increase their ability to care for others. Future research could include a longitudinal study for a long-term art therapy program to determine how frequently art-making opportunities are needed and how best to integrate the art therapy program into the existing infrastructure of the institution.

Koff-Chapin (2013) introduced her technique of "touch drawing" to clinical and non-clinical staff in workshops and small groups throughout a healthcare system. The program provided opportunities to address and honor emotions related to changes in leadership and a series of layoffs. A common theme in the data from verbal discussion and artistic drawings, through all levels of hospital employees, was "the power of soul-level art, both process and product, to help access a fuller range of our human capacities: communication, compassion, creativity, intuition, generosity, authenticity, and a sense of wholeness and love" (p. 329).

Further research on the integration of arts-based self-care modalities in healthcare institutions could support the need for attainable self-care practices for medical caregivers. Koff-Chapin (2013) wrote:

> Imagine what it would be like if every hospital had a creative studio available for staff breaks. Rather than coffee, sugary snack or cigarette, a nurse might create a drawing, move, or write a poem. Soulful creative expression allows one to touch the sacred aspect of the work, and explore and integrate the deeper impact. This also provides a buoyancy and resiliency, something more than the typical form of self-care might provide. (p. 320)

Moon (1999) also promoted art making for art therapists to express their own feelings in response to clients and their images; a way to employ healthy self-care practices and protect the self from vicarious trauma.

Oncology and self-care.

Nainis (2005), an art therapist, acknowledged the essence of oncology nursing care as extending beyond clinical skills and knowledge to include compassion, dedication, and solidarity with coworkers. She proposed that one could claim this position requires "heart" (p. 150). Nainis recognized that essential to being a successful and healthy oncology nurse is learning to manage the inherent challenges of oncology work, and to know how to meet these challenges efficiently and effectively while also caring for oneself. She found art therapy to be a valuable resource that can assist oncology caregivers in safeguarding their inner health through awareness and expression of emotions, and creating a safe and healthy environment.

Nainis (2005) argued that two of the most neglected areas of self-care for oncology nurses are processing their grief and dealing with their own emotional reactions when caring for patients (p. 150). Nainis implemented an art therapy retreat for the oncology care team. Due to the size of the care team, she offered the retreat seven times, each a two-hour session with 14-25 participants. The task for the retreat's art therapy project was to create a hand-painted canvas rectangle. The small groups were instructed to collaborate and create an image that expressed what it meant to be a part of an oncology care team. At the end of each retreat, the paintings were hung on the wall for everyone to view their own and the other groups' creative images. Nainis identified common images that emerged, which included the stormy side of oncology, depicted with clouds, tears, lightning, and tornados. These images were often balanced with depictions of sunshine, rainbows, and blue skies. Other images that emerged were hands and circles representing teamwork and collaboration. The most prevalent theme was the heart, a symbol of love and caring. Nanis noted that almost every panel had a heart on it, and that without loving care, the oncology team could not do this job.

The resulting image panels were put together to create a quilt, which was used during the memorial services offered twice during the year to honor the patients who had died. The quilt was a symbol of the loving care the team brought to the patients and families treated. The outcome of this retreat also provided the oncology care team with another effective coping tool. Nainis' (2005) study supports the need for continued self-care practices to be integrated into healthcare systems. Self-care retreats such as the one Nanis implemented would offer continued support, increase communication, and provide a sense of respite for medical caregivers.

This concludes the literature review, which aimed to examine the scholarly resources related to this study. Relevant research indicates that self-care practices are important in preventing and healing from the phenomena of compassion fatigue, vicarious trauma, and burnout. Additionally, the use of arts-based methods to assist practitioners in expressing and addressing emotions, thoughts, and experiences related to their role as caregivers is supported in art therapy, nursing, social work, and other psychosocial research. The challenge remains to identify ways to help practitioners sustain and maintain self-care practices. This research will explore the qualities within the therapeutic relationship and the experience of practitioner vulnerability to illuminate the role of self-love in self-care practices.

Methodology

Heuristic Research and Art-Based Inquiry

Heuristic research is a process of inquiry that begins with a question of interest or a problem that the researcher seeks to illuminate or to answer. This method of inquiry enables the researcher to engage through processes of self-inquiry, as well as dialogue with others, to seek underlying meanings of important human experiences (Moustakas, 1990). In reflecting upon the experiences that led me to my current research project, I realized that the past few years of doctoral education could be considered a process of heuristic inquiry that led to my current art-based inquiry.

After reflecting upon my 12 years as an art therapist in the field of pediatric oncology, and both experiencing and witnessing the relationships formed between practitioners and patients, I was curious about the dynamics within these relationships. This curiosity led to my initial interest in exploring the role of love within the therapeutic relationship. This could be considered what Moustakas (1990) referred to as *initial engagement*, a time when the researcher is drawn to an intense interest or passionate concern that may hold important social meanings and personal, compelling implications.

As I continued to explore the role of love within the therapeutic relationship through self-inquiry, dialogue with colleagues, and art making processes, I began to question the role of self-love in self-care practices. A part of the *immersion* process is to reach inward for clarification and further illumination of the question. During this time I engaged in my own self-care practices of yoga and body awareness through movement to further explore these concepts of love and self-love. As I moved into what Moustakas (1990) would define as the *immersion* stage, I found myself connecting to this question in

multiple areas of my personal and professional life. My interests in exploring self-love and self-care practices began to permeate conversations and experiences, which led me to conduct a pilot study in which a small group of healthcare practitioners were invited to engage in art-based methods of self-care. This small group experience, coupled with my presentation of a continuing education event on creative self-care for health care practitioners, expanded the dialogue around such topics of love, self-love, and self-care.

Incubation is the next phase of heuristic research (Moustakas, 1990). During this phase of research, one retreats from the intense focus on the question and allows for a deeper, more intuitive process to happen. By shifting direct focus away from the topic, the information is given the opportunity to grow and expand without conscious effort.

The following stage is *illumination,* which opens the door to new awareness; a modification of an old understanding, or a new discovery of something that has always been present yet was beyond immediate awareness (Moustakas, 1990). My illumination occurred as part of an additional art process, which evolved over three and a half months. I engaged in an ongoing, weekly art piece, with the intention of allowing my art process to intuitively unfold and inform my research. The resulting painting was of a woman with her head leaning toward an anatomical heart (Figure 1). Each week I intuitively added definition and bolder color to bring focus to the heart.

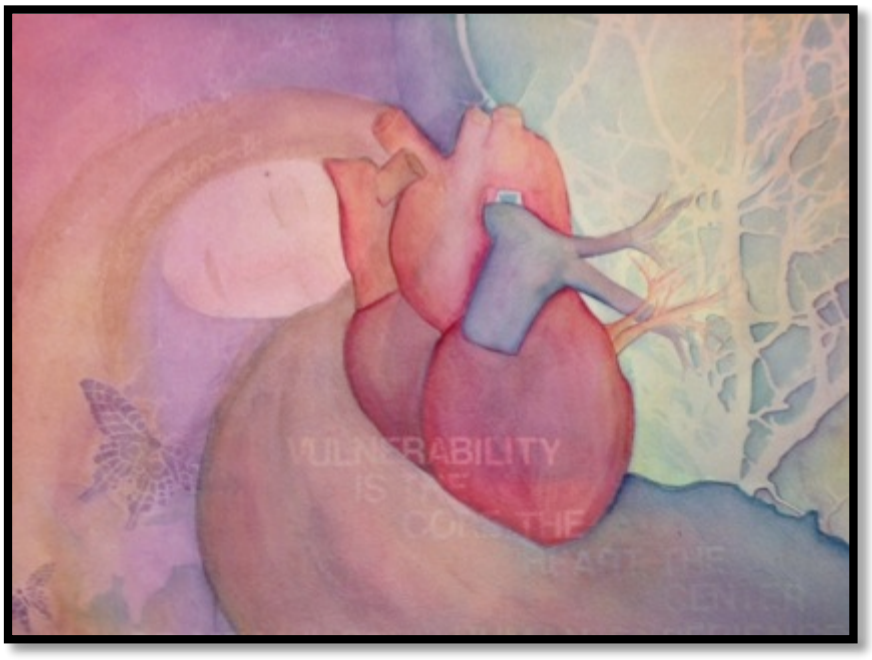

Figure 1. *Meditation of the Heart*. Watercolor on watercolor paper.

During this painting process, it occurred to me that perhaps I had overlooked an important component within a loving relationship. This was the role or experience of vulnerability, symbolized by the exposed heart in this painting. My research question shifted slightly at this time to the presenting question of inquiry: What is the experience of practitioner vulnerability within the therapeutic relationship, and the role of self-love in self-care practices? This slight shift in my inquiry brought me into the *explication* phase (Moustakas, 1990), and the desire to bring this question to other practitioners in the field, to further understand and explore the phenomenon of vulnerability and the role of self-love in self-care practices. I provide a description of the interview processes in the subsequent section of this paper, in which interviews and art-based inquiry were employed to further explore the practitioners' experiences in pediatric oncology.

Art-based inquiry was used [during] as part of the interview process of pediatric oncology practitioners, in addition to my own process of heuristic inquiry, as described

throughout this section. Art-based methods were integrated into the interview process to provide the participants with an opportunity for reflexivity. Kapitan (2010) claimed that artistic expression, as a form of inquiry, provides a medium for connecting to the self, while simultaneously distancing the self in order to see something from a new perspective. By inviting the participants to engage in an art experience post-interview, the participants were given an opportunity to connect with their experiences while also providing a bit of distance for reflection. The oral interviews and artistic participation of the interviewees were audio and video recorded for accuracy and reliability.

In response to the interviews and my personal experiences as an oncology practitioner, art-based inquiry was further employed during the *creative synthesis* stage. Creative synthesis is the final stage of heuristic research, in which the researcher has mastered knowledge of the material and explicated that understanding in a form that illuminates the questions (Moustakas, 1990). Creative synthesis may take the form of a verbatim narrative description in the form of a poem, story, drawing, painting, or other creative form. My creative synthesis resulted in three figurative sculptures, which are highlighted in the video portfolio. The validity of this heuristic and art-based inquiry will be further supported through sharing photographs of the sculptures and culminating video, both with the participants and with other health care practitioners.

The validity of heuristic inquiry is not quantifiable, and relies upon judgments of the primary researcher to determine if the meanings and essence of the experience are presented comprehensively, vividly, and accurately (Moustakas, 1990). To further support the validity of heuristic inquiry, the researcher will often return to the research participants and share with them the meaning and essence of the phenomenon explored,

and seek their feedback. A follow-up email was sent to participants sharing preliminary findings of my artistic inquiry. The culminating video and summary will be presented to the participants and colleagues at a self-care workshop and retreat.

I chose to engage in arts-based inquiry in part because artistic creation is an essential component of the art therapy relationship. In addition, arts-based methods were chosen to provide reflexivity, as well as to integrate sensory, emotional, and intellectual experiences in response to the interview data, and personal connection to the exploration of vulnerability and the qualities within the patient-practitioner relationship. I engaged in my own art process to explore the themes that emerged from the interviews. A theme was defined as a concept that was shared by two or more participants. Such themes included: communication, relationship, trust, courage, teamwork, vulnerability, risk, love, hope, and faith. These themes were integrated into my art making process, the choice of materials, and the final artistic representations.

