Advocating therapist Lived Experience: Towards an Australian peer art therapy model (PATh); signposting the pivotal role of art therapy education[1]

Mahlie Jewell and Catherine Camden-Pratt

Abstract

Writing from our own co-locations and intersections as people with Lived Experience[2] and art therapists, we speak into an epistemological gap we identify in art therapy literature and practices. We map a new approach, a new paradigm, and name it peer art therapy and peer art therapist: PATh and PAThR. Drawing on relevant literature in art therapy and in peer work, we begin to chart this terrain. We explore its ledges of knowing, its approaches, practices and theories, including the pivotal role art therapy education can have in supporting peer art therapy and peer art therapists. We begin to build theory and practice, writing into the identified gaps in art therapy literature and its practices. Our writing is a practice of social justice, a political act that signals expertise by Lived Experience, saying, "we are here".

Keywords

Therapist Lived Experience, peer art therapy, dual-experience, art therapy education, mental health, peer work.

Acknowledgement of Country

This work was written across many Countries and has been witnessed by the ancestral lands of the Wangal people (Mahlie's adopted home), the lands of the Dharawal people (Mahlie's workplace and childhood home), Gundungurra lands (Catherine's chosen home) and, importantly, the lands of the Darug people on which we have spent the vast majority of our time together. Working, learning, yarning and listening with each other and the land has been a privilege and an honour. The lands on which we meet to deeply listen are as important as each of us. These lands, rivers, oceans, mountains, trees and all those they home and protect walk with us purposefully and have facilitated much understanding, clarity, growth and healing. Alongside Mahlie as she moves across these lands are her guiding ancestors from the Wiradjuri nation, her pop's people. They bring thousands of years of knowing and being with this land, the fire and passion for change,

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1. Both authors are trained in and have qualifications in art therapy – this is our common professional ground, "practitioners calling themselves art therapists have been trained to work therapeutically using the visual arts, including drawing, painting, and sculpture" (ANZACATA, n.d., para.2). There is no 's' after art in our respective qualifications, and our professional post-nominals are AThR. This article focuses on art therapy practices and literature, not the wider creative arts therapies such as dramatherapy, music therapy, play therapy, or other creative arts modalities. It may well be that the article has relevance for other/all creative arts therapies and modalities. Without researching with those with Lived Experience in other creative arts modalities, and researching the relevant wider creative arts therapies literature, we cannot make this claim.

2. Lived Experience indicates experience of 'mental illness', or the symptomology that could be considered criteria for a diagnosis and/or the use of mental health services. Lived Experience signals this specific location, as distinct from lived experiences not described as 'mental illnesses' (such as racism). In the United Kingdom (UK), the term denoting Lived Experience is Service User, and we use this where relevant to the UK literature and practices. In the United States of America (USA) context, Roots and Roses (2020) use Service User. In this article we use capitals – Lived Experience – to denote its specific difference from lived experience. A 'Peer worker' is a person with Lived Experience who works professionally in the mental health sector.

and the ancient practice of creative story-telling. Catherine lives with deep appreciation for and gratitude to Gundungurra Country in Darug Nation that holds her today, and Kuring-Gai Country that loved her from early childhood as she sought refuge on their earth, under their skies, with sunlight soaking her skin, moonlight holding her in the darkness, and trees welcoming her in friendship – it is part of her fabric.

Introduction: Multiple subjectivities

Our vibrant critical conversations advocating a new model of peer art therapy – PATh – and becoming peer art therapists, began in 2019 on Darug Country beside the Burramatta River, in the Master of Art Therapy program at Western Sydney University (WSU), New South Wales, Australia. Mahlie (she/her) as a student, and Catherine (I/we; she/her/they) as a teacher/Course Advisor. These richly layered and sustained conversations took place across many academic settings. We talked passionately: in classrooms and studio art-making spaces, within experiential teaching–learning workshops and art therapy training groups; sitting on Country with Mahlie's chosen-Mother Tree, a steadying wisdom; in carparks, conversation picking up where it left off; across emails; through Catherine's mentoring feedback in the margins of Mahlie's essays; and in sometimes challenging Course Advice meetings. And throughout, Catherine's grounded respect for, and her own connection with, Mahlie's cultural knowledge provided a safe place for Mahlie, a place that didn't need or ask for explanations that violated Mahlie's cultural boundaries. Mahlie, *"I didn't have to explain my relationship with my chosen-Mother Tree, you just got it, and sat with me beside her. Honoured her with me. Listened, didn't ask. Genuinely listened, and when I mentioned Dadirri (Ungunmerr, 2017) you didn't ask me to educate you, you had done the work. And you knew where I'd be when things were hard, and didn't pathologise that. I have had my relationship to Country pathologised so many times, it is no longer safe for me to speak about it out loud."*

Multiple subjectivities were alive in our 2019 conversations – alive in the one academic site. A site that fixes locations of 'student' and 'teacher' in similar ways that 'therapist' and 'participant/client' are often fixed in therapeutic discourses, erasing multiple subjectivities. We were not simply 'student' and 'teacher', we were also people with some shared, though differently located, lived experiences/Lived Experiences (Roots & Roses, 2020). We share in-common experiences as survivors of child abuse and neglect, child sexual assault, adult sexual assault, family-member suicide, self-harm, domestic and family violence, and the criminal justice system. These are influenced by our privilege, class and 27-year generational differences. Mahlie: First Nations, poor, cisgendered, queer, parentified child and childless mother, chronically suicidal, unrecovered. Catherine: European, middle class, incest survivor; parentified child; parent with diagnostically located severe and persistent mental health challenges (Camden-Pratt, 2006, 2003); self-supporting from the age of 15; mother and grandmother; gender fluid. We know these words signal experiences and do not show the respective specificities of our lived experiences. This may open up biographical questions and curiosities; however, discussing these is not the purpose of this article, except as relevant to peer art therapy.

