Art therapists with experience of mental distress: Implications for art therapy training and practice

Abstract

As part of its ongoing work to support and value the contributions to art therapy from service users, the British Association of Art Therapists (BAAT) conducted a survey of art therapists with dual experience as professionals and mental health service users. The survey aimed to establish if art therapists disclosed their experiences as service users when applying to train, during their art therapy training and/or when qualified. Participants (N = 20) were also surveyed on their motivation for disclosure or non-disclosure, their experiences of the process and the quality of responses they met. They were additionally asked whether their experiences of mental health services had impacted on the quality of their art therapy practice and if so, how. The findings from this small sample suggest that disclosure was not easy. Reported responses to participants' disclosures were mixed, with many experiencing both helpful and unhelpful responses. Emotional support appeared to be important for helping people both to normalise and to contain current distress. Another finding concerns self-reported increased empathy for service users. Awareness and management of one's own limitations was another reported gain, since reflecting on oneself and one's life was usually enforced through the 'breakdown', hospitalisation or disruption of career path.

Key words: Art therapists; dual experience; lived experience; disclosure; increased empathy

http://dx.doi.org/10.1080/17454832.2016.1219755

Introduction

Art therapists have a long history of working with people diagnosed as having severe mental health conditions (McNiff, 2004; Wood, 1997). Indeed, some people in mental distress spontaneously produce artworks, with a number of those who in the past spent time in asylums being famous for it and others unknown (Hornstein, 2012). According to both art therapists and people who have received art therapy, the approach enables people

to express thoughts and feelings that may be difficult to put into words and to place distressing or confusing mental contents outside oneself in artworks. Joint exploration of these artworks with an art therapist, and other members if in group art therapy, may lead to improved understanding of oneself and one's life, or to making reparative and positive connections with the therapist or other members of group art therapy (Skaife & Huet, 1998; Waller, 1993).

Over the last decade, the British Association of Art Therapists (BAAT) has supported the exploration of new paradigms of art therapy practice in light of growing evidence from academic research that suggests that the most effective psychotherapists integrate mechanisms for consistent feedback from their clients, adjusting their practice accordingly (Miller, Hubble & Duncan, 2008). BAAT has also supported and published evidence from service users' lived experience (Wood and Springham, 2011) and their insights on what good art therapy practice should be (Springham, Findlay, Woods and Harris, 2012). Therefore, new paradigms have involved developing approaches to practice that do not assume a 'therapist-as-expert' model and integrate service users' views as well as psychosocial and cultural issues in the process of therapy.

A separate development is that the Health and Care Professions Council (HCPC), the statutory regulatory body for arts therapies in the UK, has now embedded consultation with service users and carers in its Standards for Education (HCPC, 2014), recognising that people with 'lived experience' have a positive contribution to make to professional training. However, one of the paradoxes of service user involvement in training is that it can play into the 'them-us' divide (Gough, 2011). This may be because sourcing such experience from people outside the institution can be seen as locating it in 'the other', and helping to conceal any service user experience that professionals and trainees may have. Trainee professionals,

and those who train them, are seen as needing the 'expertise by experience' of those designated as service users because by definition they do not themselves have such first-hand knowledge.

While on the one hand this sets up service users as the experts, which is a better position than one of being stigmatised, it can also maintain a separation between professionals and service users, rather than recognising the humanity (suffering and joy) in everyone. Rather than reducing prejudice, as one might hope, bringing in service users as experts may unintentionally preserve it because it still positions mental distress as something external to teaching staff and students. This may emphasize differences rather than common causes, as it categorizes people as belonging to one group or another, rather than recognising the continuum of human experience.

One solution to this problem could be the application of Allport's (1954/1979) contact theory to suggest a different teaching model, such as learning together rather than the more traditional 'teacher-as-expert', since research evidence suggests that activities with shared goals can reduce prejudice (Corrigan & Shapiro, 2010). Alternatively, courses might approach involvement in different ways simultaneously. Another psychological theory that may have relevance is that of the role model from Bandura's social cognitive theory (1977). This theory suggests that equipping professionals who have service user experience to teach may also have a powerful effect in terms of facilitating understanding of mental distress and reducing any fear and prejudice. Seeing someone who exemplifies both professional and service user makes it impossible to sustain the belief that they must inevitably be separate and different groups.