Heuristic research was chosen because it is a method that seeks to obtain qualitative representations that are at the heart or core of a person's experiences, which include depictions of situations, events, relationships, feelings, thoughts, values, and beliefs (Moustakas, 1990). The researcher collects detailed descriptions, direct quotations, and case documentation to obtain the raw material of knowledge and experience from the empirical world. My interest in exploring the experience of practitioner vulnerability and illuminating the role of self-love in self-care practices was best explored through qualitative methodology. Heuristic inquiry provided the guidance to deepen my questioning and explore the experience of such phenomenon as it related to my own experiences and that of other practitioners.

This project was designed as a qualitative exploration using arts-based inquiry into the unique and intense relationship and quality of vulnerability that often develops between oncology patient and healthcare professional, and the role of self-love as a component of self-care for the healthcare professional. For my project, I defined a medical caregiver as any health care professional, such as a nurse, physician, social worker, therapist (e.g. art, music, dance, physical, occupational, speech), chaplain, child life specialist, and others working within a medical institution such as a hospital or clinic.

My purpose was to honor and witness the stories and experiences of the oncology practitioners as shared by the participants through verbal communication and creative arts expression. The creative arts expressions included visual art, poetry, movement, and photography. In the weeks following the interviews, I returned to a period of incubation, which was a period of time to allow the tacit dimension and intuition (Kapitan, 2010; Moustakas, 1990) to continue to clarify and increase understanding on levels outside of immediate awareness.

Through arts-based inquiry, I moved through a heuristic process that led to the final stage of creative synthesis, in which I engaged in a personal art making process in order to deepen my understanding, explore the phenomenon of vulnerability, love, pain, and other themes from the interviews, through the metaphors of the chosen materials and the art making processes. The process of creative synthesis and the culminating result of this project are described in the subsequent section. A video portfolio highlighting the art-based inquiry process was created with the intention to acknowledge and honor the relationships and connections that occur between patient and practitioner; to illuminate the importance of maintaining self-care practices; and to acknowledge the role of self-

love in self-care practices. This video will be presented to oncology professionals to highlight the need for caregivers to tend to the self through self-love and self-care practices.

Participant Selection

Participants were pediatric oncology professionals who agreed to participate after being solicited by this researcher via an email invitation. The email invitation (Appendix A) was sent to 15 pediatric oncology practitioners, who were affiliated with three different medical institutions. The invitation was limited to 15 practitioners for four main reasons: (a) data collection within heuristic and arts-based inquiry is typically gathered from a small number of participants with a shared interest in the phenomenon (Kapitan, 2010); (b) a small sample size was desired to parallel the intimacy of a small pediatric oncology multidisciplinary team; (c) the availability of practitioners to participate in the interview process; and (d) potential participants were based upon a colleague's referral as well as my previous acquaintances in the field. Of the 15 solicited, 8 agreed to participate and, after attrition, a total of 7 were able to participate within the time limitations of this study. The pediatric oncology professionals who participated were nurses, child life specialists, a physician, a nurse practitioner, and a musician/chaplain. I made a follow-up phone call to one colleague who was not an interview participant, but who served as a liaison in coordinating the interviews.

The email invitation included a description of the study, expectations of the volunteer participants, and a description of risks and benefits of participating in the study. Participants were informed that participating in this study might increase self-care practices through new shared and learned experiences. Art-based self-care practices

provide an opportunity to honor relationships, stories, and experiences through the art making experience and resulting art products. The risks of participating in this study may have involved minimal discomforts that are sometimes encountered in daily life, such as emotional upset when reflecting upon meaningful, traumatic, or grief experiences. Additional psychosocial support was available as needed and requested through additional time with myself, an art therapist, as well as a list of referrals for counseling and support.

Participants were given the option to opt out of the study at any time. I asked all participants to sign an informed consent form, which specified confidentiality of the participants, their patients, and the medical institution or organization in which they practice. Volunteer participants also signed a release allowing me to record the interview with video and photography, and to utilize their visual, verbal, and written expressions (or representations or reproductions of their visual, verbal, and written expression) in the culminating creative project (Appendix B). The participants were informed that portions of the project might be incorporated in future professional and educational publications and presentations. This was made clear through verbal consent at the time of the interview and followed by an email confirmation and consent (Appendix C). The confidentiality of the practitioners, their patients, and institution of employment was protected and remains unidentified in the culminating creative dissertation. This project was submitted to and approved by the Institutional Review Board at Mount Mary University.

Materials and Procedures

Selected art materials offered a choice and unrestricted time for participants to complete. Materials were chosen without bias or personal gain, and included 11″ x 14″ Bristol board, 11″ x 14″ watercolor paper, watercolor paints, various sized paintbrushes, oil pastels, colored pencils, markers, pencils, ink pens, ruler, scissors, and white glue. I chose the materials based on ease of use, accessibility, and the space constraints of the office space.

Data was collected from the participants, who engaged in a creative art interview facilitated by this researcher. The interview provided an opportunity for the participants to creatively express themselves with art making, expressive writing, and movement, in order to communicate experiences and the unique qualities of their relationships with patients. As the primary investigator, I facilitated the interviews using directive and non-directive art therapy techniques. The interviews were conducted on an individual basis and each interview took an average of 60 minutes. I was active in the interview by focusing on the dialogue between us.

I interviewed the participants over the course of two days. Interviews took place in a small office space located in an outpatient pediatric hematology oncology clinic in a medical institution. The office space had previously been the personal office of a senior oncologist on the team of professionals who I interviewed. This is important to note, as those interviewed work closely together, and the loss of this physician (to relocation in another state) had been felt as a major loss for the team. Interviewees alluded to the fact that, after numerous years in the field, the physician determined that he needed a break from the intense emotional connections and the numerous losses of young patients and

families. This particular physician had initially been invited to be a participant in this study but I only learned of his departure from the hospital through his colleagues.

Each interview was scheduled according to the availability of the volunteer participants. The interviews were video and audio recorded on two separate iPads, which were strategically placed in the office to minimize any self-consciousness about being recorded. All participants were seated in a chair with wheels, with their back to the door and facing me. During the interview process the door to the office was closed; however, during clinic hours, the participants being interviewed could take a break from the interview if needed, or in the event of a medical emergency. Participants were given a printed copy of the interview prompts (Appendix D) to guide them in the beginning of the interview. Before beginning the interview, I verbally reviewed the study, risks and benefits, consent, and confidentiality with participants, and affirmed their option to withdraw from the study at any time.

The interview was initially designed to be an expressive arts intervention by incorporating visual, verbal, and kinetic responses to the interview prompts. Due to the limited physical space in the office, the time constraints of the participants' schedules, and the participants' comfort level while sharing personal recollections, I asked the participants to respond to an open-ended verbal interview utilizing the interview prompts as guides. This approach enabled the participants to openly share personal experiences and stories, and connect intimate details within their practice and relationships with deeper reflection. At the end of each interview, participants were invited to create an art image in response to the reflections that surfaced for them in the interview and/or their experiences as a professional caregiver in pediatric oncology.

Interview prompts.

Participants in the study shared personal stories and experiences from their years in the field of pediatric oncology. Interview prompts were chosen to stimulate this dialogue and to inspire personal reflection. For example, some of the following prompts were employed in the verbal interview process:

- "Tell me about your role in pediatric oncology and how you came to this field."
- "Do you believe you chose oncology or oncology chose you? Explain."
- "Tell me about a poignant moment or time from your work in pediatric oncology."
- "Tell me about your ability to sustain this work."
- "What are the most rewarding and the most challenging parts of your job?"
- "Where in your body do you hold these stories or experiences?"
- "How do you care for yourself? What kinds of self-care practices do you engage in, if any?"
- "What prevents you from being able to maintain or engage in self-care practices?"
- "Please share anything else you feel compelled to share about your role in pediatric oncology."

The interviews were informal in that we allowed the conversations to unfold naturally, to enable authentic responses that would stimulate the next prompt or topic for discussion. An important element elicited in the interview process was nonverbal communication. I was mindful of the body language of the participant as he or she verbally shared stories and memories from the field. The participants shared without

hesitation and relaxed into the interview after the first few minutes. These oral interviews were rich with metaphors and imagery, which provided me with thick qualitative data to reflect upon and visually respond to in the weeks after the interviews were conducted.

All participants engaged in art making and utilized the desk space in the office to create their images. When the art images were complete, participants were invited to talk about their images. Participants were given the option to take their artwork with them; however, all participants gave the original artwork to this researcher. I have since photographed the images for documentation purposes and inclusion in the video portfolio, and I will frame and return the artworks to the participants. My purpose in returning the artwork is twofold: to encourage the participants to display their work as a reminder of their motivation and inspiration for the work they do. Additionally, the artwork can be a visible reminder of the importance of practicing self-care.

As mentioned, I was an active participant in the interview by asking questions, providing reflective responses, taking written notes as the participants were speaking, and observing nonverbal cues in their body language. After the first day of interviews, I realized the need for my own self-care practices in order to witness the stories and information being shared. After each interview I created entries in my visual and written journal as a way to transition between the interviews. These artistic journal entries became integral in the creation of the culminating artworks described later in this essay.

Results

In this section I highlight the artworks created by the seven interviewees and the thematic selections of their oral descriptions of their art. The common imagery that

emerged from the stories, images, and body language included gratitude, honor, hope, love, strength, faith, relationship, passion, and trust. The content of the interviews at times revealed stories of both great loss and great love, eliciting emotional responses in both the interviewee and, at times, myself. The sharing relationship between us served as a reminder that the interview itself could be considered a time for self-care for the participants, because of the opportunity to honor their caregiver roles through the sharing of stories and experiences. The interviews provided a pause to participants' routine workday, and an opportunity to honor the stories they hold, the relationships shared, and the intangible gifts they offer to their patients and colleagues. Perhaps some practitioners, like the interviewees, assimilate to the culture of pediatric oncology and overlook opportunities to truly honor and acknowledge their role in the lives of their patients, as well as the impact their patients have upon them.

Participants created spontaneous imagery that emerged from emotions stirred in the interviews and sharing of stories (Figures 2–8). The following vignettes include a version of the interviewee's description of their work and some highlights of what they shared in relation to their work in pediatric oncology, what motivated them, and what sustained their ability to continue this work. Five of the seven participants had been working in the field of pediatric oncology for over 18 years. Perhaps, as indicated in their interviews, an important aspect of their work was the value of a closely working team and their dedication to it. These practitioners had established a support system with each other that allowed them to be vulnerable and to experience the array of emotions as they arose. As one participant observed,

> The team consoles each other. It's like a sponge effect; the team… absorbs the impact of each other. Each person has his or her own ways to heal him or herself. In oncology, you have to be prepared for the mental stress because you are giving a lot to families. It's not just giving facts… it's sharing. The "art of healing." It's the relationship. It can be a phenomenal experience.

This use of the metaphor of a sponge for the team's ability to support one another spoke to an important element that was repeatedly shared throughout the interviews: the importance of a cohesive team. It was evident in the way they spoke of each other that a deep sense of commitment and appreciation was present among the team members. As "sponges," they soak up or absorb the impact of one another, supporting each other through the array of emotions experienced in caring for their patients. When one practitioner is having a rough day, they honor and validate those emotions, and the other practitioners fill in where needed, or simply support each other by allowing the other to emote. One thought that came to my mind was, what happens when that sponge is saturated? How then, do they support each other? Perhaps, what has been working so well for this team is that each member expressed personal ways in which they care for themselves, in addition to the ways in which they support and care for each other. The team members individually acknowledged the differences in personalities and coping styles, however, they returned to acknowledging the deep sense of commitment to each other as a team. They consider one another a part of their extended family.