We are located differently inside the medical model and both experience marginalisation as people with mental health diagnoses (Roots & Roses, 2020). Catherine, *"Gosh, my experience of the public mental health system and the medical model is an archeological dig. Growing up with a mother inside this system, there was no way, when things got really really hard for me, that I went there for help. I saw what it did to her. If I had, I wouldn't be here now, or would definitely not be the person we are. I'm certain about that. Remember, I'm 66! Imagine the medical-model prognosis for me 40ish years ago, with my family background and what I was experiencing as our internal selves began breaking through. And I've mostly stayed outside the public mental health system and resisted the medical model. Making that first choice was easy and I didn't seek any professional 'help' until my late 20s. The ongoing work required of me in my/our becoming was and is hard. At worst it included repairing significant damage from psychotherapists who did not work from trauma models, and who did not understand what we were/I was experiencing – they had very limited maps. Where would I be without my self-initiated creative processes, buddhist and shamanic practices, and community-based support groups? Thankfully, at 50 or so, I found a social-work trained counsellor who saw us, and*

had the professional experience and skills to begin to support us in becoming a mandala-ed whole." Mahlie, *"I didn't have that choice of public or private mental health support. All my experiences with mental health services are inside the public system due to enduring poverty, and they all occurred against my will from 7 to 24 years old. These were controlled constantly by broken systems that recreated trauma and did so much more damage. I was diagnosed with the alphabet, and had 17 diagnoses in the end, which eventually were reviewed to a solid four that persist. As much as that system destroyed me, it also led me to the treatment that finally worked, and some amazing individuals who worked hard against the broken system to reach people like me, 'treatment exhausted and too complex'. I got really lucky."*

And we are also more than all of this. And we are all that emerges with continual, deep, hard-won personal work that meets, faces and transforms pain – like the alchemical gold formed from base metals subjected to intense heat and pressure for prolonged periods. As with our individual biographies, the specificities of our respective personal healing journeys/becomings, and each of our ongoing effective engagement in these, are not the focus of this article except where they speak into peer art therapy.

Catherine's 2020 academic leave transferred our in-person critical conversations into traces and reverberations – as guiding questions for Mahlie, *"What would CCP do?"* and as influences for Catherine, *"Ah, that's what Mahlie talked about."* Our connection was not severed, it was in flux. Mahlie, *"That was really hard for me at uni, without you as an ally for Peer Work and Lived Experience knowledge."* In early 2021, after Catherine resigned from her tenured position at WSU, Mahlie emailed her with a draft article exploring a critically overdue conversation about becoming peer art therapists and addressing this gap in art therapy education, and invited her to co-author the article. Catherine replied, *"How amazing, thank you, such great work here, so good to see you doing this… and definitely an overdue publication… Your draft resonates with an assessment-based and unsubmitted draft article I wrote when I was an art therapy student at WSU in 2009 – it's attached. I've used it in my teaching – updated of course – you might recognise some of it? And you can see I had some similar challenges as you have and do, though unlike you, I didn't know about peer work then. I researched literature on art therapists who were members of 'participant/client groups' – I already had work in the public domain that showed how many I was part of. Among other things, I critiqued client categories* (Foucault, 1975; Hogan, 1997). *The main thing for me was – and remains – challenging the therapist/participant binary. Back then, I asked myself, 'in this binary, am I an "us" or a "them"?'"* After reading Catherine's 2009 draft article, Mahlie responded with, *"You have the art therapy literature history that I don't have, and your own responses to it – and most of that connects with mine. Plus, we have this in common – we are pre-located in the public sphere with our lived experiences, before we became art therapists. We can't hide (Eastwood, 2021), even if we wanted to… and I don't want to, I've got no desire to perpetuate stigma and internalise it."*

So, in 2021, across Zoom on Wangal and Gundungurra lands, and sitting in Grandmother Tree on Wangal land, we expanded threads of 2019 conversations that now included both of our earlier draft articles. These conversations turned into in a new co-written article text – its document Comment Boxes filling up with passionate discussions. In our emergent reflexive conversations, we also talked about feeling 'othered' and alone in the art therapy profession, about practices of power, our beginning locations as student and teacher, and the shift to co-authors and colleagues. In common with Roots and Roses (2020), we are guided by social (in)justice and our motivation to combat stigma and discrimination.

As co-authors, we gave each other permission to directly edit and write into our new article, trusting our collaborative voice as we worked on iterative versions. Our many conversations in the Comment Boxes of this article's drafts are now invisible, except where they move into the main text *in italics*. It is a multi-voiced text (Camden-Pratt, 2003, 2007; Higgs et al., 2007) that includes responsive art-making (Gilroy et al., 2019; Green, 2021) inspired by our conversations with and in Grandmother Tree. We are writing to know (Richardson, 1994). Making art to know (Allen, 1995; Camden-Pratt, 2003, 2007; Kapitan, 2014). We are learning our way towards new ways of doing art therapy – peer art therapy. Here, we begin to theorise about peer art therapy and becoming peer art therapist. Central to this, we signpost celebrated, respected and safe spaces for peer art therapy in art therapy education. This article is a freeze-frame of our multi-layered continuing conversations.

Figure 1. Mahlie Jewell and Catherine Camden-Pratt, *Grandmothering*, 2021, digital photograph with mixed media. Mahlie, *"There is power in where we place our hands together, a sacred sharing of energy. My hands are grounding, connecting. There is no doubt – this is who I belong to – 80,000 years of (Grand)Mothering."* Catherine, *"It's more complex for me. I have so much political conflict around voicing this connection, this feeling of belonging. Yet Country and our relationship with trees helped me/us survive as a child."*

Movement One: "I have lived this"

The peer-support movement began like most revolutions do, as an uprising. Initially posed as 'psychiatric survivors', a collective of people viciously harmed by the mental health system of the 1940s sought a new path to healing (Church, 1995; Everett, 1994). Sharing experiences collectively, telling truths that exposed the invalidating, violent world of psychiatry, they experienced healing amongst themselves. They created new ways to process and heal, free to be who and how they were, supported by those who shared what they had endured. Free from punitive withdrawal of their autonomy and basic human rights, they found validation, were held and heard, and in control of their own narratives (Church, 1995; Everett, 1994). In Australia in 1992, this revolution meant that the participation of people with Lived Experience of mental ill health in the design and delivery of mental health services was mandated within policy (Australian Health Ministers, 1992). This policy direction is crucial – one in five of all Australians will experience mental ill-health in their lifetime (Australian Institute of Health and Welfare, 2021).

