A trainee art therapist's reflections on attachment and attunement theories while working with an older adult client living in a residential aged care home

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Abstract

As a trainee art therapist on placement, I was convinced by art therapy literature of the centrality of art materials and art processes to the therapeutic potential of the client undertaking art therapy. Sitting in the background was some understanding of attachment and attunement theories and their focus on how our early relationships with caregivers shape our relationships in the future. What I had not anticipated was how profound this learning would be personally. This article recalls some therapeutic events that I found to be particularly significant in shaping my development as a psychodynamically informed art therapist while working with a client I will call Fay.

Keywords

Trainee art therapist, art therapy, attachment, attunement, art materials, residential aged care

Introduction

There is encouraging research into the ability of the brain to change through psychotherapy (Siegel, 2007). Art therapy is particularly well placed to offer this support. It is a verbal, sensory and visual mental-health modality, which promotes whole brain activity (Elkis-Abuhoff & Gaydos, 2016; Hass-Cohen, 2008; Lusebrink, 2004; Malchiodi, 2012; Michaels, 2015). Art therapy also encourages neuroplasticity (Bagan, 2012). For example, dual coding theory (Partridge, 2019) explains how images are encoded in verbal and non-verbal areas of the brain. One area of the brain does not prioritise over the other. This demonstrates that as art therapy is a multi-modal, whole-brain-engaging therapy, it is an excellent mental health support for older adults.

Psychodynamic theory and therapy have their roots in psychoanalysis and are influenced by object relations and attachment theories (Hogan, 2016). Psychodynamically informed art therapy emphasises the interpersonal, collaborative relationship between the therapist and the client, and art media, processes and products within the therapeutic space (Case & Dalley, 2014; Howie et al., 2013; Rubin, 2011). Making art together with my client while I was on placement in a residential aged care (RAC) home helped establish and support the process of developing a compassionate and respectful alliance with my client (Siegel, 2010). Winnicott (1988) would suggest that I was functioning as a 'new object' compassionately holding the client's experience (Irwin, 2016) in the 'here and now' (Bowlby, 2005; Crago & Gardner, 2019; MacWilliam, 2017). The provision of a safe and supportive therapeutic space was forefront in my mind. Winnicott (1988) likened this type of space to a nurturing space that could facilitate play. The freedom to be creative and play facilitates growth (Case & Dalley, 2014). Winnicott (1988) believed that in creativity we use the whole personality and we can discover the 'self'. Making art together and in response to therapeutic work deepened my knowledge and experience of how we both related to the processes of art-making and its expression (McNiff, 1998a).

After finishing my clinical placement, I have grown in knowledge and understanding of how the qualities of materials can support or inhibit cognitive and psychological functioning (Hyland Moon, 2010; Lusebrink, 2004; Pénzes et al., 2016). I have felt this learning in very personal and profound ways. This

included when I engaged in reflective response art, which amplified and focused my experience (Fish, 2019; McNiff, 1998b). Allen (1995) and McNiff (1992) both demonstrate that art-making is a way of creating space for imaginative awareness. This awareness became central to my experience and learning. I found creating portraits of my client helped me to heal and reconsider some of my past relational experiences (Nash, 2019). McNiff (2019) would call this 'good medicine'. I could explore imaginatively, openly and with empathy who my client was, by considering McNiff's (2019) approach to art objects as living expressions. I was able to reflect on how we engaged together in the 'here and now' and how I could develop a sense of becoming a 'good enough' therapist (Wadeson, 2016; Winnicott, 1988). I was able to uncover and clarify experiences of counter transference (Fish, 2019; Jongeward, 2015), through the use of artistic works as transitional objects of remembrances of attachments (MacWilliam, 2017; Rubin, 2016). It was through reflective portrait-making of my client that I was able to think and speak freely and make way for the new (McNiff, 1988b). Fay had lived in RAC for two years and we worked together over a ten-month period.

Fay

Fay is 69 years old and had a complex medical history, including type 2 diabetes, stage 5 chronic kidney disease, bipolar type 1, depression, anxiety and adjustment disorder (unresolved grief). She underwent dialysis three times a week. Since 2016, issues with short-term memory, aggressive mood, and noncompliance with medications and medical care had been ongoing.