Stories and Creative Responses.

Personal reflection.

As an art therapist with over 12 years in the field of pediatric oncology, I have often been asked how it is that I can do this work. Many people I have encountered make the assumption that the field of pediatric oncology is only filled with sadness and devastation. I have seen it in their eyes when I would begin to tell them about this beautiful world in which I have been blessed to reside. I have struggled to find the words to accurately describe how blessed I have felt to be welcomed into the lives of these children and families during some of the most difficult and intimate moments of their lives. In some instances, these people would respond by magnifying my existence to that of angel or of having a heart of gold. While I do believe pediatric oncology is not for everyone, I do not believe the qualities I possess as an individual are any more or less significant than those working in other emotionally challenging fields such as abuse, trauma, or grief. In the past, I was quick to counter the assumptions, to help them to know the other side of pediatric oncology: the celebrations, the triumphs, and the life. In this process, what I didn't realize I was doing to myself was minimizing the pain and loss I had experienced. I came to the realization that I needed to verbally honor all of the experiences I have witnessed, the love and compassion as well as the pain and loss.

As an art therapist, I often use my own art and creative journaling as a way to process the stories I hold from the encounters and experiences with young patients and their families. Through my art I have consistently been able to acknowledge and honor the shadows and light of the experiences I have had. Yet, in my early years as a practitioner, I struggled to verbally acknowledge the shadow side of pediatric oncology

when speaking with those who inquired. Perhaps I wanted to protect those around me from truly knowing the heartache and loss by emphasizing the hope and resiliency, or perhaps I wanted to protect and honor those relationships between the patients and myself to sustain my resiliency by remaining in the light. Throughout the years, I have continuously turned to my art as a container to hold the stories of honor, love, pain, and loss I have both witnessed and experienced.

As a result of my experiences, and after years of reflection, I became curious about these unique and intense relationships that often form between the young patients and myself. In response to witnessing similar relationships develop between my colleagues and their patients, I began to question what this dynamic was, and if it was unique to pediatric oncology. While I don't believe it is unique to pediatric oncology, I do believe there is something unique that happens within these relationships. My belief is that there is an element of love in the therapeutic relationship that contributes to the ability to tend to another during the emotionally intense experience of witnessing intimate moments in the lives of these children and their families. The love I refer to is rooted in compassion and empathy for another human being. As I reflected on and made art about this idea of love for the patient, my thought processed deepened. If I am opening my heart to offer love to the patients I care for, then it is also within this openness that my heart is exposed and at risk for pain and loss. As a practitioner, I asked myself, how do I protect my heart from being continually exposed to both the pain and love or shadows and light within my relationships with children diagnosed with cancer?

I turned to my art once again to explore this question, and came to the idea that the experience of offering love, witnessing pain, and holding these patient stories was a

process of continuously allowing myself to be vulnerable in the therapeutic relationship. In order to offer love and be authentic in each patient encounter, there was a risk of emotional pain and loss. This loss was most often experienced as the death of a patient. Through my art making processes, I tended to myself by honoring and responding creatively to these patient relationships and the emotions they elicited.

As I continued in my personal art processes, I was led to wonder about the role of self-love in self care-practices. Perhaps by offering love (compassion and empathy) toward ourselves as practitioners, we can better sustain self-care practices that contribute to minimizing the risk of compassion fatigue, vicarious traumatization, and burnout. This process of examining my experiences through art, reflection, and inquiry led me to the explore the following questions with the participants of this study:

1. What are the unique qualities within the therapeutic relationship that contribute to the intensity of the experience of the oncology caregiver?
2. How does vulnerability contribute to the practitioner's experience within the therapeutic relationship?
3. How do expressive arts interventions in the context of self-care illuminate the role of self-love as an element of self-care for professional caregivers?

As an art therapist, I utilize my own creative art processes as a way to care for myself and honor the memories, experiences, and emotions of this work. The creative arts have offered me the opportunity to explore my artistic images, as well as the use of materials as metaphors for experiences that are often beyond words. If other pediatric oncology practitioners have similar intense experiences and relationships with their patients, many of which are unable to be given a voice due to the confidentiality of the

patient, as well as the sensitivity of the oncology experiences, then perhaps the creative arts would provide an outlet for these practitioners to express and honor their experiences, emotions, memories, and relationships.

The following case vignettes include an overview of the interview, the art images created by the participants, and a brief verbatim excerpt from their respective interviews. Pseudonyms have been used to protect the confidentiality of the participants.

Beth, pediatric oncology nurse.

Beth, a pediatric oncology nurse with 40 years in the field, spoke eloquently about her work in pediatric oncology. I could sense her passion from the tone in her voice as she reflected on children and families who had left lasting impressions upon her. She used the metaphor of a butterfly, and reflected, "You're there. You stop for a little bit of time, a child is with you for an amount of time, and then they die. You kind of touch their lives and then they fly on, or you fly on." She continued:

> *It really gave me a perspective on how to live and what is important in life. I think [pediatric oncology] it's a life. It's a family; that perspective to live through some of these kids and their families and the amount of courage they have through their cancer journey. [To witness] their courage is the highlight of the day. There are highs and lows, but it's the journey. You journey with them…. You have frequent flyers [the children who visit the hospital often]. And it's like one kid ends and another begins. It's that whole cycle. Those journeys. And I marvel because they [the children] entrust you in the journey. They feel safe in asking questions, the hard questions [about death and*

dying]. These kids are amazing. They are like gold threads. You have a tapestry of life; our lives are woven together with those we meet. This tapestry of my life would have a lot of gold threads.

Beth spoke of journeying with her patients and the "family" relationships that develop over time. As a pediatric oncology nurse, she has journeyed with many patients through the ups and downs of the cancer experience. I believe that journeying with the patient and accompanying the patient through the highs and lows is a practice in vulnerability. As an experienced practitioner, Beth is aware of the risks of developing close relationships with patients; there is a risk of death and loss of the young life with each cancer diagnosis. Yet she continues to choose to be emotionally present for each child and family. Perhaps the elements she embraces and marvels at within her patients (courage, strength, trust, hope, faith) are the same elements within herself that strengthen her resiliency and enable her to continue to sustain her work.

Beth has witnessed the death of many young patients. She shared, "Absolutely there is an element of love. The single most important thing is to have colleagues who can share that with you. To be able to laugh and to cry together." Beth spoke of her strong faith. She stated that it is with "faith-driven knowledge that there's a time to be born and a time to die. You have to have strength through that faith. Even those who are dying still have something to be said. I want to hear what they have to say."

Figure 2. *My Circle of Life*. Oil pastel on paper.

Beth created the image in Figure 2, and shared the following in response to her creation:

> *This is my circle of life. I mean my circle as far as the [pediatric] oncology. It's been the sunshine of my life. You know, I watch kids blossom [pause] from being the seed. We're giving kids chemotherapy, which I always say to them, it's kind of like putting fertilizer or weed killer on a field of flowers. And you can't pick and choose that it only affects the weeds but it affects the flowers. And for a while they are kind of wilty and not strong, but if you nourish them; if you give them the food they need and then provide them with something that makes them happy and strong… they'll survive and they'll grow and the petals will come and they will be beautiful and strong. But if you let that chemotherapy, that weed killer, overpower the strengths that you have, that flower isn't going to grow. You have got to find things to make you grow.*

She continued pointing out specific areas in her image, saying, "This is my tapestry and this is my butterfly. That's my fire ring at camp. This is the boat traveling the sea of life. These are my friends, my friends I work with. This is my circle of life. What I need to professionally practice and to say that I enjoy what I do and how I do it."

Beth's garden metaphor for her work was quite powerful. Perhaps her advice to the children she works with, "You have got to find things that make you grow," might be similar to what enables her to sustain her work. Beth identified the things in her life that enable her to grow: her family, her faith, her colleagues, gardening, sewing, cooking, and reliving the memories of the children she has cared for throughout the years. She acknowledged the importance of carefully setting boundaries, and the risk of staff disharmony and burnout from over-extending. She used the metaphor of a spark or a flame, and said, "Sometimes that spark goes out and then it rekindles. But what brings back the flame? You have to look within the mirror and remember that tapestry of life."

I believe Beth's reference to looking within the mirror is symbolic of the need to look within and to reflect back to the self what she offers to those she cares for in the form of love, kindness, hope, and compassion. Beth, in common with the other interviewees, spoke of the ability to use the challenging times as strength and motivation to move forward and help the next child and family. She uses both the challenges and successes in this work as motivation and inspiration.

Ajay, pediatric oncologist.

Ajay, a pediatric oncologist who has been practicing in the field for 18 years, spoke about the challenges of balancing caring for the children and families and caring

for his own family. He stated, "This field touches you at your raw emotional core. [These relationships] become long-term relationships and it can be hard to separate from your family. But if you get too involved it can burn you." He continued to share how many physicians and nurses get burned out because of the emotional toll.

> *There are no set rules to take care of yourself. You know, I don't know if I know how to address self-care. How do you separate personal from professional? If you are dedicated, you become extended family and invited to participate in celebrations and in happy stuff. Yet there are times when you follow a family for seven or eight years and then the child passes.*

When he spoke of the risk of being burned by getting too close, I thought of the metaphor of a candle. When lit, the candle gives off heat to warm the cold and light to brighten darkness. That light, when shared with others, extends further and becomes brighter. Ajay, and other practitioners, acknowledged the joy and love they have received in caring for these children, as well as the insights and lessons they have learned about what is important in life. The risk of an open flame, of getting too close to the heat, is a risk of getting burned. Perhaps, Ajay is referring to the risk of being vulnerable by caring too deeply and becoming too involved with patients. The burning sensation he refers to could be the experience of the death of a patient or perhaps the loss of self, if one gives too much and doesn't take time to care for his own self. Ajay allowed himself to be honest and vulnerable in this interview, sharing his struggle to find balance in caring for patients and caring for his own family, as well as the acknowledgment that there are no set rules to care for the self.

Ajay, like Beth, spoke of the gifts within the field of pediatric oncology, which included gratitude. He stated, "You can make a difference in lives. In no other specialty can you turn a life-threatening illness to hope and cure." Ajay emphasized the relationships and sharing that is essential to caring for children with cancer, as well as the importance of the relationships and sharing that needs to occur among the team of oncology practitioners. He shared his appreciation for being able to see growth and progress in his patients because of the long-term relationships, and while he tends to the illness, he also gets to witness "normal" stories from the patients.

In reference to his colleagues, he stated, "We heal amongst ourselves. We support each other and each person has their own ways to heal themselves." Ajay spoke of the importance of carving out time outside of the hospital and the importance of tending to his own family. "It's hard. I don't want to share suffering [with my wife and children]. I hold and contain it. I think of things to heal myself." Ajay spoke of the struggle that often happens in the healthcare field. He reflected that patients share very intimate pieces of their lives because of the level of comfort [they have with their treatment team]. When such intimate moments and experiences are shared between practitioner and patient, how does the practitioner process the emotional responses that may surface? Who can he share these stories with? How does he share with or connect with his own family when he is unable to speak of his work experiences because of confidentiality, the risk of traumatizing his own loved ones, or, at times, not having the words to accurately describe the intensity of the experience. While Ajay spoke of his personal challenges in implementing self-care, he shared the following response to the art image he created.