A negative sense of difference is often already present before service users come to teach, because of prejudice or negative attitudes within society, and even more

pronouncedly within mental health professions (Charles, 2013; Hansson et al, 2013; Stuber et al., 2014). People who wish to train as professionals are aware of this and may hide their distress experience (Stanley, Ridley, Harris & Manthorpe, 2011). Prejudice also affects professionals who may need to use mental health services during their career (Stanley et al., 2011). However, as Richards, Holttum and Springham (2016) note, growing numbers of mental health professionals are sharing their experiences publically in print or at conferences.

Gilbert and Stickley (2012) surveyed a small number of social work and nursing students who had experience of mental distress, and reported that they felt able to draw on this experience for the benefit of service users: in particular, they felt increased empathy. In keeping with the recommendation of Shepherd, Boardman and Burns (2010) for supporting recovery in mental health staff with mental distress experience, Morgan and Lawson (2015) have produced some preliminary suggestions for guidelines on staff sharing their personal experience of mental distress for the potential benefit of both service users and staff themselves.

Woods and Springham (2011) researched what one might learn about improving art therapy from the lived experience of an art therapist who was admitted to a mental health unit. Following the publication of this article, several art therapists with lived experience expressed their approval and relief to the paper's authors (Woods, personal communication) at seeing this issue named and valued within the art therapy profession.

Rationale and research questions

To date there has been no research on art therapy trainees' experiences of art therapy training in the context of having personal experience of mental distress, or on the

way courses respond to disclosure of such experiences. There are also no studies on what effects, if any, experience of mental distress has on art therapists' practice.

The research questions were as follows: Regarding art therapists with experience of mental distress:

1. Did participants disclose their experience of mental distress at interview or during their art therapy training, and if so, what was their experience of disclosing and the reactions to it?
2. What effects, if any, do participants perceive their experience of mental distress to have had on their practice?

Methods

Participants

A questionnaire was sent to 26 art therapists who responded, and 19 completed it. A further participant requested and completed the questionnaire following her attendance at a training day to prepare network members to teach on art therapy courses. These 20 participants represented a response rate of 1.25% the total membership but an unknown response rate from those with service user experience. Service user experience was defined as having received a mental health diagnosis and having needed to use mental health services before, during or after training as an art therapist. In order to maximise confidence in anonymity in relation to reporting the findings, we did not collect demographic variables. However, the diagnoses and problems people mentioned in their responses included: depression, anxiety, breakdown or crisis, psychosis, brain injury, eating disorder, bipolar disorder and personality disorder. Treatment included inpatient, outpatient, psychological therapies including art therapy, and medication.

Design

This was a cross-sectional survey, using a questionnaire with open-ended questions to allow people to tell the story of their experience of mental health service use, the responses they perceived art therapy training courses to have made to their disclosure, and any perceived impacts of their service user experience on their practice.

Procedure.

In January 2014, members of the BAAT were contacted by email and were informed that the BAAT valued the experiences of those who have had to use mental health services. The message espoused the aim of developing a network of art therapists with these experiences, in order to do research and create learning opportunities. The network would offer lived experience as expertise. Confidentiality was assured. A month later, the BAAT survey on art therapists with dual identity was sent to all the respondents.

Survey questions

The survey addressed experiences of mental distress and service use before, during and after training, eliciting the 'story' of what happened, asked whether people disclosed this experience at interview for art therapy training, what reactions were experienced, asked what, if any, impacts participants felt their experience had on their art therapy practice, and asked what participants looked for in an art therapist and if there was anything they felt would not be helpful. The data from these last two questions will be reported in a future publication.