Research has shown that depression is the most common complication found in patients with end-stage renal disease (De Sousa, 2008; Keskin & Engin, 2011; King-Wing Ma & Kam-Tao Li, 2016). It is often accompanied by anxiety, and it has been shown to be a significant predictor of mortality in the dialysis population (King-Wing Ma & Kam-Tao Li, 2016). Keskin and Engin suggest that symptoms increase with age in patients with chronic renal failure. The research recommends that older patients should receive regular psychiatric evaluation and support. Despite this research, depression in dialysis patients is often under recognised and under treated (King-Wing Ma & Kam-Tao Li, 2016).

I was referred to work with Fay by the centre manager at the RAC home, who reported that staff experienced significant behavioural challenges when caring for her. She required physical assistance with all activities for daily living. Challenges I was made aware of included poor insight, ongoing non-compliance issues with diet, medications and health-care procedures, and aggressive and/or inappropriate language.

Fay lived with her mother for the last 18 years of her mother's life, up to her death in January 2018. Fay's ongoing grief over the death of her mother and increasing incapacity to care for herself led to her adult children seeking supported living options. Fay moved into full-time residential care at her current facility in October 2018.

I observed that Fay's vision was weakening, and while she carried her mother's glasses in her bag, she herself did not have prescription glasses. I wondered whether this may be due to her only wanting her mother's glasses as a type of security blanket or transitional object (MacWilliam, 2017; Winnicott et al., 2010). Fay was encouraged to use a walker as much as possible but she was predominantly

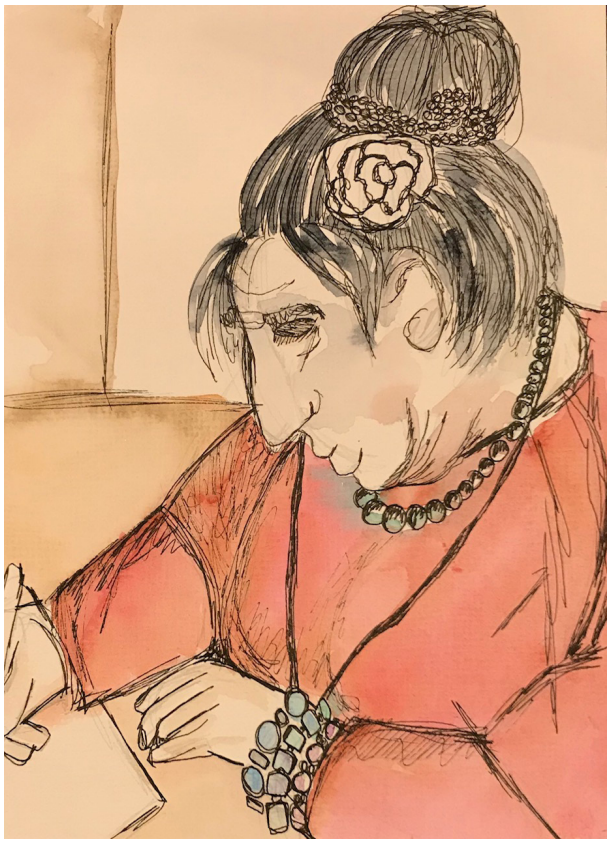

Figure 1. Sylvia Marris, *Fay*, 2020, watercolour and ink on paper, 300×210mm.

in a wheelchair. I heard her vocalise loud noises frequently, sometimes when she was alone in her room, sometimes in the dining room and at staff. This was accompanied by verbal resistance when staff assisted her with daily care routines.

I painted a portrait of Fay (Figure 1) using watercolour, as it was her preferred medium. This helped me sense her as a whole person, rather than a list of symptoms and behaviours. Fay had a great sense of humour, though sadly I saw it significantly decline over the ten months that we worked together. When it was expressed, it was done generously in both gesture and voice. She loved to wear the colour red, lots of jewellery and, sometimes, flowers in her hair. She liked to wear her hair in a bun on the top of her head, held in place by a bejewelled scrunchie. She enjoyed the company of others during group art therapy and showed a keen interest in learning to paint. She said painting relaxed her, and she said, "I don't want anything to stop me from painting." Some of her favourite things were sharks, watching movies (especially if they were about sharks), pineapple sandwiches and listening to rock and roll music on the radio.