Figure 3. *Sounds of Waves Crashing*. Oil pastels on paper.

> *The best thing for my self-care is to sit by the beach and then to see the setting sun. To see the birds flying there and to listen to the sound of the waves crashing by, and the clouds and the birds coming down. That's the thing, which I find to have the most calming effect on me, just staring at the ocean, looking at the horizon. There is nothing like the setting sun going down into the water or into the beach, or looking into the distance and [seeing] a boat or a small fisherman out in the ocean. And then you hear all the sounds related to that. I find they are the most calming and most pleasant things in my life.*

When asked how often he is able to get to the beach, he laughed and stated, "I try to make it. I go every year. Walking by the shore, especially an early morning walk. It's my most relaxing thing. The beach is really my place, just walking by the beach and

hearing all the things." On days when he experienced emotionally heavier patient stories, Ajay shared that he will listen to the sounds of the ocean as a way to relax.

I reflected back to Ajay that it sounded like he uses guided imagery and meditation to help him mentally retreat to the beach when he physically cannot get there. He agreed, and affirmed that he listens to sounds of the ocean as he falls asleep. He believes there is an "art to healing" and that this work is about relationships. Ajay, along with the other interviewees, acknowledged that relationships are essential: the relationships with the patients and families, the relationships with colleagues on the treatment team, and his relationship with his faith.

I think the other relationship that is essential in this work that he didn't mention, is the relationship one has with oneself. The ability to care for, tend to, and love the self may be an essential element in being able to journey with young patients as they face existential concerns of death, loneliness, isolation, and meaning, as well as experiencing the joys, triumphs, celebrations, and "normal" moments of childhood. For practitioners to consistently accompany others, especially young children, on their journey, forming these relationships, offering love, care, and concern, and risking pain and loss, the practitioner must have a relationship with his or her own self so as to not become detached or aloof. It seems having a relationship with the self, an awareness of boundaries, and the capacity to tend to the self through love and compassion, contributes to the practitioners' resiliency in maintaining and sustaining a highly integrated level of care for the pediatric patients.

Taryn, inpatient oncology child life specialist.

Taryn has been working as a child life specialist for 5 years, and spoke of her compassion for children and families faced with chronic and terminal illnesses. She was led to the field of child life in part because of her personal experiences as a child who had frequent hospital visits. She had a desire to give back and to do for others what had been done for her and her family.

Child life is a field in which practitioners use age appropriate medical play and education to comfort and educate children about illness and medical procedures. Child life specialists offer procedural support through comfort and distraction, and normalize the hospital experience through opportunities for play and other childhood activities. Taryn, while at first a bit reserved in conversation, spoke candidly about her experiences and the necessity of the relationship that develops between practitioner and patient. She shared that the work can be hard, and often the most challenging part of her work is time. She said there is sacrifice in this work that often involves going above and beyond. While she recognized that giving more of herself is sometimes a sacrifice, she also acknowledged she would want someone to do the same for her children.

Taryn had recently attended a workshop about compassion fatigue. She appreciated that the presenters of the workshop provided tools to assist with coping with compassion fatigue. She claimed that many know about compassion fatigue and burnout, but questioned how to implement it [self-care] when we are still giving so much? She affirmed that she has ways in which she cares for herself, which included family and quilting. Taryn acknowledged the importance of a good support system at home or at work, and was grateful that she was a part of a team that supported her. She disclosed that

she was currently experiencing burnout, and how grateful she was that her supervisor came to her to express concerns. Taryn felt the challenge with burnout is that as practitioners, perhaps we don't know how to ask for help in caring for ourselves. Taryn created the picture in Figure 4 and shared the following in response to her image.

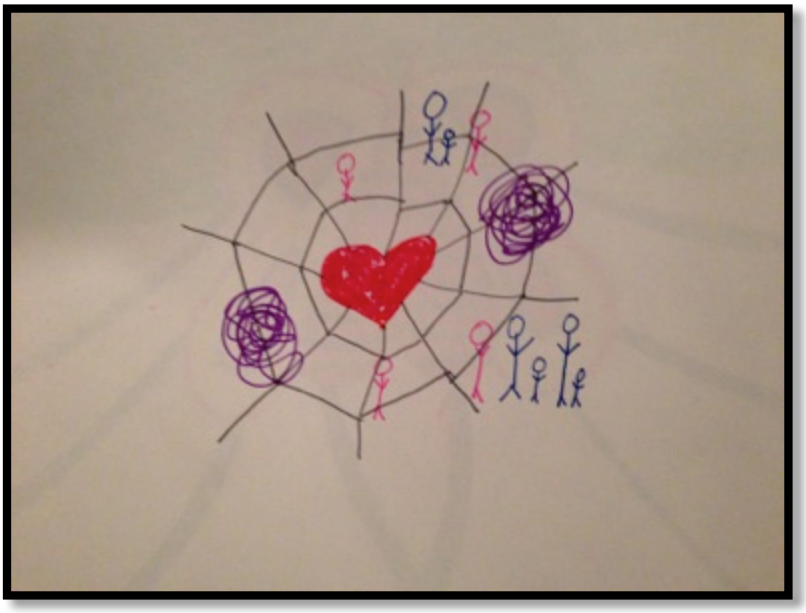

Figure 4. *Spider Web of Helping*. Oil pastel on paper.

So I have a spider web and my blue figures are my families and my pink figures are my healthcare workers. The purple are the storms or tangles. When we talk to these families, if their kid is in the hospital or has an illness, you are throwing complete chaos into their lives. Sometimes parents don't know what's happening, so my job is to help the whole family understand what is happening and talk about it. Those are my tangles or storms. At the center of this, I do this because I would want someone to do it for me or for my kids. And it's still about people and about helping, and to me that's about heart.

She said that she held the stories in her heart and head: "If it's not ok in my head, some of the issues weigh on my heart. It is important to have a good support system at work or at home."

As I reflected upon my conversation with Taryn, I wondered about the role of vulnerability and the risk for the practitioner when acknowledging the need for help in caring for the self, setting boundaries, and in feeling supported through the array of emotions that surface. I admired Taryn's openness about her experiences with burnout and compassion fatigue, yet wondered about her relationships with the other team members. Perhaps she was experiencing a bit of a disconnect with the oncology team due to her position on the inpatient unit, versus in the clinic with the rest of the team members who were interviewed. We discussed this briefly, and she spoke of feeling a stronger connection within the child life department than within the oncology team. She is responsible for caring for oncology patients, but her responsibilities include caring for other patients as well. While Taryn was able to speak of the importance of a supportive team, she appeared to be keeping herself at a bit of an emotional distance. In response to the energy I was receiving from her, I offered additional support and encouraged her to contact me if she felt she needed an unbiased perspective in relation to her current experiences.

Angie, pediatric oncology outpatient child life specialist.

Angie was the outpatient child life specialist in the oncology clinic. While she only had two years of experience in the field, she was referred to this interview because of her deep compassion and commitment to the field. Her colleagues acknowledged her

innate ability to connect with and be with the children and families during difficult procedures and challenging conversations. She had made connections with the medical staff and quickly adapted to being a part of the team. Angie spoke passionately about her work, and claimed, "oncology chose me." She spoke of the challenges in working with children diagnosed with cancer, and in living far from her own family.

Angie reflected, "There are ups and downs. The down days are sad and hard. Down days are really down, but the up days are really up." She said, "The resiliency of the kids and their coping—that's what helps. [It's an honor] to be a part of moving them forward. It's the little things every day." Angie, like Beth, used the metaphor of a butterfly when referring to her patients: "It's like the changing of a butterfly. This work is physically and emotionally changing. Every day." She practices self-care through yoga and running, and spoke of the importance of having a strong head and a strong heart. While Angie has only had a few years in the field, she appeared to be well grounded in her current self-care practices. She shared that her professors ~~[in college]~~ strongly encouraged self-care and for that she is grateful. Angie created the following picture in response to her work and shared the following reflection.

Figure 5. *My Heart's Work*. Oil pastel on paper.

When you first said, "art work" in relation to this work and how I feel, I thought of a heart. Just because I really think this is my heart's work, and I know that because of how it stirs at my emotions almost every day. And I know it's meant to be, deep down in my core. I used yellow on top as bright; this is where I know I need to be and this is good for my heart. But sometimes the blue waves symbolize that sometimes I'm wavering. It's hard sometimes, this work and being away from home. The wings represent both the butterfly symbolism and my leaving home. It was big for me to leave home. The green grass represents home for me. It works itself from the middle of the page out. It symbolizes my work.

I connected with Angie in relation to her belief that this is her "heart's work." I have often felt that way about my work as an art therapist. She spoke passionately about the awareness of the mind-body connection and the need to tend to herself. While she is

a fairly new practitioner, she was able to speak of her ability to honor the emotions that get stirred up, and her self-awareness in relation to boundaries and self-care. Like her colleagues, Angie finds strength in the small moments, and uses the hope and resiliency she witnesses in the children as a source of her own sense of hope and resiliency.

Karen, pediatric oncology nurse practitioner.

Karen has been working as a nurse practitioner for over 30 years. She chose nursing because she desired to help people and wanted to make a difference. In nursing, she stated, "You can personally make an impact." It seems that many of the practitioners are drawn to this field by a desire to establish personal relationships, to help others, and to know that a difference is being made. Similar to what other participants spoke about, Karen emphasized the importance of the atmosphere one works in, and having a good support team. She spoke to the need to have clear boundaries and self-awareness because of the level of caring that occurs. Like the others, she spoke of her innate ability to do this work, and that she gains strength from the kids. She spoke to the vulnerability in caring for these children and again emphasized the need for self-awareness. The following is the art piece she created in response to her work and her description.

Figure 6. *Clouds Parting, Sun Shining, Rainbow*. Oil pastel on paper.

I tend to be a more independent person. Seriously, The way you maintain doing this forever and ever and ever. It's really sad when you see some of these kids don't make it and it's really sad, but most of them do. And I think the fact that you are able to help them through a horrible situation. I have pins… one mother gave me a pin. It's an elephant. It's meaning is "remover of obstacles." She said that's how she always thought of me. If she had a problem she would come to me. She felt if it was possible, I could remove the obstacle. That's how I view my role…I see myself more as a facilitator for these families. That's how I view my role, to help them through this horrible stuff. I get involved in just about every single aspect of it. And that's good and I like it that way.

Reflecting on her artwork: "I would envision sky and clouds. Because that's how you feel when your child is diagnosed with a bad disease. You see the clouds parting and

the sun coming out and maybe a rainbow coming through. There you go. There's the sunshine, the rainbow and the rain." She also stated, "I gain strength from the kids. There's an innate ability to do this. And you have to be vulnerable and self-aware."

Wendy, pediatric oncology clinic nurse.

Wendy, a pediatric oncology nurse in the outpatient clinic, stated that her love for these patients is so intense: "Something drew me to them. I could give so much of myself to them." She recognized this extension of herself and talked strongly of her faith. She spoke of the privilege in caring for these children and families. I asked how she is able to sustain this work in relation to the intensity she described. She stated that she believes God gives her the strength to do this work. She acknowledged how heartbreaking it can be when children die; yet how grateful she is to have a job where she knows she makes a difference. Similar to the other interviewees, she then spoke of the importance of a good support team. She shared how she and her colleagues support each other through all of the emotions and deeply care for each other. Wendy created the following picture and her reflection follows.