'Peer worker' means something overt within the mental health system. 'Peer' is a statement and a disclosure; right up front it means, "I have lived this" and/or "I am living this". There is difference and diversity within the peer workforce and no 'right way' to be a peer worker. The commonality is that, within their profession, a peer worker positions themselves consciously and openly as a person who has 'lived this' (Barr et al., 2020b). Mahlie, *"It is how peer workers position ourselves in these experiences that sets us apart, and the professional training and personally reflective experiential work we complete"* (Mead & MacNeil, 2006). In the peer art therapy setting, 'peer' retains its specific mental-health system meaning. This is different from its meaning when used in other non-mental-health settings, such as 'students as peers' or 'peer supervision' or when used with those who have similar lived experiences that are not described with diagnoses – such as racism, living with cancer, miscarriage. And we recognise the possible intersections of these examples of lived experiences with mental health challenges. It is this above articulated identification of peer worker/Lived Experience in peer art therapy that we begin to map in this article.

Becoming a peer worker requires training. In Australia, training in states and territories emerges from different paradigms and uses different terminology. In this article we refer to Intentional Peer Support (Intentional Peer Support, 2021; Mead & MacNeil, 2006), in which Mahlie found her community, her voice and her training. Intentional

Peer Support is not the dominant peer model in our state of New South Wales, although it is well recognised in the Australian state of Victoria, where Mahlie also works. Grounded in the psychiatric survivor movement, it diverts from and provides an alternative to medical models. The core components of Intentional Peer Support are connection, worldview, mutuality and working towards (Mead & MacNeil, 2006). Peers connect to others at a mutual place, and are always seeking to move closer to a life worth living, whatever that means for the person. Removing hierarchy is foregrounded in peer support. Mahlie, *"Our language is purposeful, we use terms like 'people we are working with', 'moving towards', 'co-reflection'. We remove ourselves from a position of knowing, into a place of curiosity and learning. We gain as much as we give, not by coincidence as teachers might, but by actively doing so. We are all 'experts by experience' and we may have something to offer to, and to receive from, another human being who has lived/is living this."*

As an identified peer worker, Mahlie's diagnostic experiences and experiential knowledges are as important a resource as her ability to listen actively to a participant or notice emotional states within artworks. Mahlie, *"Being transparent is how I remain authentic and integrated as a trainee art therapist in the peer art therapy spaces that I initiated in my placement. Conforming to the idea that I must compartmentalise these aspects of myself as most clinicians and art therapists do* (Roots & Roses, 2020) *is personally harmful in its replication of shame and self-stigma."* People ask Mahlie how she identifies in various settings. Mahlie, *"I'm living well with Borderline Personality Disorder, Complex Trauma, Panic Disorder, brain injuries and chronic health conditions"* (APA, 2013). We both agree that healing/becoming is not a linear process and doesn't replicate notions of 'being cured' that can be present in physical health models (Camden-Pratt, 2006, 2003). Mahlie, *"I know I move in and out of clinical presentations and diagnostic thresholds as I navigate life."* Many people may enter a 'remission' of their mental health issues and consider themselves recovered. This isn't Mahlie's personal experience, *"I locate myself in the unrecovery movement, which notes that the term 'recovery' has been medically colonised to mean 'symptom remission'* (Recovery in the Bin, 2021). *I've got an active accepting relationship with my mental states, we work in skilled ways together with pride to embrace the beauty and benefits of a neurodiverse adaptable brain."* Both of us agree that every day we actively decide to 'live well with'.

Open disclosure has significant impact for people living without hope and is key for peer worker practices (Barr et al., 2020a, 2021; Jewell, 2020, 2021; Ng et al., 2018). Peer workers contribute the practical experiences of living with mental health issues, such as navigating mental health systems (Jewell, 2018c; Jewell & Rao, 2018), managing stigma and discrimination (Jewell, 2018b) and active demonstration of well-being strategies (Jewell, 2018a) within their job roles (Jacobson et al., 2012). Also, they contribute demonstrated experience of – and the survival of – living in a world that sees you as 'other' and often 'less than', and navigating systems that are often harmful (Brophy et al., 2016).

Having Lived Experience alone does not make a person a peer worker. Doing their own personal therapeutic and/or other healing work that may include art making, dance, movement, music, or writing is an ongoing requisite for peer workers. Rigorous ongoing reflection on these experiences and where they emerge in daily life underpins peer work. Moon (2015) draws on Corey et al. (2014) to discuss the ways in which for all art therapists "the focus of therapy can shift from the client's needs to the needs of the therapist when the therapist lacks self-awareness" (p.98). This could also be in play for the peer art therapist without rigorous, well-supported personal reflexivity that can lead to effective mentalisation (Fonagy et al., 2008).

Being located as a peer worker is purposeful. Mahlie, *"I openly identify in the hope that those I work with can see a living example of thriving despite challenges. It provides proof that they can also live well – with access to the right support and skilled professionals that work in person-led ways* (Ng et al., 2018; Ng et al., 2019; Barr et al., 2020a). *It's also an antidote to imposed shame and self-stigma associated with having the world's most 'disliked' mental illness* (Jewell 2018b; Lewis & Appleby, 1988). *I will not have my narrative controlled by others."* Catherine names this loud and proud act as political, and Mahlie agrees. It challenges Catherine's politically located ways of doing transparency.

Catherine's doctoral research (Camden-Pratt, 2003) was profoundly influenced by the psychiatric

survivors and their once-forbidden narratives (Church, 1995). *"Because of my art-based and autoethnographic publications, art exhibitions, radio podcasts, and word of mouth (Camden-Pratt, 2018, 2009, 2008, 2007, 2006, 2003), I have people with some of the same lived experiences seek out therapy specifically with me. AND I don't foreground my lived experiences, or share my diagnoses with participants. As an art therapist I live these tensions and liminalities. I'm always accessing their wisdom. I share relevant life experience only when in the service of participants' therapy, for example when they ask me directly – and then what I share is well-boundaried and contextual. My approach is guided by the question, 'What's in the service of what?' It's similar in the teaching–learning space. Importantly, my transparency about my lived experiences, Lived Experience and my diagnoses is always in the context of critically opening up art therapy theory and practice, including responding to student questions. It's relational and contextual, and becomes part of a conversation. Thing is, I resist the medical-model discursive practices that diagnoses sit inside. They can be so reductive, and collapse subjectivities. For me personally, it pathologises our creative and intelligent responses to unbearable relational trauma and what that asked of my psyche in our simply surviving. I also don't like or agree with the ways in which diagnoses risk self-pathologising – I am and we are brilliantly, intelligently and creatively ordered; I am not and we are not 'disordered'. Yes, I also appreciate that being given a diagnosis as a potential map, and the supports that can come with this, can be helpful for people. And yes, it was and is for me too. And it isn't the territory! And fundamentally I need to, and must, critique diagnosis as a category and the set of discursive practices that come with it – one of these is the way diagnosis operates as 'the truth' about a person and about specific experiences. And I do this alongside any personal location in them. And I don't take up this diagnosis-located power in the ways we hear you can and do, as a peer worker, Mahlie. So many 'ands'! Perhaps, there's a way I can do all this?"*

Over a number of years and from our respective shifting locations, we each sought guidance in art therapy literature on how art therapists practice with Lived Experience and with its open disclosure. And emergent from this, we sought belonging in the art therapy profession.