From our first session I was conscious of working towards a respectful and trustworthy alliance (Rubin, 2011). Siegel (2010) describes the concept of alliance as the quality and strength of the collaborative relationship, and that empathy is essential to be able to understand the client's point of view.

In the beginning of our work together, I focused on getting to know Fay. She was open to exploring art materials, talking and reminiscing. She took a firm liking to watercolour paint, preferring strong colours, partly because I think she could see them. When I organised watercolours for her, she always asked me to name them as I set them out. Over time I realised she would remember the placement of the colours. This enabled her to choose her preferred colours independently. This routine was also enacted when I set out other materials such as textas, paint pens and paint sticks. To choose a painting surface she ran her hand over the paper, and preferred to use textured watercolour paper or acrylic canvas paper.

For the first six months I did not find her medical history to be a deterrent to engaging in the processes of art-making. For the last four months there was a steady decline in her willingness to engage in art therapy, socialise with others and in her stamina for art-making. Episodes of low mood, chronic pain and complications of dialysis, together with poor sleep, were affecting her quality of her life. She was experiencing repeated episodes of frustration and hopelessness.

At the beginning of our work together, Fay was able to engage in over an hour of art-making and socialisation. In the last six weeks her art-making was reduced to only a few minutes. She socialised less, and frequently took her meals in her room. The tone and content of her conversations changed. It was generally focused on expressing frustration about dialysis treatment, feeling trapped in a sick body, wanting to die but being afraid.

In the final six weeks of our work I took to visiting Fay at the renal clinic once a week. The clinic staff reported an escalation of challenging behaviours while she was receiving dialysis. I learned that her compliance and mood were declining to such an extent while at these appointments that her doctor informed her that dialysis would cease at the clinic if this continued. The only option would be admission to hospital or no dialysis. Without this treatment Fay would die very quickly from renal failure.

When I arrived, Fay usually felt unwell, and often reported feeling angry and frustrated. Within the RAC home she frequently said that art-making was the only way she could relax. At dialysis she refused to make art on her own and so together we collaborated and worked on images together, or I would make an image under her guidance. She commented that watching me and working in this way also relaxed her. When she was relaxed, she told me, her body hurt less and she felt less angry.

Fay had experienced ongoing challenges around noncompliance with health procedures (blood-sugar assessment) and medications (refusing insulin), yelling, swearing and aggression. These had been long-term issues and were present before Fay's move into RAC. They had escalated in the last twelve months as her renal failure entered its final stage. Fay refused to participate in any assessments on admission to RAC in 2018, and she had not been assessed or supported for mental health concerns in the last two years.

This exposes a gap in the provision of holistic care within the Commonwealth-funded RAC model. The current Commonwealth-funded instrument, the Aged Care Funding Instrument (ACFI) (Department

of Health, 2020) is used to allocate Australian Government funds in the form of subsidies to RAC providers who will allocate resources to core needs among the residents. One of the three domains assessed on entry is titled 'Behaviour', which in part assesses mood. It specifically addresses symptoms of depression.

To qualify for a subsidy from ACFI the resident is required to undertake a range of assessments to be completed within a month of their moving into aged care. If a resident refuses, they do not qualify for extra support. Even if Fay had complied with the assessments, ACFI does not provide funds or services for mental health counselling or other mental health services within the RAC model. Only pharmacological interventions for mood, such as antidepressants, are provided for. In Fay's case, even if medications were prescribed, she had the right to refuse them. Holistic person-centred care, when I view it from Fay's needs, is multilayered and nuanced. Aspects of care that she requires for psychological support are neglected through the current Commonwealth-funded model.

Older adults are able to self-assess their health (Nordhus, 2015; Partridge, 2019). Fay's expressions of feeling hopeless and being ready to die were documented by a few staff, myself included. However, she denied this when asked by two GPs servicing the care home and again with a specialist. Self-reporting research confirms that older adults under-report medical symptoms and their severity (Partridge, 2019). I speculate that in this case it may have been due in part to medical staff's lack of establishing rapport with the client before asking probing questions.

I observed that the materials and processes of art-making used in a therapeutic setting gave Fay a safe and supported way of communicating and connecting with her body, memories, thoughts and feelings.