Figure 7. *Smiles*. Oil pastel on paper.

> *I don't know how I get the strength. But He [God] put me in this position and I truly believe that. I think I do a good job. I hope I do a good job…You get to be a part of their family and you have to extend yourself." She continued, "The greatest compliment families give me is that they look for me when they come to clinic and the kids come running down the hall to give me a hug. Even though it's hard, they still like to come see us. Some of the things we do hurt and cause physical pain. They trust me because I tell them the truth when something is going to hurt. I think trust is a big part of the relationship. Kids are special and they can really tell who really cares.*

She added, "I think you really made me think about my family and how hard that is [when you have to take care of your own parents who are sick]… It's not easy. God gives me the strength to do it." In response to her drawing, she simply stated, "This is me

smiling at some of my patients. The laughing and the smiling. It's these moments and these relationships."

Wendy spoke of a deep love for the work that she does, and I could sense her passion in the tone of her voice and in her body language. Like the other interviewees, she emphasized the importance of the relationships that form not only between patient and practitioner, but also among colleagues. She reflected on the challenges she experienced when caring for her dying parents, because of her experiences caring for dying children. I acknowledged and validated how challenging that role must have been and wondered aloud how she had cared for herself during that time. Her eyes teared up in response to reflecting more deeply about that time in her life. She told me she hadn't thought that hard about what she had experienced. Perhaps that small piece of our dialogue gave her the permission to acknowledge the difficulties in consistently caring for others without taking a moment to honor her own role and experience.

Wes, volunteer chaplain and musician.

Wes has been working with children who have medical illnesses for numerous years. He has a unique role, in that he is not a hospital employee; rather, he volunteers his services and uses music as his ministry to connect with and care for hospitalized children and their families. Wes founded a non-profit organization that enables him to travel through the states and share his special gifts of music and ministry with ill children and their families.

Wes used music as a metaphor when talking about his passion for working with sick children. He believes his work is a faith journey, and that everyone has a

"soundtrack" to his or her life, whether we realize it or not. He spoke of the reciprocal relationship between patient and practitioner; that although he is there to give to the children through music, ministry and humor, what he receives in return is immeasurable. "It's gifts both ways, and strengthens you for the next hurdle." His mission is to allow children to be children. He uses his music as self-care, and often writes songs in response to, or in memory of a child. He also has songs he listens to for certain times, or moods. "Music elicits and allows for emotions. The arts empower us to feel, whether we want to or not."

He spoke of the privilege to be a part of someone else's soundtrack. Wes believes, "You come out much fuller. By entering into suffering, life takes on another dimension and colors everything you do." Wes spoke passionately about his work, and, as in conversations with the other practitioners, I could sense his deep commitment and connection to his work. He stated that he doesn't feel like he works, because, "I get to immerse myself in what I love every day. The joy of music is that which connects us. In this life it's what we make of our trials. They can either break us or redirect us."

Wes spoke of the connections and relationships he has formed throughout the years with the children, families, and medical staff. He has a deep faith, and spoke of the role of love within the relationships with the children and families. He feels as though his family "has just gotten really big." As a part of his self-care practices, he reads letters from the children and families. He said, "It's important to remember and to never forget our roots." Wes created Figure 8, and shared the following.

Figure 8. *Hearts Joined in Music*. Oil pastel on paper.

In relation to his drawing, he stated, "Just hearts joined in music." Earlier in his interview he reflected, "I'm just trying to live my faith. We all have a soundtrack to our lives, whether we realize it or not. It is an incredible privilege to be a part of someone else's soundtrack." He continued:

> *Everything is connected to music. Everybody has a song. You can connect with a song. We become one voice. We have that one moment. It's a privilege to be let in. I don't take it lightly. It's a very special place and I guard it…. I realized, again, none of us [is] promised the next breath. These kids have taught me to grasp each one, and say, let me run with this one. We might not have tomorrow. My kids have experienced the gift of that; my wife has experienced the gift of that. I try to guard my time with them, and when I'm with them, I'm with them. And that to me is very important because of what*

I've seen. One of the things I've learned in this journey is that it's not about strength; it's more about passion. I've fallen in love. I'm a hopeless romantic and to me love is something to fall into everyday. Every one of these kids just seems to immediately get under my skin, and I think the families in a way sense that.

Conclusion

The case vignettes demonstrate the deep connections that were formed within the field of pediatric oncology. Each interviewee spoke of their connection to the work, as well as the importance of the relationships with the patients and families, and their team of colleagues. Based on the stories shared, I sensed the importance of a relationship with their faith, whether that faith was connected to religion, spirituality, or the human spirit. I also argue that there was a relationship with the self that was present in the self-awareness of the practitioner and the willingness to journey with the patients throughout the cancer experience. The interviewees were reflective and thoughtful in their responses, offering personal stories and memories from their experiences. Within their stories, I was able to hear qualities of love, hope, commitment, compassion, faith, presence, suffering, empathy, communication, courage, and vulnerability. Some of these qualities were spoken of directly, while others were revealed in subtle ways, when the participants talked about being with patients for the difficult moments, as well as the joyful moments. These practitioners have had many years in the field and have experienced the deaths of numerous children. They spoke of the honor and privilege to be invited into the private lives of these children and families. The interviewees

expressed a deep gratitude for not only the work that they do but for the relationships that have been formed as a result of this work.

While two of the participants spoke of struggles with self-care, maintaining self-care, or experiencing the phenomenon of compassion fatigue, they each were able to identify ways in which they do practice self-care. Often, the self-care practices of the participants were related to faith, family, and relationships. Many of the practitioners spoke of the importance of a strong team as well as the need to experience all of the emotions related to working with children diagnosed with cancer. Perhaps this ability to be with their emotions and allow the self to feel all of the emotions is an expression of self-love. The participants spoke of the presence of love in both direct and indirect ways, from the power of human touch, in hugs, to the verbal expressions of loving their work, loving the children, and loving their colleagues.

One of the most consistent messages I heard from this group of practitioners was in the reciprocal relationship between patient and practitioner, and the ability to transform challenging experiences into motivation, hope, and resiliency. When each interviewee spoke of challenging times in their work, or the death of a patient, he or she reframed the experience, speaking of it as a source of inspiration to continue this work. The memories of former patients are honored through continuing to be present and positive with future patients. In the subsequent section I share my artistic responses to the interviews and information collected. The art works were created with the intention of honoring the stories, while focusing on the research questions related to the unique qualities in the pediatric oncology practitioner-patient relationship, the experience of practitioner vulnerability, and the role of self-love in self-care practices.

Creative Portfolio of Works

The creative portfolio for this culminating project is comprised of my own artwork created in response to the oral, visual, and kinetic data from the interview sessions, and a professional video that presents these results to professional audiences who are interested in self-care practices. The purpose of this arts based inquiry was a process of creative synthesis to illuminate the results of the interviews, which sought to explore the following:

(a) What are the unique qualities within the therapeutic relationship that contribute to the intensity of the experience of the oncology caregiver?

(b) How does vulnerability contribute to the practitioner's experience within the therapeutic relationship?

(c) How do expressive arts interventions in the context of self-care illuminate the role of self-love as an element of self-care for professional caregivers?

The interview process revealed core themes that were woven within the seven interviews, including relationship, faith, love, hope, courage, empathy, compassion, and vulnerability. Within heuristic inquiry, the process of creative synthesis involves taking the core material discovered, and synthesizing it through intuitive, reflexive, and meditative processes into a comprehensive expression of the essences of the phenomena that were investigated (Moustakas, 1990).

The aim of this research was to illuminate the experience of practitioner vulnerability and the role of self-love in self-care practices. Guided by my intuitive and reflexive processes, I created three sculptural pieces that further explored and synthesized the stories and images gathered from the interviews, and worked with common themes

that emerged from the participants' experiences of vulnerability and self-care. The following section provides a description of the researcher's engagement in art-based research processes as a vehicle to reflect, illuminate, and explore the subject matter revealed through the interview processes. Both the process and the product of this creative synthesis were important, as the tending to, working with, and problem solving within the process provided metaphors for the complex role of a caregiver, and thus the process of creating the figurative sculptures is shared here.

The result of this creative synthesis is a series of art works intended to be displayed publicly, to invite viewers to reflect upon the experiences of the pediatric oncology practitioner. The beauty and the pain, as well as the strength and vulnerability one experiences in caring for children with cancer is expressed in the delicacy, beauty, and rawness of the figurative sculptures. A culminating video was created for the purpose of sharing these findings with other practitioners, in the hope of creating awareness of the experience of vulnerability in the therapeutic relationship, and thus providing an additional reason to maintain self-care practices. It is my belief that an element of self-love exists in self-care practices, and perhaps is the quality that enables some practitioners to better maintain and sustain their self-care practices. When we love and tend to the self, we are better able to love and tend to our patients and clients.

Figure 9. *Moment Held*. Tissue paper, starch, origami paper, hot glue.

Body of Work

This body

of work

Holds

Stories

Tender and deep

Precious and dear

Painful and raw

Of love, of loss, of hope, of fear

Stories held

In my hands

I reach out, I touch, I hold, I hug

In my stomach

They stir, they churn, they brew

In my mind

They weigh, they linger, they rest

In my heart

They nestle, they grow, they flutter

Stories

Held

In this body

Of work.

Process.

The images in my mind appeared rather quickly as the interviewees were sharing their stories. They flooded my state of being and created a conflict between taking notes and sketching what was appearing in my mind. I attempted both. Because I was audio recording the interviews for accuracy, I needed my written notes to capture the key words that spoke to me: these words resonated, created conflict, warmed, and chilled me. I scribbled my notes across the pages and quickly sketched images as they appeared. The stories they shared were so rich and so personal.

The first day of interviews felt heavy. My heart and my head filled with their stories and my own professional memories that stirred within me. My choice was to interview a third participant or to call it a day; I went home to rest. The first two interviews had been emotionally intense and I needed to tend to myself. I needed to sew.

I began to sew small, palm-sized hearts, one for each of the participants (see Figure 10). The participants each had genuinely thanked me at the end of their interviews for giving them the space, attention, and opportunity to not only share their story but to remember their own story. The interviews served as an opportunity for the practitioners to reconnect to the memories and to the reasons they practice in the field of pediatric oncology. Their gratitude was evident in the authenticity in their voices, their eye contact, and in their offering of a hug of appreciation.

Figure 10. Sewn Hearts. Fabric, thread, and polyester stuffing.

The small hearts were carefully stitched and sewn. Each heart was made from two fabrics, one side purple crushed velvet, and the other side cotton, batik fabric of the interviewee's choosing. The differences in the texture of the two fabrics represented the balance between the challenges and the rewards within caregivers' work. The crushed

velvet was chosen for its tactile, potentially self-soothing quality. The batik cotton fabrics were chosen for the firmness in texture and for the unique colors and patterns. I carefully hand stitched, stuffed, and sealed each heart, holding in my mind the thought of being attentive and loving while mending the heart. I was mindful of the metaphor of sewing; in order to mend and form each heart, I had to repeatedly, yet carefully, puncture the fabrics in order to connect them with threads. Numerous times I unintentionally pricked myself with the needle and had to pause to tend to my own small wound. Each practitioner caregiver on the multidisciplinary team is a part of whole. While they each work independently, they also work collaboratively. I sewed a snap into the seams of each heart to connect with the other hearts, representing the independence of each of the individual caregivers and their connectedness to the clinical caregiver team.