Movement Two: Seeking community on the page

We are interested in the epistemology of art therapy theory and practice and its pedagogies – its teaching and learning practices (Gilroy et al., 2019: Leigh, 2020). What knowledges are silenced? What know(ing)-ledges are heard? How come? Who decides? In whose interests? What are the gaps? For each of us, examining, questioning, and negotiating silences and gaps is a way of life. Catherine (Camden-Pratt, 2003, 2006), *"These kinds of questions have driven my life – and work – since I was a kindergarten child in a Catholic school. There, we had to pray to Holy Mary Mother of God, who heard the voice of the angel Gabriel and became the mother of Jesus, the son of God. My mother's name was Mary, and she heard voices. She was locked away in a psychiatric hospital and labelled schizophrenic/psychotic/manic depressive. Sometimes on weekends I visited her there. The class didn't pray to my mother. I didn't share my weekend as news at school on Monday, and I couldn't ask the nuns how come these two Marys had such different lives. It didn't make my questions go away; the silencing intensified them."* Mahlie, *"These questions demand answers, I'm a product of the force and power of peer support that asks questions constantly and will not be silenced or disrespected."* Here we identify and speak into an epistemological gap in art therapy theory and practice; our writing is a practice of social justice.

In 2009, as an art therapy student, Catherine expected some rich discussion of the various performative locations of being art therapist. After all, there was autoethnography as research methodology (Bochner & Ellis 2003; Denzin & Lincoln, 2000; Ellis & Bochner, 2000; Fine, 1992; Richardson, 1994), arts-based methodologies (Camden-Pratt, 2003, 2007; Denzin & Lincoln, 2000; Higgs et al., 2007; Slattery, 2001), poststructuralist approaches in art therapy (Hogan, 1997; Linnell, 2006; Skaife, 2008,) and discussion about the importance of therapist self-reflection in therapeutic practice (Dudley et al., 2000). Instead she found a deafening silence, with a few notable exceptions. Boston wrote her beautifully detailed account 'Life story of an art therapist of colour' (2005, p.189). Estep (1995) named her own experience of incest and, like Catherine, had exhibited art works about this, though Estep didn't explore in detail how she navigated this in the art

therapist role. Sibbett (2005) richly discussed her "professional liminality" (p.236) in living with cancer and how this impacted her work as an art therapist working in cancer care. Sibbett's critical reflections on her embodied experiences in re-searching professional liminality were important for Catherine, whose own research included somatic research (Camden-Pratt, 2003, 2007; Horsfall et al., 2007) – here was an art therapist modelling and validating somatic ways of re-searching in art therapy.

Catherine, *"Alongside lived experience, I had hoped to find art therapists critically discuss their Lived Experience and their locations in mental health systems, maybe even some talk about their diagnoses. I wanted guidance and, yes, the possibility of belonging in this profession. Very disappointingly, I found none."* In 2009, the then head of program suggested Catherine submit her critically positioned autoethnographic and diagnostically located literature-review assessment as an article to the *International Journal for Art Therapy*. Deafening silences, and lack of guidance or nuanced mapping of these important territories in her art therapy education as well in art therapy literature, contributed to her decision at that time to not publish and to walk away from becoming art therapist. *"As a long-term activist, I knew this was political action I couldn't take on my own. There was no visible professional art therapy community to hold the risks I'd be taking as a trainee, or as a future, art therapist. No visible allies. Plus, I wasn't sure I wanted to pursue training in a profession that silenced Lived Experience in these important ways. I guess, too, I was tired of 'being the change I wanted to see'. I'd spent so many years working at edges, on margins, bringing things into the conversation and onto the table. I needed active allies in this one – and in art therapy."*

In 2014, unable to ignore her organic professional movement into becoming art therapist, Catherine returned to complete training, this time in Transpersonal Art Therapy. Between 2009 and 2021, publications have emerged in art therapy literature exploring art therapist lived experiences. For example: an art therapist's own grief process while practising therapy (Iype, 2010); the value of autoethnography in art therapy research (Gray, 2011); an art therapist's devastating miscarriage and its impact (Seftel, 2001); lived experience of art therapists working in palliative care (Thomson, 2016); a trainee art therapist's critique of and queering of the genogram (Zappa, 2016); an art therapist's multi-located intersectionality, and critique of white privilege in art therapy (Eastwood, 2020, 2021); personal hauntings alive in performances as "an a/r/t/s-based practitioner… artist / researcher / therapist and teacher / and supervisor" (Green, 2018, p.139); exploring the liminalities alive for the creative arts therapist when both she and her participants share the same disrupting event of an earthquake (Green, 2021); and the queering of pregnancy, birth and (m)othering (Linnell & Zappa, 2021).

In 2021, there remain few voices in art therapy literature (Huet & Holttum, 2016; O'Neill, 2007; Roots & Roses 2020; Woods & Springham, 2011) about an art therapist's Lived Experience of diagnosis and related mental health challenges, and how these may intersect with, and influence, their art therapy practice.

The British Association of Art Therapists' (BAAT) 2007 Newsbriefing traces O'Neill's experiences as an art therapist living with a bipolar disorder who was brought before the Health Profession Council in the United Kingdom as a result of a car accident that occurred during "an episode of hyper-manic depression" (Woods & Springham, 2011, p.61). The Health Profession Council found no case to answer. While O'Neill does not directly discuss how she navigates being an art therapist with Lived Experience, hearteningly, she acknowledges the invaluable support and advice from BAAT in the challenging Health Profession Council process (O'Neill, 2007).