Fay's health and stamina were quite variable over the four or so hours that she attended dialysis. When I arrived for our sessions (usually two hours into the treatment) she could often be experiencing symptoms such as pain, cramping, variable blood pressure and nausea. I learned to begin very quietly. I would say hello and ask her if I could sit and keep her company. This usually elicited "I don't care, I'm too sick" as the response. I would sit quietly, smile, then avert my gaze, my art bag on my lap. I let Fay direct any conversation. This usually didn't take long, as she was curious about what might be in my art bag.

I worked collaboratively with Fay in the processes of art-making while at dialysis. One of her arms was connected via a cannula to the dialysis machine and had to be kept in a specific position. Her other arm (non-dominant) was continually used to measure blood pressure via a cuff for the whole period of treatment. There was a very limited range of movement for that arm as well. On one of our collaborations we constructed her family tree. Fay didn't do any art-making for this project, though she guided and made all aesthetic decisions from the size and shape of the tree to the colours that were chosen, the media, and the size and placement of leaves and fruit. The leaves and fruit represented family members. Information Fay wanted included for each family member's leaf or fruit was their name and age. Her family tree consisted of her mother and father, her two brothers, two ex-husbands, her children, their partners and their children. We completed the family tree over one sitting of 90 minutes.

It was through the construction of the image of a tree with its leaves and fruit that Fay and I were in part reconstructing a narrative of her past. Through this remembrance I discovered what Stern (2018) would call a key therapeutic metaphor for understanding Fay's current thinking about her life. The key, according to Stern, is that the narrative points to the origin of a pathology, or vulnerability, to her core self. When it was hard for me to know the subjective early life Fay experienced, I relied on the intersubjective therapeutic relationship. It allowed me to enter and share her current affective state in an empathetic and supportive way. Stern describes that the sharing of affective states is the most relevant and appropriate feature of the therapeutic encounter. I interpreted affect sharing as my ability to share the space of the experience and communicate that I was there. This could be through a light touch, a facial expression, or I might offer a few words. I offered a response and gauged its level of acceptance as to whether I was on the right track.

Fay described her relationship with her mother in very positive ways, such as "she took care of me and my children". She only referred to her brothers a few times, to say that they were dead. During the constructing of the image of her family tree

she referred to them this way again. Sometimes she muttered as we were working, "they are dead, they are all dead". Death had become a pivotal narrative for Fay. It was layered with her own current experiences of life-limiting illness and the end stages of renal failure. She seemed stuck there. Stuck in the helplessness of it.

During this session it was the first and only time that I would hear the names of her family members, rather than terms such as mother or daughter. She also asked me to include the cultural names for herself, her siblings and her parents. This was the only time she spoke these names. Her identity, heritage and culture became deeply significant in the moment. I felt I was recording some kind of epitaph.

The placement of the family members as 'leaves' was carefully considered for herself and her mother. This confirmed for me the deep connection she had had and still felt for that relationship. She asked for one of her three daughters to be placed under her leaf on the tree. Fay said that this daughter was her favourite. The word favourite touched a painful nerve for me. I wondered whether being the favourite was a good experience for this child, as it wasn't for me. I was never confident or secure in knowing how acceptable or unacceptable I was to my mother. I felt her attention and behaviour was always conditional. Referring to Bowlby's internal working model (IWM) theory, Fonagy (2001) writes that if a child perceives the carer's IWM as rejecting them, then the child's own IWM reflects this. In the self–other relationship they perceive themselves as unlovable. Reflecting on this, I would describe it as I felt I was disappointing to my mother. My mother, like Fay, has a diagnosis of bipolar and has not complied with treatment or medications. Up to my adulthood she had also verbalised frequently that her life was hopeless, and she had threatened or tried to take her life on a few occasions.

My experiences with Fay often felt similar to my experiences with my mother. At times I found this unsettling. In between sessions, on a few occasions, I would avoid walking by her room. I needed space to process my own reactions to working with Fay. I learned over the ten months to better maintain my objective therapist frame while working with my client's personal and subjective experiences, and in turn my own. This was largely achieved through completing a number of response art (Fish, 2019) self-portraits and client portraits. I would complete these portraits post art therapy with Fay. I also engaged in witness writing (Rubin, 2011), to reflect on the product, the art processes and any feelings or thoughts that were aroused at the time and for a period after. I began presenting these portraits at weekly supervision. In this forum, I felt well supported to explore my learning and ongoing questions.