Although my memories from the interviews were vivid, I needed time to reflect and synthesize the rich material they offered. I was unclear about how to make my mind's eye image come to life in sculptural form. The process of sewing the palm-size hearts allowed for a time of reflection and meditation related to each individual interview. I also felt a strong desire to honor the individuals who generously offered their stories and experiences. Once the seven hearts were completed, I was ready to immerse myself in the creation of this series of artwork. As a caregiver and the facilitator of the interviews, I first wanted to creatively honor and acknowledge their role in my process before I continued deeper into my personal artistic process. Perhaps this was reflective of my role as a caregiver, tending to the needs of others and my desire to tend to my appreciation for them.

The resulting sculptural figures did not arrive easily. I worked from an initial sketch I had drawn shortly after the interviews were complete. I knew intuitively that this was the artistic image that guided my art works for the portfolio. As I spent time with this image, I sketched and re-sketched its likeness in an attempt to determine what materials were needed to translate it to a larger scale. As soon as I realized this image needed to be in sculptural form, I knew I wanted to work with paper. I was drawn to the dichotomy of qualities within the relationships between pediatric oncology practitioner and patient: gentle and strong, love and pain, courage and fear, vulnerable and resilient, and believed the use of paper could demonstrate these qualities.

The figures were in part a result of the responses to the interview question, "Where do you hold these stories in your body?" The responses included: hands, heart, mind, head, and stomach. Some shared they held the stories in multiple places. I wanted to portray these places where stories reside in a gentle, supportive way. In the end, the butterflies that were intended for just one of the figures made an appearance on all of them. The butterflies, an image prominent in a few of the interviews, represent not only transformation, but also lightness. I wanted to balance the pain, the rawness, and the vulnerability with the beauty, delicacy, and hope within this field.

My choice of material was intentional for the potential metaphors that would unfold. I was drawn to tissue paper for its delicate nature, its function as a wrapping, and its possibility as a boundary or cushion between objects. These qualities were representative of some of the qualities in the relationships in pediatric oncology. Like the tissue paper, the relationships that form are delicate, perhaps wrapped in empathy, love, care, and concern, and the practitioners offer a sense of boundary or cushion to absorb

and protect. Tissue paper is a delicate material, and I desired to demonstrate its strength, much like the nature of the practitioners I interviewed, whom I perceived as both delicate and strong.

These practitioners spoke of their ability to experience all of the emotions, yet take the challenging times and reframe them to bolster their emotional, mental and spiritual strength. Rather than discarding the emotions and experiences of pain and loss, these practitioners allow themselves to feel the emotions and then reframe the experience to inform their future experiences and I would propose, increase their resilience. They expressed their ability to be in the delicate moments and find strength from within and around. This ability to be vulnerable, to use moments of challenge and pain to draw upon strength, faith, and love was like repurposing paper.

Paper is a material that can be easily recycled and repurposed. Rather than discarding ripped, torn, or worn paper, it can be reprocessed to make pulp for new paper. In the artistic process of making handmade paper, old papers are torn into small pieces and are then blended together with water, strained with a screen, then pressed firmly to extract the water, and left to dry. The new paper is created as a result of the experiences of the old paper.

I wanted to make the sculptures as close to human size as possible. With this in mind, it made most sense to create a mold of a human body, which would then be used to cast my paper sculpture. In sculpture, a mold is created with plaster, clay, latex, or rubber to create a negative imprint of an object or form. That material then sets or hardens and the object is carefully removed. Once the mold has been created, the cast, which is a replica of the original object or form, can then be created. In relation to my

intended process, I was going to create a mold of a human figure with plaster gauze and then cast the mold with paper pulp.

I quickly realized that this was going to be a challenging process. To create a plaster mold of a human body, one needs to apply a thin layer of petroleum jelly or similar substance to the exposed skin. This thin layer acts as a boundary between the person and the plaster gauze, protecting the hairs on the body and acting as a release agent once the plaster is dry. The plaster gauze is cut into strips and then dipped into warm water. Each strip is handled carefully to remove excess water and then applied directly to the body. The person having the plaster applied to his or her body remains still in the desired pose until the plaster is dried. The person applying the plaster gauze must be sensitive to the intimate nature of touching and applying the plaster gauze to another person's body. Once the plaster is dry, they can work together to remove the mold.

I was aware that this would be an intimate process and would require both courage and vulnerability in the process of applying plaster gauze to the body. I had recently moved to a new state to begin a new job, where all of my relationships were just forming. I was aware that I would need the assistance of another person either to allow me to make the plaster mold from his or her body, or for this person to make the plaster mold from my body, yet I wasn't comfortable reaching out to my colleagues, who I barely knew. I knew this would be nearly impossible to do on my own, yet I persisted. I failed in this attempt. The plaster gauze dried fairly quickly and I was physically unable to reach around myself to create a full mold of my own body. I peeled the half plaster shell off of my body and began to worry about how I would create these sculptures.

My next attempts utilized aluminum foil and then packaging tape. The aluminum foil was easier to work with in regard to the flexibility of the material and my ability to wrap it around my body. While the foil was easier to use when wrapping myself, it lacked strength and the ability to hold the shape of the body. I then attempted to create a mold out of packaging tape. I wrapped my torso, beginning at my hips, working upwards toward my chest. In order to create a figure form with packaging tape one first wraps the body with the sticky side of the tape facing out (smooth side against the skin). After the first layer, one must reverse the tape so that sticky side adheres to the sticky side creating a smooth external surface. After taping myself from hips to shoulders, I then carefully cut the tape form off of my body. This form provided a strong structure to work with, however, I ran into struggles in my attempt to depict arms, shoulders, neck and head. Frustrated, I abandoned all of these forms.

The process of attempting to create these forms, while frustrating, was very important, as each attempt informed the next. I felt vulnerable in this process; vulnerable in the exposure of using my body as the form, vulnerable in the fear that the form would fail to exist in the way I imagined it, and vulnerable in the risk of wounding myself as I carefully cut the taped form away from the exposed skin of my torso. In response, I allowed the emotions to surface: the fear, the anger, the isolation, the sadness, and the frustration. I expressed these emotions through my tears, through crumpling the aluminum form, and by allowing my self to honor the source of the emotions as well as the emotions themselves.

After these failed attempts and personal frustrations, I was unclear how to proceed with the mold. As a way to self-soothe and distance myself from that process, I began to

use the tissue paper to make origami butterflies. Butterflies had emerged in the conversations and art images during the interviews, and butterflies have been symbolic for me both personally and in relation to my work in pediatric oncology. The process of a caterpillar changing into a butterfly is often a metaphor for transformation and growth. In relation to pediatric oncology, the transformation of a butterfly is often in reference to the death of a child. Origami is a form of paper art in which square paper is folded in specific steps to create shapes, animals, objects, and other forms. The repetitive nature of folding numerous origami butterflies provided me with a meditative ritual that allowed me to reflect on my art processes. The folding of tissue paper was both complicated and intricate, yet the delicacy of the paper was forgiving in the folding process. The process and repetition in creating these butterflies became a self-care process that allowed me time for reflection before I returned to problem-solving the mold for the figures.

After some time to think about the sculpture process, I decided that the tape form would be the best method, and sought to find a mannequin or model. In a spontaneous conversation with a new colleague, I was introduced and welcomed into the university costume shop. I worked with three different sized dress forms, two female and one male, which were used by the costume designers for creating clothing. I used the same taping process that I had previously attempted on my own body. The process of taping the dress forms (see Figure 11) became a process of both strength and gentleness. I pulled the tape snuggly around the form, yet had to move with gentleness or I risked the tape unraveling or missing an area that needed covering.

This dichotomy between strength and gentleness reminded me of these qualities reflected in pediatric oncology. The practitioners, in caring for patients, must be both

gentle and strong; gentle in their approach and sometimes strong emotionally. Perhaps they are both gentle and strong in tending to the self, as well; showing compassion toward the self for holding and witnessing so much pain and loss, and strength in the ability and resiliency to continue in this field. I was careful in my approach as I cut the tape away from the dress form. Cutting the tape away from these forms seemed symbolic of those in nursing, and, as Wendy stated in her interview, "sometimes we do things that hurt." In caring for and helping these children heal, sometimes she has to inflict pain though a blood draw, needle stick, or other painful procedure, but these actions are done with the intention of helping the child to feel better or to heal. I admire her and other nurses, in their ability to be gentle yet firm when performing painful or difficult procedures. After removing the tape form from the dress form, I used the additional tape to reconnect the taped form where I had cut it.

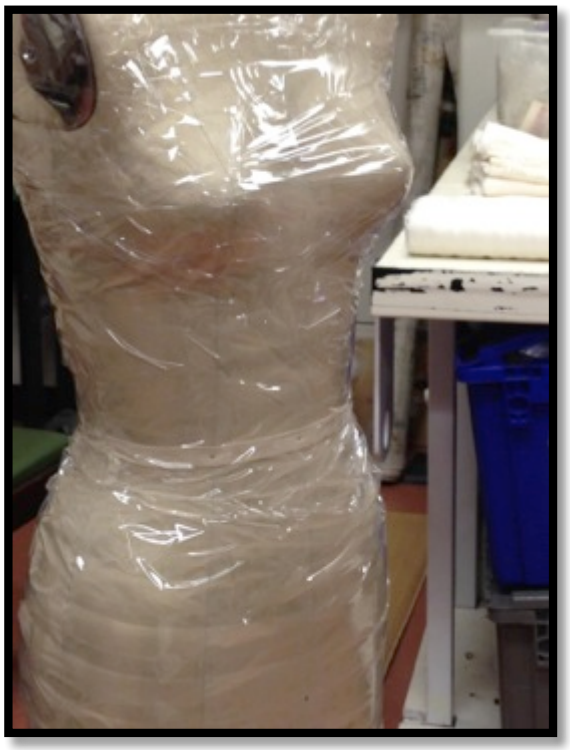

Figure 11. Taped Dress Form.

The next step in my process was to paper mache the forms by dipping strips of tissue paper into a starch and water mixture and applying them atop the taped form (see Figure 12). Once the tissue paper-covered forms had dried, the challenge was removing the tissue paper form from the packaging tape mold without damaging the paper form. Again, there was a dichotomy of strength and gentleness in the process. The tissue paper figure was vulnerable, in that it could easily tear or collapse into itself, with my firm motions of pulling and easing the two surfaces apart. I gently slid my hands between the two surfaces, easing the tissue paper off of the plastic tape. I had to tug firmly at areas where the tissue paper stuck to the sticky side of the tape. In order to pull the plastic form out of its tissue paper shell, I carefully pulled and folded the taped form into itself, as my arms stretched deeper inside of the paper body. Removing the plastic form reminded me of a butterfly emerging from a chrysalis or a snake shedding its out layer, except in this process, the paper form was shedding its inner structure.

Figure 12. Tissue Paper Mache Form.