Results

Of the 20 respondents, 16 (80%) had mental health service user experience before training and 4 (20%) not until after training. Of those who had experience before training, 8 (50%) also had experience during training, of which 5 (31%) went on to experience it

afterwards as well. Two of the 20 (10%) had experience before and after but not during training (Figure 1).

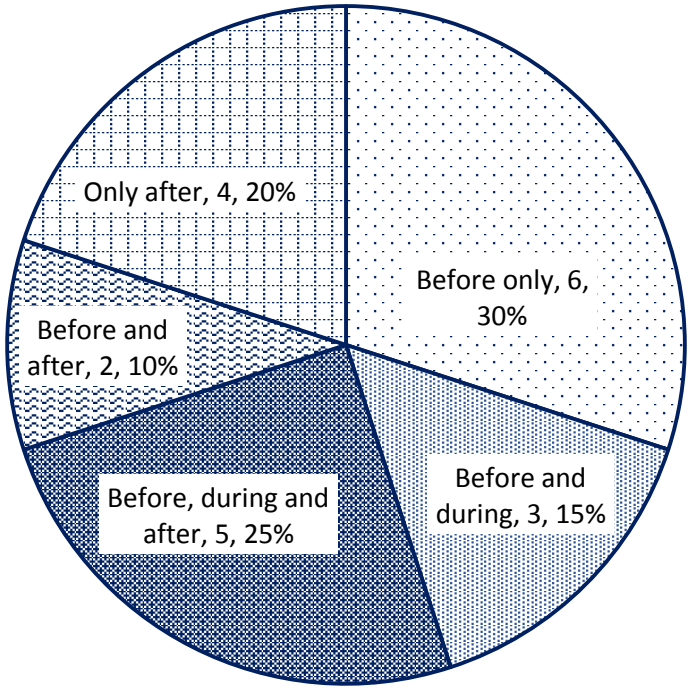

Figure 1: Timing of experience of mental distress

Proportion of participants who reported disclosing to the course. Of the 16 participants who first experienced mental distress before training, 8 (50%) reported not disclosing at interview, 4 (25%) reported partial disclosure and 4 (25%) full disclosure. Reasons cited for not disclosing either at interview or later are shown in Table 1.

Examples of quotations coded under themes in Table 1

Fear of negative judgment:

"Because of the fear of being judged negatively I did not disclose my experience as a service user with my first placement tutor until the very end of placement"

(Participant 14 [P14])

Fear tutors would doubt competence/ ability to cope:

"I did not want the course leaders to think I could not cope" (P4)

Table 1: Why people did not disclose their mental distress experience

Reason given for not disclosing	N participants at interview	N during course	Total N giving reason
Fear of negative judgment	3	6	9
Fear tutors would doubt competence/ ability to cope	5	2	6
Fear of not being accepted onto course	5	N/A	5
People who work in mental health don't disclose	3	2	5
Interviewers/ others did not make it feel safe to disclose	3	1	3
Not encouraged to disclose	2	1	2
Badly treated by another art therapy course	1	1	1
Didn't feel clear enough about the experience	1		1
Unclear	1		1
Too much disclosure could damage art therapy	1		1

Note: Non-disclosure here refers to any occasion reported by participants

Fear of not being accepted onto course:

"*Scared it would influence the decision to accept me on the course"* (P1)

People who work in mental health don't disclose:

"It only seems like an unwritten rule to me in some mental health settings" (P9)

Interviewers / others did not make it feel safe to disclose:

"Fear kept my mouth shut" (P11)

Not encouraged to disclose:

"If I had been asked directly I probably would have disclosed the information" (P9)

Disclosure during training

Irrespective of disclosure status at interview, most went on to disclose at least partially during the course, but few from early on. Of the eight not disclosing at interview, two went on to disclose to tutors and peers from early on in the course, and six disclosed partially during the course to peers, a tutor or in groups, though for three respondents, disclosure was not until late in the course. Of the four who reported disclosing fully at interview, three also disclosed to tutors from early on and discussed their experience in

groups or with peers, while the fourth disclosed partially in groups or with peers. Of the four who partly disclosed at interview, one reported not disclosing at all during the course, and the other three only partially with peers, or with groups or a tutor. Reasons for disclosure are shown in Table 2.