Siegel (2010) says the intention towards and interest in accepting and understanding another is crucial in healing relationships. Fay said, at times during our work together, that I made her feel important. I understand this to suggest that Fay experienced a felt sense of being seen, or attachment, during our therapeutic work. Fonagy (2001) describes Sroufe and Waters' understanding or goal of attachment as "felt security" (p.13). This felt sense of attachment, Fonagy writes, is applicable to every stage of life and not just to maternal caregiving. It is also influenced by the social environment. Fonagy further elaborates that our level of felt security directly influences our ability to self-regulate. This learning resonates with me as I reflect on the ten months that I worked with Fay. My observations were that while Fay spoke very fondly of her relationship with her mother, suggesting a secure attachment style, her capacity to self-regulate often appeared quite impulsive, avoidant and/or resistive. This didn't align to a secure attachment. I wondered, then, if the death of her mother and, for me, the threats and actions of attempted suicide by my mother contributed to a feeling of abandonment in us both. Perhaps this 'felt' sense was part of our attunement to each other.

Fonagy (2001), describing the work of Stern on attachment, writes that our lived experience shown through our relationships and connections to others is key to our mental health. Fay and I developed an amenable working relationship. I learned to relax and be flexible concerning what the art in art therapy looks like. Fay worked independently with materials and processes on her own images. From time to time we worked together. On a few occasions, I drew under her direction. She observed me art-making, while guiding the activity through her choices of media and colours.

Through my modelling flexibility, consistency in demeanour and respect for her memories, thoughts and feelings, I think Fay found art therapy helpful. She was developing an openness towards exploring

her personal stories and feelings through our working alliance (Rubin, 2011). Fay's sometimes overt displays of resistance at her care home and at dialysis, I suggest, could be considered as natural defensive reactions (Rubin, 2011). Their purpose, I think, was to communicate physical pain, and her experience of the intolerable emotional pain of isolation and hopelessness.

Three weeks from our ending, I visited Fay at dialysis. She complained of stomach ache and of being cold. I adjusted her blankets and told her that I had bought some new art supplies. I opened my art box, showed her the colours, and described them.

I opened my pad of paper and drew a simple bullseye-type pattern with a few circles. I showed her the box of colours and invited her to choose her favourite. She chose red. I took off the lid and wound the paint up, just like a lipstick. I asked her if she would like to try using her left hand. She said no, it hurt.

"I can show you. I'll use my left hand, just like you, today," I said. I coloured a portion of the circle red. I explained that I hardly had to press at all. As she watched me, I checked in with her and asked her how her day was going. We talked while I coloured. She asked me what colour I would use next. I replied that I was not sure. I asked her if she would like to choose one for me. She did. I placed the previous colour within her reach. After about 15 minutes Fay spontaneously picked up the red paint stick and began to colour.

Shortly after, we took a break while two nurses came and attended to a procedure. Fifteen minutes later I returned to the room. I turned the page over and intuitively suggested that we draw something together. I asked her to choose the colours for our drawing. She chose red for herself and blue for me. "What shall we draw?" she asked. I replied, "What if we start with a line and see what happens?" Still using my left hand, I drew a wobbly circle with the blue paint stick. Fay drew a circle shape in red, next to and touching mine (Figure 2). I immediately got a sense that we were visually and symbolically communicating in a new way. It was like Fay was saying, "This is something new, I'm sticking close but I'm coming with you."

Figure 2. Sylvia Marris and Fay, *Scribble drawing*, 2020, acrylic paint stick on paper, 300×420mm.

We continued to talk and add lines, Fay spontaneously shared that she wanted to eat all the time. She felt unable to stop. I asked her what she was feeling just before she ate. She replied, "Lonely." "How often do you feel lonely?" I asked. She replied, "All the time." (I was aware that I held my breath. I felt pain and sadness.) Our simple collaborative drawing had provided the necessary conditions for contemplation and self-reflection. Eisdell (2005), referring to Naumburg, suggests that Fay was engaging in symbolic self-reflection. She was then able to verbally confirm deeply private and painful feelings after contemplating in the time and space of making and observing. Eisdell further suggests that the therapeutic conversation is special in that it engages in feeling language. Guthrie and Moghavemi (2013) describe it as emotional knowing. The co-creative environment provides for a here and now response within the therapeutic alliance.