The process of change and transformation to emerge as a butterfly is one that happens within the contained, private shell of the chrysalis. During this change process the insect is very vulnerable, protected only by the soft, thin shell of the chrysalis, which it built for itself. Inside the chrysalis, a private process is happening, in which the caterpillar begins to digest itself and generate new tissue from the old tissue. What may be most amazing is that there is cellular memory, and the insect retains memories from the larval stage. During this time the insect is very vulnerable because it cannot run away.

Perhaps this private process of transformation can be symbolic of the personal transformations and self-care that occur within individual practitioners. Each of the interviewees spoke of the ways in which their relationships with pediatric patients has changed them, transformed them, inspired, and motivated them. This thin shell of a

chrysalis, offering protection during a vulnerable time, is similar to the thin personal boundaries set by each individual practitioner in the field. Perhaps at times, it is beneficial for growth and transformation for the practitioner to retreat into his or her own protective shell to allow a time for reflection, remembrance, self-love, and self-awareness, and to then emerge with renewed energy for the continued journey.

In total, I created five tissue paper figure sculptures. Of the five figures, three survived the process and were altered and adapted to comprise the series of artwork entitled *Body of Work*. Each figure was unique in size and shape, and involved risk taking in the creative process. The figures appeared to be fragile, yet are strong to the touch. I spent significant time with each figure, metaphorically tending to its needs and mending its wounds. In order to patch holes or weaker areas, new tissue paper had to be wet with the starch and applied to the vulnerable places. The vulnerable places softened to accept the new tissue, creating a temporary weakness. When the new and old tissue dried together, the result was increased strength in the structure. This process reminded me of what was shared in the interviews. Similar to the transformative process previously mentioned, many of the practitioners shared how they reframe challenging experiences or the death of a patient to inspire and motivate them as they continue their work.

Beth recalled memories of a child who had died. She had been very close with this patient, as he had been coming to clinic for many years. As she told their story, tears fell from her eyes. She said, "This work is hard and it can be heartbreaking. But it's about the relationships. These kids have taught me how to live my life. It's about taking these difficult moments and these stories of pain and loss, remembering and honoring

them by being there for the next kid." She acknowledged her tears as both happy and sad, and emphasized the importance of honoring all of the emotions that arise.

I was aware of how vulnerable I felt in my art making process with every addition, alteration, cut, and suture I made (see Figure 13). Every step was new, and required me to trust that my creative process and intuitive ability would guide me as I created these sculptural figures. "Trusting the process," a phrase used by art therapists such as McNiff, Allen, and Bruce Moon, in relation to the creative processes of art making, isn't about the artist becoming passive in the process of creating; rather, it is about trusting and having faith in the creative process as an active participant. Trusting the process in creative art making invites the materials and images to guide and inform the process of creation and personal discovery. For me, trusting my creative process is a practice of awareness and attunement to my own intuitive abilities for creation and reflection. "Trusting the process" is not a release from responsibility over what is happening or what is created; rather, it is a release from the judgment and self-criticism that may filter into and stunt the creative process.

Figure 13. *Vulnerability*. Tissue paper, starch, thread, hot glue.

It was important to me to successfully translate and create these sculptures that captured the essence of the themes that had emerged from the interviews. I felt both anxiety and excitement in the creation process—anxiety related to my vulnerability as the artist. What would happen if I went through the labor and love of creating these sculptures and then they were to tear, collapse, or fail me in some other way? (What would happen if I establish a relationship with you; I love you and then you die?) What happens if I make the wrong cut, tear, or stitch, and ruin these sculpture I am tending to with compassion, concern, and love? (What if I fail you or hurt you in my attempt to help you?) What happens if the end result doesn't communicate the essence of what I have learned and discovered? (What if I fail myself?) Just as quickly as these thoughts

emerged, they would disappear. I celebrated each small success in the construction process, whether it was the attachment of the sculpture's arms or head, or a successful tear to expose the inside of the chest.

Each hollow paper sculpture was altered with intentional tears to expose areas of the chest, stomach, and head. During the interview process I asked the participants where in their bodies they felt they carried these stories and experiences of the relationships within pediatric oncology. I intentionally placed the origami tissue paper butterflies near the space of the head, the heart, the stomach, and the hands, to symbolize and honor the stories and patients that have informed, influenced, and shaped their experiences. Each sculpture also has a gold butterfly, representative of the personal transformation of the practitioner, and a reminder to tend to, honor, and love the self, as elements of self-care practices.

To display the final figures, I used flameless, electronic candles, and lit it each sculpture from within. This internal lighting was chosen with the idea to both illuminate and cast shadows, symbolic of the experiences of the joys and rewards in this field, as well as the experiences of challenges and losses. The sculptures, when on display, sit among a field of floating butterflies. The surrounding butterflies were hung with fishing line to give the illusion that the butterflies were flying, and to add to the wonder and beauty of witnessing the rawness, pain, and beauty of the sculptures. The resulting figures, *Faith* (Figure 14), *Coeur* (Figure 15), and *Hope* (Figure 16) are the product of my exploration of the experience of practitioner vulnerability and the role of self-love in self-care practices. *Faith*, *Hope*, and *Coeur* (which means "heart" in French, and is the root word for courage) are delicately strong when independent of each other, yet elicit the

significance of relationships when viewed together (Figure 17). The figures were photographed individually, in pairs, and as a group to capture the essence of the love and the pain, the vulnerability and the strength, and the independence and the connectedness.

There is a dichotomy in the essence of these sculptures: while they are lightweight constructions, the stories they hold or represent are heavy with emotion, similar to our needs as practitioners to balance the joys and pains of this work we do. The sculptures are hollow and exposed, allowing the viewer to capture a glimpse of the inside, and best viewed when the structure is lit from within. The internal lighting was chosen with the idea to both illuminate and cast shadows, again the need for us as practitioners to rely upon our inner strength, faith and resilience, to guide us through the difficult and challenging moments and allow us to be present to all moments encountered.

When I stepped back and reviewed the photographs (Figure 18), I felt those butterflies stir within me and I was moved to tears. Perhaps my tears were in response to the completion of this body of art. The creation of the sculptures was an intimate process of creation, trust, love, hope, and vulnerability. Or perhaps my tears were in honor of the many relationships I have formed as an art therapist working within pediatric oncology. The tears that fell were few and gentle, almost as if my self were responding to *My Body of Work* by affirming, "You are beautifully painful, tender and raw, and mindfully filled with love and hope. You have been through the processes of witnessing, being with, and staying with patients throughout their life. Failure and re-creation has affirmed value in being vulnerable and the importance of tending to myself while tending to others, of loving my self when offering love to others."

Figure 14. *Faith*.

Figure 15. *Coeur*.

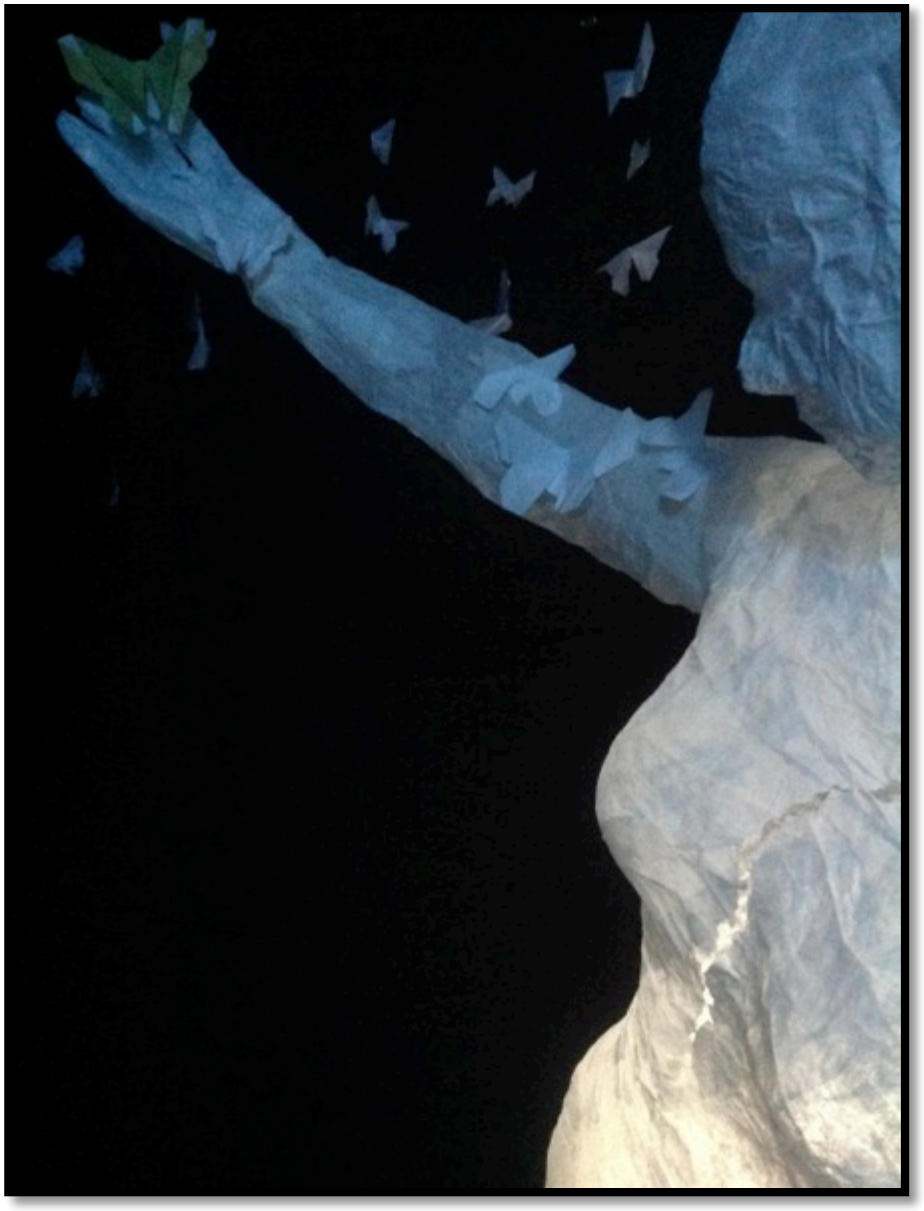

Figure 16. *Hope.*

Figure 17. *Relationships: Matters of the Heart*.

Figure 18. *Love, Witness, and Being With.*

Reflections, Implications, and Conclusion

The aims of this art-based inquiry were to explore and identify the unique qualities within the relationship between practitioner and patient in pediatric oncology; to illuminate the experience of practitioner vulnerability within the therapeutic relationship; and to explore the role of self-love in self-care practices. The seven interviewees contributed to my in-depth art-based exploration of these phenomena through their personal story telling, sharing of experiences, and reflections on their art images.

The interviews were rich with information, from which I was able to extract key words related to the unique qualities within the relationship. Perhaps what was most evident from the interviews was the importance and emphasis on relationships. I was able to identify four relationships that appeared to be essential within their work: (a) the relationship with the patients and families; (b) the relationship with their colleagues or team; (c) the relationship to their personal support system (family, friends, and faith); and (d) the relationship with the self. The qualities within these relationships were articulated with great compassion and respect. Elements that were identified included: compassion, love, communication, trust, hope, emotion, "being with," honor, honesty, resiliency, and vulnerability.