Woods and Springham (2011) carried out a heuristic inquiry into Woods' experiences of being a voluntary inpatient in a psychiatric hospital (Service User – see Footnote 2) while practising elsewhere as an art therapist. They offer insights and guidance for art therapists working with Service Users in psychiatric settings in the UK, grounded in Woods' own dual-role experiences in an art therapy group while an inpatient. Woods is clear that the Service Users gave her more support and help than staff, including the onsite art therapist. In particular, Service Users offered grounded hope (Woods & Springham, 2011), an important observation echoed in peer art therapy. Breaking the silence on this dual role of being both a Service User and a practising art therapist, is another intention for Woods and

Springham. For us, breaking this silence, is where the power of the article lies. Significantly, Woods and Springham's paper (2011) is "one of the most cited articles ever published in the *International Journal of Art Therapy: Inscape*" (BAAT, 2019). We ask, *"How come? Is it because they spoke into gaps and silences by naming Woods' dual experience, disrupting the binary of us and them, of Service User and art therapist?"* Despite this popularity, there remain substantial and persistent silences in art therapy literature. Perhaps Catherine's 2009 concerns about publication remain relevant today (Roots & Roses, 2020).

Huet and Holttum (2016) discuss BAAT's study of art therapists with the dual relationship of Service User/art therapist and its implications for art therapy training and practice, particularly with respect to disclosure. While researchers did not ask for specific demographics and used the term 'mental distress', participants included a variety of diagnoses in their responses: depression, anxiety, breakdown/ crisis, psychosis, brain injury, eating disorder, bipolar disorders and personality disorders (Huet & Holttum, 2016, p.96). Given well-documented increased levels of stigma and discrimination related to complex mental illness, such as personality disorders, psychotic disorders and dissociative disorders (Day et al., 2018; Deans & Meocevic, 2006), Mahlie asks, *"do the responses to disclosure change with the type of diagnosis?"* There is no data on this. The survey asked specific questions around the cultural response to Lived Experience/Service Users within British art therapy pedagogy and respondents addressed concerns of stigma and discrimination. The researchers acknowledged the study limitations due to small sample size, with 20 individuals participating or 1.25% of the total BAAT membership (Huet & Holttum, 2016). It is unlikely that this accurately represents the population of those with Lived Experience/Service Users practising art therapy in the UK, and may further demonstrate the presumed negative consequences of disclosure.

Despite the Australian 1992 policy inclusion of people with Lived Experience in the design and delivery of mental health services, recent research shows peer workers still experience discrimination and stigma within their workplaces, educational settings and mental health systems (Byrne et al., 2019; Edan et al., 2020; Roper, Grey & Cadogan, 2018). Most peer workers have come to see discrimination as 'normal' and expect it (Edan et al., 2020). Bullying from clinical staff and unsupportive systemic structures are the leading reasons they report for burnout and loss of job satisfaction, and the reasons for ending their employment (Byrne et al., 2019; Edan et al., 2020; Roper, Grey & Cadogan, 2018). Drawing on this recent research and the BAAT study, we are curious about how these research findings might be active for art therapists and trainee art therapists in the Australian context. During her training, Mahlie's mental health suffered from the ongoing need to advocate for peer art therapy and the value of explicitly articulated Lived Experience in the art therapy profession and pedagogies.

Roots and Roses (2020) discuss the complexities and discriminatory practices alive in art therapy as a profession and in wider clinical practice with respect to art therapists with Lived Experience. We came to it curious to see what evidenced change had come from Woods and Springham (2011) and Huet and Holttum (2016). Mahlie, *"this is the most important thing I've read in my art therapy training. Finally, a community to identify with, covert or not, starting conversations we have both tried to start and been diverted from. Conversations we need to continue, especially within educational spaces."* American art therapists Roots and Roses (2020) both identify as "users of mental health and psychiatric services… non-heterosexual, Latina, white passing, working class, cisgender, survivors of abuse and neglect… each hold social privilege and, in other ways, including as people with mental health diagnoses, experience marginalization" (p.76). They used chosen pseudonyms in order to write their article. This choice is carefully constructed in – and is testimony to – a profession and sector with widespread and subversive discrimination and ignorance towards art therapists who reveal they are users of mental health services. Mahlie and Catherine draw on the critical bravery and nuanced understanding of Roots and Roses (2020), and say *"thank you for your scaffolding"*. We actively support each other in being transparent and named. Mahlie, *"I wish they felt they could use their names. I want them to know, WE are here as well!"* It is this impetus that Mahlie takes into developing peer art therapy and becoming peer art therapist.

Movement Three: "I know that she really knows" (Jewell, 2020); Peer Art Therapy

At her core, Mahlie is a peer worker. Peer connection is her passionate vocation that she has fought to hold on to while training in art therapy and becoming art therapist. Peer art therapy evolves as she creates a new way of practising art therapy and becoming art therapist, bringing peer work and art therapy together. A trainee peer art therapist, she is actively supported in her clinical placement by Professor Brin Grenyer at Project Air Strategy (University of Wollongong) and that project's commitment to amplifying the voices of Lived Experience to ensure best practice for people living with personality disorders (Project Air Lived Experience Project, 2019, 2020, 2021). Supported by Project Air Strategy, Mahlie fought to have individual WSU supervision by a supervisor who understands lived experience. Her peer worker experience and becoming peer art therapist practices are informed by her training in Intentional Peer Support, counselling, Dialectical Behaviour Therapy (DBT) and trauma-informed diversity practices. Here we focus on peer art therapy in groups. Future articles will take up one-to-one peer art therapy.