I realised retrospectively that my focus on engaging with my client, rather than on the creation of a product, was similar to Winnicott's 'squiggle game' (Eisdell, 2005; Winnicott et al., 2010). This was a powerful moment for me. I had been anxious for Fay to make art, as it had been a number of weeks since she had done so. At that moment, I just decided to share my new art materials with her. This led us to playfully explore them together. I was more focused on just being with my client, rather than on producing images. Deep down, I believed this legitimised our time together as therapeutic and not just diversionary. I hadn't realised that I had lost sight of a critical part of therapy. That is, of being with the client rather than focusing on what I could do to or do with the client (Crago & Gardner, 2019).

Levine (2010) says that it is not the significance of an event that defines it, but the level of helplessness

experienced within it. I think it is the sense of lonely hopelessness that Fay is expressing in this artwork (Figure 2), as well as her desire to feel connected. Our verbal conversation was guided and developed through our 'visual' conversation (Case & Dalley, 2014; Eisdell, 2005). A huge shift occurred in our therapeutic relationship. I sensed clearly that she trusted me to come closer to her and her story. In this moment I felt like an art therapist. My trainee wheels had come off. It was an exhilarating and tender moment.

D.W. Winnicott writes that "each hopes for a need to be met, even if help can only be given in regard to one detail or in one area of the vast extent of the personality" (Winnicott et al., 2010, p.299). My understanding of D.W. Winnicott's work on attachment theory is that I lent the client my own ego by sensitively adapting to her needs. I didn't worry about doing therapy. I let go of the need to be in control or to be the 'expert', which would have rendered the client dependent on me (Partridge, 2019). I was able to empower Fay to engage on her terms.

Figure 3. Sylvia Marris, *Imagining Fay*, 2020, watercolour and ink on paper, 300×210xmm.

Rubin (2011) describes art therapy as a process of disclosure and closure. Working with Fay was a rollercoaster of discovery and connection. I found it to be challenging and tiring work. In part, I was a trainee with limited practical experience. I didn't take Fay's behaviour or resistance personally, but I felt the challenge of working in such a personal space. I experienced a range of emotions and reactions to working with Fay.

Siegel (2010) says that when we open ourselves to compassionate connection with others, we can cultivate a compassionate attunement to ourselves. Over time I developed not just an attunement to Fay as a client, but I became more attuned to myself. Through my work with Fay, I have a sense of being re-mothered (Figure 3).

I have no relationship or contact with my mother. I wonder how Fay's children would describe her as a mother. Working with Fay has given me the unexpected opportunity to reimagine my relationship with my mother from a distance. Fay only frightened me once in a session. She didn't physically threaten me, but her agitation transported me back to a time when my own mother was frightening. It stirred unhappy and very unsettling feelings. Stern (2018) describes this experience as "affect matching" (p.143), referring to an induced affect state in one person from witnessing someone else's affect display.

While I had a few moments of fear, I now have the capacity to assess in the moment. I can make informed choices, such as to either end the session or continue. In this case I continued. I was aware of my bias (Siegel, 2010), or what I call learned sensitivity towards certain behaviours. I was able to take conscious responsibility for the use of self in the therapeutic setting (Aponte & Kissil, 2014). I was able to keep the analytic frame or the boundary of the therapeutic relationship (Shaverien, 1998). Towards the end of our session I asked Fay if she was feeling angry or afraid. She reflected on the fear of losing her battle with renal failure and feeling angry about being "tied to a machine for hours and hours". I asked her what she would like to do about it, and she replied, "Stop." She then said that she couldn't stop, "because if I stop, I will die, goodbye."

After each session I spent a few minutes on uncensored reflective writing (Hyatt, 2020). I moved on to an art response. I wanted to explore self-awareness (Potash et al., 2015), especially around

transference and counter-transference (Hardy, 2001; Rogers, 2002) phenomena. Jongeward (2015) says that our art-making is a way of knowing and making meaning. McNeilly (2006), referring to Shaverien, says the image embodies the transference feelings. I find it is in the processes of making portraits of my client that awareness of counter transference becomes much clearer and more conscious (Fish, 2019). Perhaps it is partly due to the grounding effect of looking at my own reflection while I paint and process the feelings and thoughts from the session and from my past.