Table 2: Reasons given for disclosing experience of mental distress

Reason for disclosure	Occ. health form	At interview	During course	Total N giving reason
Experience evident in own artwork		3	3	5
Distress visible to others or disrupting work			5	5
Experience seemed relevant to learning			4	4
Part of peer friendships			2	2
Believed self to be recovered		1		1
Response to being asked about possible 'issues'		1		1
Felt safe			1	1
Felt angry about treatment by another course			1	1
Advised to disclose to placement supervisor			1	1
Honesty	1			1

Examples of quotations coded under themes in Table 2

Experience evident in own artwork:

"The issues were in the paintings I had taken to interview" (P19)

Distress visible to others or disrupting work:

"I explained to my personal tutor at the college that I was finding it almost impossible to write" (P5)

Experience seemed relevant to learning:

"Discussed slightly on course with peers when relevant. Did with tutors also when relevant or adding to the learning" (P15)

Part of peer friendships:

"There was some peers that I got close to that I discuss things with a lot" (P9)

Experience of disclosure at interview

Three of the four who disclosed fully at interview felt that they received positive responses, for example:

"It was received with compassion and I felt valued and not judged" (P6).

The remaining participant felt the interviewers made unhelpful assumptions, for example that being on medication must make them "fuzzy" (P14), which was not the participant's experience.

Experience of positive responses to disclosure during the course

Nine participants reported positive responses, with the greatest number discussing their perceptions of the way that their peers reacted, with seven participants reporting that other students on the course were supportive. Two of these and also a third participant mentioned reciprocal support, through other students also disclosing experience of mental distress (Table 3). Although only five participants wrote of support from their tutors, several examples of quotations will be provided to illustrate this, since four participants described emotional support at some length and clearly valued it greatly. Two of these four also mentioned practical support, along with another participant.

Table 3: *Themes of support in response to participants' disclosure of mental distress experience*

Theme	N participants with theme
Perceived support from other students	8
Support from supervision group members or peers	7
Mutual support among peers	3
Perceived support from supervisors or tutors	5
Emotional support from supervisors	4
Practical support from supervisors	3

Quotations illustrating perceived positive responses to disclosure

Perceived support from other students (peers). This was about feeling safe, and feeling that others were empathic and supportive:

"*I found it to be a very liberating experience, where the news was received in a very empathetic way" (P13)*

"I found it scary to raise the issue […] but I received wholly positive responses from peers and tutors" (P16)

Perceived mutual support among peers. This tended to be in terms of reciprocation and shared understanding:

"My peers were very supportive in college but I felt a lot of my friends had their own stories and issues. We supported each other" (P6)

Perceived support from supervisors and tutors. This included various kinds of emotional support, including demonstrating positive regard, normalising experiences of distress or the use of it in one's work, and containing the participant's anxieties about their mental distress:

"He [supervisor] told me he was confident I would make a very good therapist" (P16)

"[Supervisor] was wonderful, disclosed she had anxiety in the past. […] It's OK to be an art therapist and to have experienced anxiety" (P1)

"My other two placement supervisors […] encouraged me to talk about my own [experiences] that were relevant. I learned more from the supervisors than any others from being allowed to do this. I could bring in all parts of myself […] It became useful valuable knowledge that I could use as a therapist in positive ways to aid my understanding of myself and my client" (P9)

"He [tutor] offered a safe space to me to explain this [anxiety] and showed a very understanding position" (P5)

Practical support from supervisors. This took the form of deadline extensions:

"I was told if I needed extensions I could have them. I didn't need it" (P5)

Experience of negative responses to disclosure during the course

Eight participants reported negative responses to disclosure, six of whom had also reported positive responses, indicating differing contexts and people encountered during training. The greatest number of participants reporting negative reactions were those writing about a general lack of support, or a general tendency for people to be guarded and reluctant to discuss personal experience of mental distress (five participants in each case). Three participants each reported feeling shamed following disclosure and feeling that disclosure reduced staff faith in them. Other themes were voiced by one participant each (Table 4).