A peer art therapist is a registered art therapist who has demonstrated experience and training within an approved model of Peer Support, effectively explores and mentalises (Fonagy et al, 2008) their own mental health experiences and positions themselves consciously with participants as a peer who has 'lived this' (Barr et al., 2021; Jewell et al., 2021). Roots and Roses (2020) use the terms 'wounded healer' and 'mental health Service User–provider' interchangeably to name their own location (p.76). 'Wounded healer' denotes that this person has "effectively explored their own mental health struggles, strengths, and motivations, as well as gained sufficient insight and professional education to help others" (Wheeler, 2002, as cited in Roots & Roses, 2020, p.76). While we can critique the term 'wounded healer' and don't personally locate ourselves here, we acknowledge the importance of these characteristics in becoming peer art therapist, and respect Roots and Roses' (2020) chosen terminology. Substantial well-supported ongoing self-reflexivity/mentalisation is required by peer art therapists. This is both crucial in and central to a peer art therapist's own capacity to provide effective therapy with participants. Peer art therapists have completed education that signals a specific located professional knowledge in art therapy, one that gives the art therapist a capacity to apply theory and processes in their practice. For us, an industry standard art therapy qualification is political – those with Lived Experience can and do complete the same levels of study as their colleagues without experiences of their own mental health issues. And our challenges can be substantial.

Huet and Holttrum (2016) suggest "therapist-as-expert" is shifting as new models of art therapy develop (p.95). Peer art therapy is one of these. Placing 'peer' before 'art therapist' signals the peer comes first and the art therapist walks alongside. This placement interrupts the potential 'expert' location of art therapist reflected in Woods and Springham's (2011) observation of the Service User being "labelled as the 'ill' one whilst the professional reinforces a position of 'expert'" (p.67). Peer art therapists walk into spaces openly alongside their Lived Experience with its attendant healing/becoming, and their experiences are vital to their practice and process. A peer art therapist often discloses their diagnoses, as working alongside a peer with their own diagnostic experience is an important part of feeling seen, heard and safe for many (Barr et al., 2020a). This can be as simple as a clear statement at the start of a group program – for example: *"I also live well with Borderline Personality Disorder and have completed Dialectical Behaviour Therapy as a participant."* Or it may be a response to a participant that the process they are experiencing is common and survivable – for example: *"I remember DBT being really challenging, it does take time and many people experience ups and downs, but I've found what works and you will too."* As discussed above and in Movement Two, training and working in Peer Work requires rigorous and ongoing self-exploration and demonstrated living well with diagnostically located mental health challenges. It is this that brings small 'a' authority to the peer art therapist when working with people living with mental health challenges. It is also what enables rigorous self-reflexivity for the peer art therapist. In peer art therapy, the peer art therapist is both an 'us' and a 'them' – no need to choose. And with this dual location, there is a clear awareness of sitting in both located places and their respective responsibilities.

Art therapy is relational and contextual (Gilroy et al., 2019; Hogan & Coulter, 2014; Skaife, 2008). Peer art therapy is practised differently according to its relational contexts. When facilitating peer art therapy Dialectical Behaviour Therapy skill groups, openly facilitated through Lived Experience, Mahlie provides examples of each art-based skill from her personal Dialectical Behaviour Therapy and practice (Buchalter, 2014; Haeyen, 2018; Haeyen et al., 2015). In these spaces her identification as a person living with Borderline Personality Disorder is essential (Linehan, 1987, 2011, 2014). This diagnosis offers her a power that clinicians do not have – the power of 'knowing' and 'naming openly' (Barr, 2021; Barr et al., 2020a; Jewell, 2020, 2021). Participants express inherent trust and connection knowing she has Lived Experience, and are more likely to remain engaged and willing to undertake 'hard work' with her (Barr et al., 2020a; Jewell 2020; Jewell et al., 2021; Mead & MacNeil, 2006).

One of the assumed differences between art therapy and peer art therapy is 'appropriate boundaries'. There may be a misrepresentation/ fear that peer workers do not have boundaries, or that their boundaries are inappropriate. In Mahlie's practice, and as we signal for future peer art therapists, boundaries regarding personal disclosure and depth of sharing are constantly examined, investigated and questioned. This is done critically and with the mentoring guidance of others, including within supervision, and deepens art therapy practices. Catherine's earlier question, *"what is in the service of the therapy?"* is clarified by Mahlie in peer worker language as *"what benefits the connection, mutuality and moving towards aspects of our relationship?"* (Mead & MacNeil, 2006). Peer art therapists can be both professional and personally engaged as whole people – the two locations are not exclusive. Peer work acknowledges mutuality in peer relationships and, through this, responds transparently to the often-silenced mutual growth/learning/becoming in the intersubjective therapist/participant relationship. Boundaries are clear and strong and reinforced in peer worker training. They are mutual and co-negotiated in the peer relationship (Mead & MacNeil, 2006). A peer art therapist makes ongoing professional choices in how to effectively work with participants with respect to disclosure in the therapy setting. Making these boundaries consistent and clear is crucial for participants' sense of safety and models assertive boundary holding.

In reflexive peer art therapy groups, Mahlie works alongside participants as a peer and as the facilitator. They can watch her process as she watches theirs. She is required to share as they are, and they are invited to ask her about her artwork. Current peer art therapy learning edges are sharp and ever moving. This is particularly so as Mahlie is both a trainee art therapist and a trainee peer art therapist. And she is mapping a new terrain. Clinical supervision is rightly mandated by training courses, the Australian, New Zealand and Asian Creative Arts Therapies Association (ANZACATA) and other professional bodies, but there are currently no peer art therapy supervisors. Much of her supervision centres on questions exploring peer art therapy and how it differs from and intersects with the model in her training. *"During groups I maintain my peer worker ideology of authenticity and honesty and reflexively validate my current personal challenges. My difficultly is with how much of this to share with participants, given the kind of facilitator that current models of art therapy tell me I need to be. I've worked in community services for two decades, and art therapy's telling me to suppress my Lived Experience in the 'therapist' seat was new for me. When I expressed the difficulty of this, my WSU placement art therapy supervisor asked me how my own challenges affected my facilitation: "Did participants see your personal struggle?" I admitted that during my art therapy training, I had become hypervigilant around hiding my challenges and had become fearful of the potential effect on participants of my sharing. I know the participants aren't my therapist – that is clear for me. So, I told my supervisor, when I don't share my challenges because I've been told it's not appropriate in the art therapy model I've been taught, I told her 'it's painful, and I feel like a liar'. Being a peer worker does not require this compartmentalisation of self. And when I do share in appropriate ways like I've been trained to do as a peer worker, the participants value this (Jewell, 2021). For me working out this new way of doing art therapy and being an art therapist I feel more in my skin, congruent and authentic."*

Ideally, future clinical supervisors for peer art therapists will have understanding of, and training in, peer work in mental health and the requisite supervisor status in art therapy. This would enable more-nuanced clinical supervision for peer art

therapists, as Mahlie's above words demonstrate is necessary – bringing together peer work and art therapy is a new territory for art therapists. Mahlie's painful feelings about the tensions she has discussed here are released in out-of-group responsive artworks. Responsive artworks are key to her ongoing self-care and professional quality of life. These practices of making art as self-care and professional reflection echo literature about art in supervision and therapist self-care (Awais & Blausey 2021; Coulter as cited in Hogan & Coulter 2001; Estep, 1995; Sibbett, 2005).