Conclusion

Over the course of therapeutic work with Fay I developed a sense of consolation for my own scary mother, and the resilience to move forward and continue art therapy with Fay. The experiential nature of image-making in art therapy and through my own response art, Jongeward (2015) says, probes below rational thinking and reveals what cannot be understood from that perspective alone. McNiff (1998a) says that art-making is a way of breaking boundaries and making way for the new. It was through art-making that I could consider the therapeutic relationship from multiple perspectives. This included the rational, the felt, the intuitive and the visual. This allowed for exploration and understanding on a much fuller level. Fay experienced some respite from loneliness and pain, and in the process we both found opportunities to be honest and brave.

References

Allen, P.B. (1995). *Art is a way of knowing*. Shambhala.

Aponte, H.J., & Kissil, K. (2014). 'If I can grapple with this I can truly be of use in the therapy room': Using the therapist's own emotional struggles to facilitate effective therapy. *Journal of Marital and Family Therapy, 40*(2), 152–164. https://doi.org/10.1111/jmft.12011

Bagan, B. (2012). Aging: What's art got to do with it? *Aging Well Magazine.* https://www.todaysgeriatricmedicine.com/news/ex_082809_03.shtml

Bowlby, J. (2005). *A secure base.* Routledge.

Case, C., & Dalley, T. (2014). *The handbook of art therapy.* Routledge.

Crago, H., & Gardner, P. (2019). *A safe place for change: Skills and capacities for counselling and therapy* (2nd ed). Digital Publishing Centre.

Department of Health. (2020). *The Aged Care Funding Instrument (ACFI)*. https://www.health.gov.au/initiatives-and-programs/residential-aged-care/funding-for-residential-aged-care/the-aged-care-funding-instrument-acfi

De Sousa, A. (2008). Psychiatric issues in renal failure and dialysis. *Indian Journal of Nephrology, 18*(2), 47–50. https://doi.org/10.4103/0971-4065.42337

Eisdell, N. (2005). A conversational model of art therapy. psychology and psychotherapy: Theory, research and practice. *The British Psychological Society, 78*, 1–19. https://doi.org/10.1348/147608305X40840

Elkis-Abuhoff, D., & Gaydos, M. (2016). Medical art therapy applied to the trauma experienced by those diagnosed with Parkinson's disease. In J.L. King (Ed.), *Art therapy, trauma, and neuroscience: Theoretical and practical perspectives* (pp.195–210). Routledge.

Fish, B.J. (2019). Response art in art therapy: Historical and contemporary overview. *Art Therapy: Journal of the American Art Therapy Association, 36*(3), 122–132. https://doi.org/10.1080/07421656.2019.1648915

Fonagy, P. (2001). *Attachment theory and psychoanalysis*. Taylor & Francis Group.

Guthrie, E., & Moghavemi, A. (2013). Psychodynamic-interpersonal therapy: An overview of the treatment approach and evidence base. *Psychodynamic Psychiatry, 41*(4), 619–636. https://doi.org/10.1521/pdps.2013.41.4.619

Hardy, D. (2001). Creating through loss: An examination of how art therapists sustain their practice in palliative care. *Inscape, 6*(1), 23–31. https://doi.org/10.1080/17454830108414026

Hass-Cohen, N. (2008). Partnering of art therapy and clinical neuroscience. In N. Hass-Cohen., & R. Carr (Eds.), *Art therapy and clinical neuroscience* (pp.1–42). Jessica Kingsley.

Hogan, S. (2016). *Art therapy theories: A critical introduction.* Routledge.

Howie, P., Prasad, S., & Kristel, J. (Eds.). (2013). *Using art therapy with diverse populations: Crossing cultures and abilities.* Jessica Kingsley.

Hyatt, L. (2020). From compassion fatigue to vitality: Memoir with art response for self-care. *Art Therapy, 37*(1), 46–50. https://doi.org/10.1080/07421656.2019.1677423

Hyland Moon, C. (Ed.). (2010). *Materials & media in art therapy: Critical understandings of diverse artistic vocabularies*. Routledge.

Irwin, E. (2016). Addendum: Object relations. In J. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (pp.139–143). Routledge.