Table 4: ***Perceived negative responses to disclosure of mental distress experience***

Theme	N participants
Insufficient support from tutors or course	5
General guardedness around mental distress experience	5
Shaming	3
Knowledge of my experience reduced staff faith in me	3
Tutors made decisions without consulting me	1
People made unhelpful assumptions and did not check them	1
Bullying by peers	1
Rigid attitudes	1

Quotations illustrating perceived positive responses to disclosure

Insufficient support from tutors or course:

"And [tutor] didn't appear to understand anxiety in a student" (P9)

"I felt the tutors were largely cold, unapproachable and disapproving" (P20)

General guardedness around mental distress experience.

"One placement supervisor made it quite clear whenever I reached a certain point that she did not want to talk about some things" (P9)

"One peer shared his own story of being a service user and suggested I be careful about what I shared and with whom. He has opted to keep his history and current difficulties to himself" (P16)

Shaming following disclosure:

"She [tutor] also freaked out once when I did a scary image in a group and told me I shouldn't have done it. This became a debate between the school and placement. It made me feel I had to hide parts of myself" (P9)

"There seems to be some disgrace about being needy" (P20)

Knowledge of their experience reduced staff faith in them:

"I felt quite distressed and felt that I was being judged negatively as someone who might 'mess up' rather than someone with experience that might be useful to bring to placement" (P14)

Reported effects of mental distress experience on practice

The most frequently reported effect on practice was 'increased empathy with service users' (n=14). Within this overall theme we identified different sub-themes (Table 5). Generally, fewer negative effects were reported. Themes are illustrated below.

Empathy for clients was most often explained as understanding the patient position:

"*I still have very clear memories of what it feels like to be a patient e.g. going into ward rounds etc. I feel I can really empathise with the patients" (P4)*

Participants also felt an understanding of distress and difficulties:

"*I empathise quickly and easily with the dark and shameful side of the illness" (P3)*

Table 5: ***Reported effects of mental distress experience on practice***

Positive reported effects	**N**	**Negative reported effects**	**N**
Increased empathy	14	Lack of confidence	7
Understanding the patient position (or as parent of a child patient)	10	Limiting or stopping work as an art therapist	6
Understanding distress and difficulties	9	Need for own care and containment	5
Sense of responsibility towards client	6	Taboo against distress in a therapist	3
Humility	3	Risk of over-identifying with a client	3
Awareness of stigma	2	Worry about getting ill again	2
Awareness and management of limitations	11	Client story resonating strongly	1
Bringing hope	8	Over-stretch	1
Unspecified positive effects	8	Discomfort about charging	1
Ability to work with distress	7	Focus on client to avoid own distress	1
Ability to work collaboratively	7		
Drive to advocate	5		
Knowing how to make it feel safe	5		
Insider service knowledge	5		
Experience of positive therapist role models	3		
Experience of negative therapist role models	2		

The empathy participants felt towards service users also seemed to connect to a sense of responsibility towards the client:

"It helped me to remember how these moments at the therapy room can be strange and warm at the same time, and to keep the boundary between the client and me in a professional but warm way" (P5)

Humility seemed to be part of the process of empathising:

"*I did not ever think of myself as 'better' than my clients or think that I could never end up in their position" (P4)*

Finally there was empathy due to awareness of stigma:

"Sadly my experience as a service user allows me to see how much stigma and internalised stigma still exists around mental health – that to be a client in public services is still often to be 'other' and inferior" (P14)

The next most frequently voiced theme, by 11 participants, was 'awareness and management of limitation's:

"I have had to ensure that I manage my anxiety through a daily routine of meditation, mindfulness and self-reflection" (P17)

Eight participants felt that they were particularly able to bring hope to clients in great distress:

"I bring hope and belief in recovery to my work with [specific disorder] and have discovered that I am often the first person to hold this attitude with them" (P3)