When Mahlie shares in the group about her current related challenges, participants tell her they value this highly (Barr et al., 2020b; Jewell, 2020). This appropriate mutuality enables shared empathy from participants and can be an empowering act that builds their mastery and purpose, in a mutually supportive group. Simultaneously, it reinforces Mahlie's peer influence – she is living this. As participants reflected, "It's also inspiring and hopeful to me to see her journey and how far she has come – gives me hope in my own journey" (Jewell, 2020) and "Mahlie's [sharing] lived experience helps me to feel less like a 'patient' and more like a person" (Jewell, 2020). She models the observation of Woods and Springham (2011) that "this power dynamic [between service users and professionals] is radically different between Service Users [see footnote 2 – authors] at a peer-to-peer level and this can have a positive effect" (p.66). Our sense is that appropriate opportunity for mutuality in peer art therapy can lessen and "ameliorate[s]… the burden one feels to others [when] in that state, yet being with people who have shared experience seems to create understanding and acceptance" (Woods & Springham, 2011, p.66). Shame and self-stigma are leading drivers in suicide completion (Broadbear et al., 2020; Hastings et al., 2002). Peer art therapist modelling interrupts this. Mahlie, *"It IS okay to struggle, we encourage people to reach out, speak up, be unashamed. If we then 'lock away our own challenges' and label them 'not welcome here' what are we really communicating?"* Curiously, this aspect of peer art therapy that accepted models of art therapy might have great difficulty with is one of its strengths. Where do participants see modelled the seeming paradox that 'living well with' can mean 'struggling well with'?

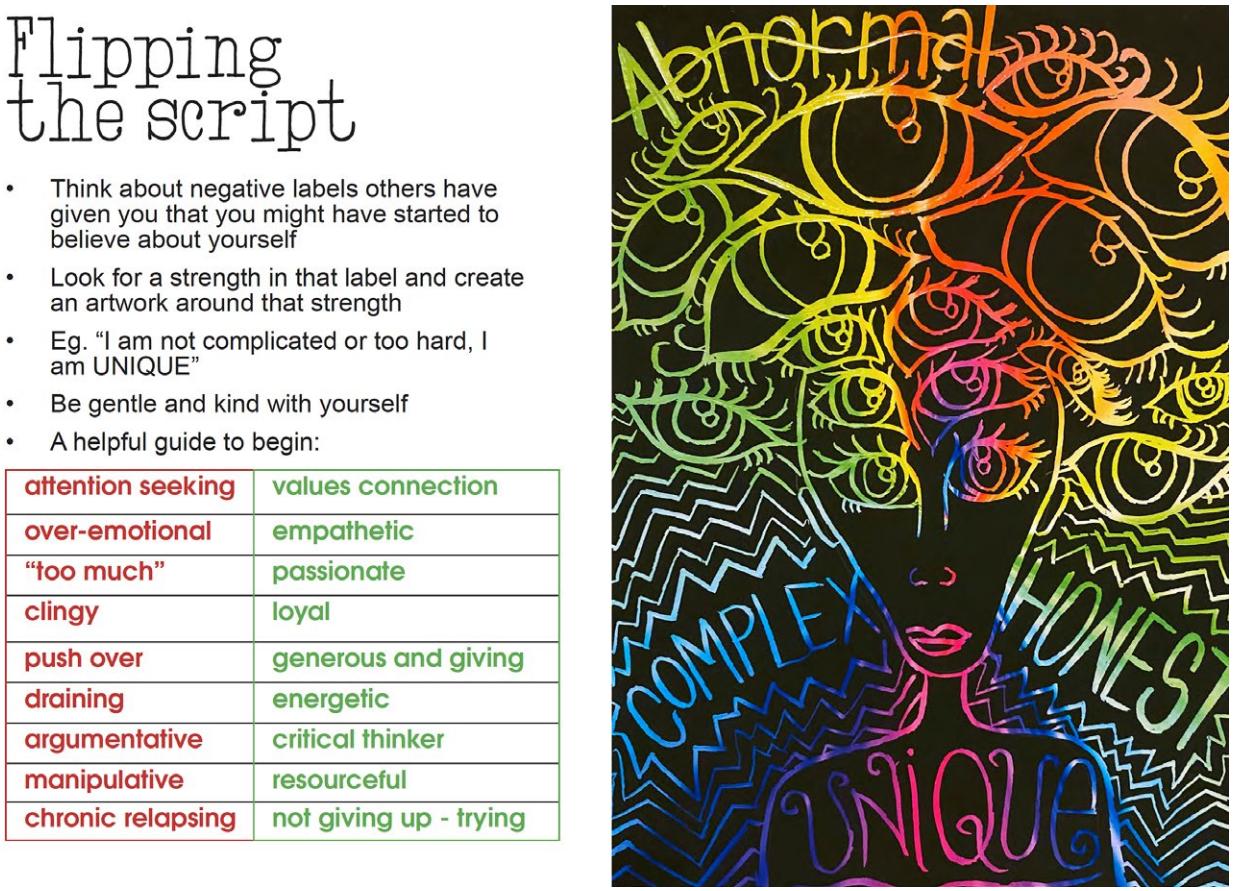

Figure 2. Mahlie Jewell, *Flipping the script on mental health language*, 2021, black rainbow scratch paper, addressing self-stigma. (Dialectical Behaviour Therapy Art Skills Group.)