Jongeward, C. (2015). Visual portraits: Integrating artistic process into qualitative research. In P. Leavy (Ed.), *Method meets art: Arts-based research practice* (pp.253–265). The Guilford Press.

King-Wing Ma, T., & Kam-Tao Li, P. (2016). Depression in dialysis patients. *Nephrology, 21*(8), 639–646. https://doi.org/10.1111/nep.12742

Levine, P.A. (2010). *In an unspoken voice: How the body releases trauma and restores goodness.* North Atlantic Books.

Lusebrink, V.B. (2004). Art therapy and the brain: An attempt to understand the underlying processes of art expression in therapy. *Art Therapy, 21*(3), 125–135. https://doi.org/10.1080/07421656.2004.10129496

MacWilliam, B. (2017). The language of grief: When there are no words. In B. MacWilliam (Ed.), *Complicated grief, attachment and art therapy: Theory, treatment and 14 ready to use protocols* (pp.16–34). Jessica Kingsley.

Malchiodi, C.A. (2012). Art therapy and the brain. In C.A. Malchiodi (Ed.), *Handbook of art therapy* (2nd ed.) (pp.36–47). The Guilford Press.

McNeilly, G. (2006). *Group analytic art therapy.* Jessica Kingsley.

McNiff, S. (1992). *Art as medicine.* Shambhala.

McNiff, S. (1998a). *Art-based research.* Jessica Kingsley.

McNiff, S. (1998b). *Trust the process: An artist's guide to letting go.* Shambhala.

McNiff, S. (2019). Reflections on what 'art' does in art therapy practice and research. *Art Therapy: Journal of the American Art Therapy Association, 36*(3), 162–165. https://doi.org/10.1080/07421656.2019.1649547

Michaels, D. (2015). Neurology and art therapy. In M. Liebmann & S. Weston (Eds.), *Art therapy with neurological conditions* (pp.39–61). Jessica Kingsley.

Nash, G. (2019). Response art in art therapy practice and research with a focus on reflect piece imagery. *International Journal of Art Therapy, 25*(1), 39–48, https://doi.org/10.1080/17454832.2019.1697307

Nordhus, I.H. (2015). Manifestations of depression and anxiety in older adults. In B. Woods & L. Clare (Eds.), *Handbook of the clinical psychology of ageing* (pp.95–109). John Wiley & Sons.

Partridge, E. (2019). *Art therapy with older adults: Connected and empowered.* Jessica Kingsley.

Pénzes, I., van Hooren, S., Dokter, D., Smeijsters, H., & Hutschemaekers, G. (2016). Material interaction and art product in art therapy assessment in adult mental health. *Arts & Health, 8*(3), 213–228. https://doi.org/10.1080/17533015.2015.1088557

Potash, J.S., Chan, F., Ho, A.H.Y., Wang, X.L., & Cheng, C. (2015). A model for art therapy-based supervision for end-of-life care workers in Hong Kong. *Death Studies, 39*(1), 44–51. https://doi.org/10.1080/07481187.2013.859187

Rogers, M. (2002). Absent figures: A personal reflection on the value of art therapists' own image-making. *Inscape, 7*(2), 59–71. https://doi.org/10.1080/17454830208414044

Rubin, J.A. (2011). *The art of art therapy: What every art therapist needs to know.* Routledge.

Schaverien, J. (1998). Individuation, countertransference and the death of a client. *Inscape, 3*(2), 55–63. https://doi.org/10.1080/17454839808413062

Siegel, D.J. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being.* Norton.

Siegel, D.J. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration.* Norton.

Stern, D.N. (2018). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology.* Routledge.

Wadeson, H. (2016). An eclectic approach to art therapy. In J.A. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (pp.479–492). Routledge.

Winnicott, C., Shepherd, R., & Davis, M. (Eds.). (2010). *Psycho-analytic explorations, D.W. Winnicott*. Routledge.

Winnicott, D.W. (1988). P*laying and reality.* Penguin.

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Editorial team

Peer review

The editorial team wishes to thank all the peer reviewers who have generously contributed their time and expertise to this edition of *JoCAT*. Accepted submissions are reviewed by people well-versed and respected in the subject or methodology of the submission. Articles 5, 6, 7, 8, 9, 10 and creative contribution 11 were double anonymously peer-reviewed.

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