Eight participants also wrote about unspecified positive effects:

"The difference in my clinical practice feels subtle […] In terms of change – this experience, unexpectedly, leading to my sense of more capacity as a therapist." (P7)

Some participants felt they had greater ability to work with distress:

"[Experience of distress was] helpful because of where I was able to go to personally" (P15)

Some participants emphasized an ability to work collaboratively, which included explaining therapy clearly, checking in with the client frequently, adapting to their needs, and enabling them to feel some power within the therapeutic relationship:

"I am also more explicit about what I think we are trying to do so I can check this out with the client" (P8)

"One of the things I tell service users in our initial meeting is that there is a clear complaints procedure" (P11)

Five participants mentioned a drive to advocate the service user perspective:

> *"I found it appalling how clients were talked about at times […] I found myself being able to stand up for the service user far more than I can stick up for myself" (P1)*

There was a sense of knowing how to make it feel safe in a therapy session or group:

> *"Knowing […] how to put people at ease and provide a sense of safety and trust" (P6)*

Insider service knowledge was felt to be useful in a practical sense:

> *"It has also enabled me to share things […] that I found helpful with first-hand experience of the knowledge that they can work" (P6)*

Three participants felt that they had experience of positive therapist role models:

> *"I found some self-disclosure from my counsellor very helpful although I understand that we were quite far along in our therapeutic alliance so I would be cautious about this in work" (P8)*

Two participants mentioned learning from negative therapist role models:

> *"Some of the bad experiences I had [in therapy] informed me of ways I did not want to be" (P9)*

Among the negative effects participants reported on their practice, lack of confidence was mentioned by the greatest number (n=7):

> *"I became very unsure, unconfident and could not be assertive within my team" (P2)*

Six participants wrote about limiting or stopping work as an art therapist:

> *"And also undertook only joint work for over three years in a [...] therapy role" (P10)*

Five participants wrote about the need for own care and containment:

> *"And I constantly examine [in personal therapy] the impact that my family life has on work life and my own well-being" (P12)*

Three participants felt that there was a taboo against distress in a therapist:

> *"It is very difficult to cope with these feelings [distress] from the perspective of being a […] therapist" (P5)*

A few participants worried about risk of over-identifying with a client:

> *"I think it has sometimes been negative because I can make assumptions based on my own experience rather than [...] wait for their [client's] own experience to emerge" (P3)*

Two participants wrote about concern that they might get ill again:

> *"I battle with weekly. What if I get ill again?" (P1)*

Discussion

The findings from this small sample of art therapists with experience of mental distress suggests that disclosure is not easy, which is consistent with previous findings Richards et al., 2016; Stanley et al., 2011). One reason given for disclosing would be unique to training in expressive therapies, since the arts are media of expression and may aid the sufferer's coping: some participants felt that their distress was visible in their artwork. That experience of distress was relevant to learning seems in keeping with recommendations for training mental health workers in the recovery approach (Shepherd, Boardman & Burns, 2014), whereby owning and drawing on one's own distress fosters empathy with service users.

Reported responses to participants' disclosures were mixed, with many experiencing both helpful and unhelpful responses in different training contexts. Many found peers especially supportive, with some reciprocity. Fewer participants reported positive responses from supervisors and tutors, but where they were supportive, it went beyond deadline extensions. Emotional support appeared to be both important for helping people to normalise and contain current distress, and for their learning so that their own experience

could become more of an asset than a concern. Other experiences seemed to suggest that a tutor or supervisor's non-engagement or negative response could worsen anxiety and be unhelpful to learning. These findings are consistent with those of De Figueredo et al. (2014), who reported that students and clinicians with access to reflective supervision were most likely to report finding it helpful for their practice working with families where there was a traumatised child.