The experience of practitioner vulnerability was communicated in a less direct manner. I believe vulnerability was communicated in the stories of death, loss, and pain, and the ability to return to the work after experiencing multiple significant losses. Some of the interviewed practitioners had been working in the field for numerous years. They spoke of their ability to be with and journey with their patients and families through the

ups and downs of the cancer experience. As practitioners who are aware of the realities of a cancer diagnosis and side effects of aggressive treatments, these practitioners willingly form close relationships with their young patients, aware that there is a risk of loss of life. I believe the ability to continue to form authentic relationships and accept the risk of the loss of that relationship to death, is a practice in being vulnerable. While many of these practitioners, as well as myself, don't tend to focus on the experience of vulnerability; I believed that by providing an opportunity for practitioners to honor and acknowledge the ways in which they are vulnerable, self-awareness would be increased. These practitioners, whether they are aware or not, utilize these vulnerable experiences as opportunities for personal growth and resiliency. This was communicated in their stories of reframing the challenging experiences of witnessing pain and death into hope and motivation for continuing to help other children.

Similar to my personal realization as an early practitioner, that perhaps I was quick to focus on the lighter side of pediatric oncology, rather than the darker or shadow side, as a way to protect those around me, perhaps the reframing of challenging experiences was a way to protect the sacredness of the relationships with patients and the experiences of being with and witnessing intimate moments. Perhaps this was a way to protect others, outside of this field, from knowing the emotional pain of experiencing or witnessing the death of a child. Perhaps reframing pain and loss into hope and motivation was a way to protect the self from being vulnerable in the sharing of these experiences with others who may not be able to relate to vast experiences of love and life and pain and death.

How then do we care for the self as a result of the relationships we have experienced and witnessed? What is the role of self-love in self-care practices? As a result of this art-based inquiry, I continue to believe that there is an element of love in the therapeutic relationship. While this phenomenon was more challenging to explicitly identify in the interview stories, perhaps the presence of self-love, or the compassion and empathy for oneself, was demonstrated in their ability to express and honor the array of emotions they experience in relationship to their personal experiences as pediatric oncology practitioners. Perhaps by honoring the light and the shadows, or the love and joy as well as the pain and loss, they are tending to and loving the self. Each practitioner was able to identify ways in which they practice self-care, whether through family time, prayer and meditation, music, art, or exercise. Perhaps this relates back to the strength in the relationships these practitioners have formed. To be a part of a loving and supportive team may provide and enhance the opportunity to take the time to honor, love, and care for the self in the midst of this beautiful and challenging work.

The results of this arts-based inquiry support the need for healthcare practitioners to maintain self-care practices. Beyond the potentially simple act of doing self-care, I believe these interviews support the importance for self-care to include opportunities to remember and share the experiences, honor all of the emotions elicited in this work, and validate the role one has in being with others during their journeys. As Wes believed, "We all have a soundtrack to our lives, whether we realize it or not, and it is an incredible privilege to be a part of someone else's soundtrack." Perhaps we, as practitioners, need to take a mindful approach to self-love by listening to, honoring, and loving the music and melodies of our own soundtrack.

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Appendix A

Email Invitation

Dear ,

I am writing to you this evening to request your participation in my study, *An Arts-Based Exploration of Practitioner Vulnerability and the Role of Self-Love in Self-Care Practices.* This study is an expressive arts interview for my dissertation in completion of my Professional Doctorate of Art Therapy. I am recruiting 6-10 pediatric oncology professionals to participate in an individual expressive arts interview facilitated by myself. The intent of the expressive arts interview is to capture the essence of your work and what compels you to continue this work through personal narrative, artistic response and verbal dialogue. The interviews will be recorded to best capture your stories. You, your patients, and the medical institution to which you are affiliated will remain unidentified. If patient stories are shared, we will ensure that confidentiality is protected.

I have submitted my proposal through the IRB at Mount Mary University and have reviewed [*Name of Hospital's*] Research Identification Worksheet. I do not believe these interviews qualify as research according to [*Name of Hospital's*] standards as they are in no way affiliated to or about the hospital, patients and/or patient care. The focus of the expressive arts interviews is on you as a pediatric oncology practitioner, your story, and the essence of the work you do.

I would be incredibly grateful and honored for your participation. If you are interested in participating in an interview, please respond to this email at your earliest convenience, as I will be available to travel to [*location*] Thursday- Saturday of this week (perhaps as early as Wednesday if the snow is delayed). I am working with [*name of liaison]* to secure a location on site at the hospital for ease and convenience with your work schedules. I will also make my self available after traditional work hours for those of you who may be unable to fit this in during the work day. If you have questions or concerns, please email or call so that I can best support you in your decision and ease any concerns you may have.

There are no physical risks in this interview process. You do not have to have any artistic ability to participate in this study, just a willingness to explore and express through artistic mediums. You will be recorded to ensure my accuracy in responding through my own art and writing to your visual and verbal responses. The benefits to participation in this interview is an opportunity for self-expression and self-care, to communicate your story verbally and visually, and to honor your role and the relationships you have formed throughout your experiences.

In appreciation of your participation, I am offering to return at a later date, to facilitate an arts-based self-care workshop for the pediatric hematology/oncology department. [*Name of liaison]*, I would also like to extend this to the child life department in appreciation of your assistance and support of my doctoral studies.

As soon as I have confirmations, I will begin to work with each of you to find the best time to meet with you when I am in town. The interview process may take anywhere between 45-90 minutes. This is to ensure you have time to reflect and respond to questions and engage in art making experiences. While that may seem like a lot of time for an interview in the mist of your busy schedules, keep in mind that the intent of my study is on self-care.

Appendix B

CONSENT FORM

You are invited to take part in a research study of *An Arts-Based Exploration of Practitioner Vulnerability and the Role of Self-Love in Self-Care Practices*. The researcher is inviting oncology professionals who are age 18 and over and who have been employed in pediatric oncology for a minimum of 3 years to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Lori Mackey, MA, ATR-BC, CCLS, who is a doctoral student Mount Mary University.

Background Information:
The purpose of this study is to explore the experiences of vulnerability within the therapeutic relationship that occurs between oncology patient and practitioner in order to explore the role of self-love in self-care practices.

Procedures:
If you agree to be in this study, you will be asked to:

- Participate in an expressive arts interview which will meet for approximately 2-3 hours to allow for creative expression and verbal dialogue
- Participate in expressive arts activities which may include visual art (painting, drawing, sewing, photography), creative writing (poetry, response writing, story telling), and/or movement (stretching, dancing, gentle movements)
- Verbally and visually share stories and experiences of working in the field of oncology
- Allow the interview process to be recorded through video and photography recordings
- Be willing to participate in follow up communication within a month of the initial expressive arts interview

Here are some sample art directives:
Create an image to represent your relationship to your work
Create an image of the gifts you offer to your patients.
Create an image of self-care.

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at Mount Mary University or your place of employment will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minimal discomforts that can be encountered in daily life, such as emotional upset when reflecting on meaningful, traumatic, or grief experiences. Being in this study would not pose risk to your safety or wellbeing. If at any time you are uncomfortable with the images, stories, and/or emotions shared, the

researcher will provide additional support via an individual meeting and a list of referrals for additional counseling and support.

Participating in this study may increase your self-care practices through new shared and learned experiences. Art-based self-care practices provide an opportunity to honor relationships, stories and experiences. Group self-care can enhance community, communication and group cohesion while providing individuals opportunities to support each other through shared experiences and emotions. Participants in this study may benefit from increased psychosocial support from colleagues and peers in addition to expanding current self-care practices. Participants may gain awareness of the risks for compassion fatigue, burnout and vicarious traumatization, which will increase self-awareness and reinforce the importance of establishing and maintaining healthy self-care practices.

Payment:
Participation is voluntary. As a result of participation in this study, this researcher will offer an onsite arts-based self-care workshop for the pediatric oncology department at their affiliated medical institution if desired by the practitioners. These interviews may or may not take place onsite of a medical institution.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. The research will not identify the participants, their patients or place of employment by name or any other identifying factors in the culminating creative dissertation. Identifying factors will be limited to job title and years of experience. Data will be kept secure by a password-protected personal computer and back up hard drive. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via phone or email

This researcher will give you a copy of this form to keep.

Printed Name of Participant

Date of consent

Participant's Signature

Researcher's Signature

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below I understand that I am agreeing to the terms described above.

Appendix C

Informed Consent
Media Release

As a participant in the research study, *An Arts-Based Exploration of Practitioner Vulnerability and the Role of Self-Love in Self-Care Practices*, you were invited to engage in a recorded narrative interview and creative arts process. By signing this release you give permission for this researcher, Lori Mackey, MA, ATR-BC, CCLS, to use your verbal and visual expressions and/or representations or likenesses of, in the culminating contextual essay and creative video portfolio. By signing this agreement, you understand that portions of your interview and/or your artwork will be a part of the final project and may be shown in education and professional environments. The privacy of you as a practitioner, your patients, and your places of employment will be protected through the omission of any direct references to yourself by name, your patients by name, and/or your places of employment by name. The interviews were recorded by video for accuracy only. Your voice will not be used in the final product unless you check the box below giving permission for your voice to be used. Video of you will not be used with the exception of the video clip of your hands creating your artwork. Your face and likeness of you will not be shown in the culminating video to ensure confidentiality of you as a practitioner, your patients, and your places of employment. Your participation in this study is greatly appreciated to further our understanding of the elements within the patient-caregiver relationship, the experience of practitioner vulnerability, and the role of self-love in self-care practices.

Check one:

- ☐ I am comfortable with my recorded voice being used as a voice over in the final video project.

- ☐ I am NOT comfortable with my recorded voice being used as a voiceover in the final video project.

I, _____, give permission for Lori Mackey, MA, ATR-BC, CCLS, to utilize my verbal and visual expressions in the culminating project for her research on *An Arts-Based Exploration of Practitioner Vulnerability and the Role of Self-Love in Self-Care Practices.* By signing this form I understand that my confidentiality will be protected and entrust that I will be represented accurately and professionally.

_____
Signature of Participant

_____
Signature of Researcher

Appendix D

INTERVIEW

You are invited to take part in a research study of *An Arts-Based Exploration of Practitioner Vulnerability and the Role of Self-Love in Self-Care Practices*. The researcher is inviting oncology professionals who are age 18 and over and who have been employed in pediatric oncology for a minimum of 2 years to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Lori Mackey, MA, ATR-BC, CCLS, who is a doctoral student Mount Mary University.

Participant Qualification
☐ I confirm that I am 18 years and over.
☐ I confirm that I have been working in the field of pediatric oncology for at least 2 consecutive years.

Biographical Information:
I identify as: ☐ Male ☐ Female
Age:_____
Years in Pediatric Oncology:_____
Occupation: _____

Interview Prompts
Please take a few moments to reflect and respond to these questions and prompts through narrative, poetic response, and written reflection.

Think about your role and your time in pediatric oncology. Create an image that represents your work.

Recall a poignant moment for you as a practitioner in pediatric oncology. Create an image that shares the story and core themes or values. After creating this image, share through creative writing the message of this story.

Do you believe you choose oncology or oncology chose you? Explain.

What enables you to work in pediatric oncology?

Describe the risks and benefits of your work with patients.

Please explain your understanding of compassion fatigue, vicarious traumatization, and burnout.

Have you ever experienced any of these phenomena and how did it present for you?

Do you currently engage in self-care practices? Please share your current self-care activities.