The major finding in our study of self-reported increased empathy for service users is consistent with the finding of Gilbert and Stickley (2012) for social work and nursing students. Participants gave sufficient detail of their own experiences and practice, as illustrated by quotations, to provide a compelling account of this. Awareness and management of one's own limitations was another reported gain, since reflecting on oneself and one's life was usually enforced through the 'breakdown', hospitalisation, or disruption of career path. People without severe mental distress experience may gain some self-awareness through the personal therapy that is part of most psychotherapy trainings, but may be able to avoid facing some aspects of self through not experiencing certain levels of jeopardy. Whilst this in no way means that people without such experiences cannot be good therapists, it does raise the issue of some differences due to service user experiences being real and needing to be acknowledged (Collier & Stickley, 2010).

Limitations

Our sample of participants was relatively small and may not be representative of all UK art therapists with experience of mental distress. However, the congruence between our findings and those of surveys of other mental health and social care practitioners suggests that our sample was not particularly exceptional. We do not know how many may stop practising altogether and thus not be represented at all in our sample, so it is also possible

that our sample is over-representative of people who have overcome or found ways to manage any ongoing distress sufficiently to carry on.

Implications for practice

Although the experience of mental distress is not one to be desired, participants felt able to draw on the experience for the benefit of service users. The present authors wish to highlight these and suggest that they can best become realities if tutors and supervisors on training courses do what many reported them as doing, namely helping people to feel that these experiences are acceptable rather than stigmatising, and being open to hearing how trainees' own experience and their client-work interacts. We did not ask whether people disclosed to clients, and there is debate about when this is appropriate (Morgan & Lawson, 2015). However, it seems clear from participants' reports that they had much to draw upon. Trainees on many different forms of psychotherapy, mental health and social care courses will experience something in a client's story resonating with them at times. Having one's own experience of deep distress is just one of these and should be treated in the same way to help trainees separate their own and their client's material and be able to use their own material to best effect.

Further research

Training is the formative period for therapists, where role models can help them grow into their professional role (Bandura, 1977). In this formative period, experience of mental distress (or other life experiences) can be either suppressed or valued and worked with to enable trainees to 'bring all parts of themselves' alongside their technical, theoretical and research knowledge and be and become self-aware and reflective mental health professionals. Yet there is relatively little research on how training courses should best achieve this, and indeed what the wider picture is in relation to supervisors' and tutors'

responses to disclosure. Research is needed to find out how confident training staff feel in responding, given that they themselves may have trained in courses that were less open to it, and to determine what training they may need in order to foster trainees' ability to draw on their distress experience in ways that can be helpful to themselves and their clients. Our findings have hinted at some things training staff can do, but a survey of a wider pool of trainees in mental health and therapy trainings could build a more comprehensive picture of what is helpful, for whom, and in what circumstances.

In addition, there may be a need for training staff who themselves have experience of mental distress to be able to gain more support or positive responses from their institutions. It seems likely that a staff member with distress experience who is supported would be better able to address such issues in a trainee than one who feels the need to conceal their experience.

Conclusions

This is the first survey of art therapy practitioners about their recalled experience of disclosing mental distress during art therapy training, and their perception of its impact on their practice. The mixed responses participants received from their courses and the known evidence of stigma suggests that more needs to be discovered about how training staff in mental health and therapy training respond to mental distress experience in their trainees, especially in terms of what is helpful in normalising it and enabling it to be drawn upon in trainees' learning and client work. Participants of our survey are engaging with innovative training to bring their experiences of valuing these experiences to art therapy education, but there needs to be further research to inform the range of psychotherapy and mental health education as to how they can best foster the use of such experiences, as well as other human life experiences in working with clients.

The authors wish to thank Ami Woods who helped to develop the BAAT survey questions for this study.

References

Allport, G.W. (1954/1979). *The nature of prejudice.* Cambridge MA: Perseus Books

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

Charles, J.L.K. (2013). Mental Health Provider-Based Stigma: Understanding the Experience of Clients and Families. *Social Work in Mental Health*, 11 (4), 360 -375

Collier, R. & Stickley, T. (2010). From service user involvement to collaboration in mental health nurse education: developing a practical philosophy for change. *Journal of Mental Health Training, Education and Practice*, 5, 4-11. http://dx.doi.org/10.5042/jmhtep.2010.0685

Corrigan, P.W. & Shapiro, J.R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness, *Clinical Psychology Review*, 30, 907-22.

De Figueiredo, S; Yetwin, A.; Sherer, S.; Radzik, M.; & Iverson, E. (2014). A cross-disciplinary comparison of perceptions of compassion fatigue and satisfaction among service providers of highly traumatized children and adolescents. *Traumatology*, 20 (4), 286-295.

Gilbert, P. & Stickley, T. (2012). "Wounded Healers": the role of lived-experience in mental health education and practice. *The Journal of Mental Health Training, Education and Practice,* 7 (1), 33-41.

Gough, M. (2011). Looking after your pearls: The dilemmas of mental health self-disclosure in higher education teaching. *Journal of Mental Health Training, Education and Practice*, 6, 203-210.

Hansson, L.; Jormfeldt, H.; Svedberg, P.; & Svensson, B. (2013). Mental health professionals' attitudes towards people with mental illness: Do they differ from attitudes held by people with mental illness? *International Journal of Social Psychiatry,* 59 (1), 48-54.

Health and Care Professions Council (2014). *Standards of education and training.* London: Author Accessed 15 March 2016 at http://www.hcpc-uk.org/assets/documents/1000295EStandardsofeducationandtraining-fromSeptember2009.pdf

Hornstein, G. (2012). *Agnes's jacket: A psychologist's search for the meaning of madness.* Monmouth, UK: PCCS

McNiff, S. (2004). *Art heals: How creativity cures the soul*. London, England: Shambhala.

Miller, S.; Hubble, M.; & Duncan, B. (2008). Supershrinks, *Therapy Today,* April, 4 - 9.

Morgan, P.; & Lawson, J. (2015). Developing guidelines for sharing lived experience of staff in health and social care. *Mental Health and Social Inclusion,* 19, 78-86. DOI 10.1108/MHSI-01-2015-0001

Richards, J.; Holttum, S.; & Springham, N. (2016). How Do "Mental Health Professionals" Who Are Also or Have Been "Mental Health Service Users" Construct Their Identities? *Sage Open, January to March 2016,* 1-14. DOI: 10.1177/2158244015621348

Roberts, G., & Boardman, J. (2014). Becoming a recovery-orientated practitioner. *Advances in Psychiatric Treatment ,* 20, 37-47. DOI: 10.1192/apt.bp.112.010652

Shepherd, G.; Boardman, J; & Burns, M. (2010). Implementing recovery: A methodology for organisational change. Sainsbury's Centre for Mental Health. Author Accessed 9 April 2016 at http://www.workingtogetherforrecovery.co.uk/Implementing_recovery_methodology.pdf

Skaife, S. & Huet, V. (Eds.). (1998). *Art psychotherapy groups: Between pictures and words.* London & New York: Routledge.

Springham, N.; Findlay, D.; Woods, A.; & Harris, J. (2012). How can art therapy contribute to mentalization in borderline personality disorder? *International Journal of Art Therapy: Formerly Inscape.* 17 (3), 115 -129.

Stanley, N., Ridley, J., Harris, J. & Manthorpe, J. (2011). Disclosing disability in the context of professional regulation: a qualitative UK study. *Disability and Society*, 26, 19-32.

Stuber, J.P., Rocha, A., Christian A. & Link, B. G. (2014). Conceptions of mental illness: Attitudes of mental health professionals and the general public. *Psychiatric Services* 65 (4), 490-497.

Waller, D. (1993). *Group interactive art therapy: Its use in training and treatment.* London & New York: Routledge.

Wood, C. (1997). The history of art therapy and psychosis 1938-95. In K. Killick & J. Schaverien (Eds.), *Art, psychotherapy and psychosis* (pp. 144-175). London, England: Routledge.

Woods, A., & Springham, N. (2011). On learning from being the in-patient. *International Journal of Art Therapy: Inscape, 16* (2), 60-68.