A peer art therapist's need to prioritise and model self-care may mean stepping back from active group facilitation, becoming solely a participant. This proactive self-care is a result of the peer art therapist's ongoing required self-reflexivity and ongoing effective engagement in their own healing/becoming. It needs to be validated and encouraged. Having another peer art therapist guest-facilitate, while the ongoing peer art therapist is present, would enable this supportive move – supportive for participants and for the peer art therapists. Participants would know they and the group are well supported within a peer art therapy model. The peer art therapist who steps back is able to view the group from this different location and take up their own self-care needs knowing the group is well held. This capacity to learn from experiences of personal distress is recommended as a way to foster empathy with people with Lived Experience, and valued by mental health workers being trained in the recovery approach (Huet & Holttrum, 2016). Being able to model this capacity for participants is one strength for peer art therapists. By modelling self-care in action, a peer art therapist is creating evidence: *"If she can do it, so can I"*, followed by "*how do I?"* (Jewell, 2020). Supporting a peer art therapist needs to be proactive, non-judgemental and non-pathologising (Roots & Roses, 2020), and goes to the heart of the current challenges for art therapists with Lived Experience as evidenced in art therapy literature.

We turn now to signposting the ways in which art therapy education can proactively support and nurture peer art therapy and becoming peer art therapists, acknowledging there is more to be written about peer art therapy.

Movement Four: Signposting possibilities – art therapy education as a "practice of freedom" (hooks, 1994, p.21)

Art therapy education and its institutions are instrumental in supporting peer art therapy and becoming peer art therapists, and in creating a peer art therapy community viewed as essential in the profession. If art therapy is to respond to Kapitan's (as cited in Gilroy et al., 2019) vision for future art therapists, "freed from false binaries of art and therapy… forever creating new approaches based on where and with whom you practice… skilled third space thinking that attends to reciprocity and exchange..." (p.420), then peer art therapy and becoming peer art therapists need a place in art therapy pedagogies. Re-visioning *this* binary of art therapist/person with Lived Experience.

Art therapy pedagogy is a relatively new theoretical field (Gilroy et al., 2019; Green, 2021; Hahna, 2013; Hogan & Coulter, 2014; Leigh 2020), however, there is a rich established field of critical pedagogy (Camden-Pratt, 2008, 2009, 2011; Davies & Gannon, 2009; Freire, 1970, 2005; Gablik, 1991; Giroux, 1998; hooks, 1994; Whang & Waters, 2001) that can be drawn on to build its pedagogical practices and theories. Hahna's inclusion of second wave feminism's 'the personal is political' into art therapy education has far to go – Green's (2020) exploration of herself as "wounded-educator" (p.1) is a notable exception. Teachers are implicated in this, echoing hooks:

> When education is the practice of freedom, students are not the only ones who are asked to share…. Engaged pedagogy does not seek simply to empower students. Any classroom that employs a holistic model of learning will also be a place where teachers grow, and are empowered by the process. This empowerment cannot happen if we refuse to be vulnerable while encouraging students to take risks. (1994, p.21)

Open explicit inclusion is crucial (Barr et al., 2020a; Ng et al., 2018; Ng et al., 2019). As Huet and Holttum (2016) observe, Lived Experience voices can enact important change from the classroom, via the route of persuasion, influence and modelling. Art therapists who do not disclose their Lived Experience may make this choice based on evidenced understandings that the profession is not ready to welcome a peer approach with its necessary peer worker/Lived Experience professional location. They may fear the stigma and discrimination – subtle and overt – that comes with having an identified mental illness (Edan et al., 2020; Huet & Holttum, 2016; Roots & Roses, 2020). Roots and Roses (2020) emphasise the unique opportunities that art therapy education has in opening up conversations with students about professional locations that may seem "mutually exclusive or taboo" (p.81).

Mahlie, *"In my art therapy training, no one identified as a peer art therapist and worked from a place of open disclosure. This isn't uncommon given what it means to carry the word 'peer'."* Catherine responds, *"I haven't seen my lived experiences including experiences of mental health challenges and diagnosis as something that sets me apart in the profession in positive ways. My not sharing this in the wider art therapy profession, is indicative of the discourses we're talking about and how they function to stigmatise, marginalise and erase the art therapist's Lived Experience."* Mahlie, *"Perhaps you haven't been able to have this positive view of being a peer worker modelled for you. I wouldn't have seen it this way until mentors and elders told me I should be proud. In those first weeks of the course, in class discussion about our first assessments, you gave us a glimpse of your lived experience that signalled complex trauma, and that mattered to me. I admired that bravery in a teacher. And you modelled thriving alongside challenges, and that was important for me. In that final first-year lecture of yours 'Challenging binaries: Art therapists as members of participant groups', you explicitly – and critically – disclosed your diagnoses and your Lived Experience. Again, that was important. It could be done."*

Becoming peer art therapists need active relevant educational support, recognising the relationship between art therapy training and the wider art therapy profession (Huet & Holttum, 2016; Leigh, 2020). Leigh found there was 100 percent agreement on specific important aspects of art therapy education: "(a) experientials involving art materials, (b) practicum/internship placements, and (c) art-based experiential learning" (p.8). With this in mind, art therapy education is well positioned to integrate a peer art therapy model into established pedagogies.

What may be required is a paradigm shift that asks all involved to join in critically questioning the discourses that shape both art therapy and art therapy

Figures 3 and 4. Mahlie Jewell and Catherine Camden-Pratt, *Grandmothering: Beyond the gatekeepers*, 2021, digital photographs.

Exploring Grandmother Tree's surroundings, we both laugh with recognition at the concrete walkway with its aluminium seat and the smaller sentinel trees that we have to pass through when she is approached from the established pathway. *"It's the gatekeepers"* says Catherine with a laugh, *"let's see what's out the back."* We both delight in the room and space we discover there. Mahlie, *"There's always room out the back."* It's in this room, this metaphorical space out the back of established art therapy, that our conversations took place. Beyond the gatekeepers.

education, with respect to explicitly valuing and integrating people with Lived Experience and peer workers among students and teachers without their well-evidenced fear of stigma and discrimination (Edan et al., 2020; Huet & Holttum 2016; Roots & Roses, 2020). Springham and Xenophontes (2021) and Ford et al. (2021) model a new way of doing art therapy research, practice and publication: co-production with Service Users of art therapy and art therapists. We suggest that this co-production can be brought into educational spaces between teachers who are willing to identify as having Lived Experience and have training in peer support work, and students who have Lived Experience and may also be peer workers. Modelling this co-location – or 'dual-experience' (BAAT, 2021) as it is called in the UK – radically interrupts the binary that suggests art therapists and art therapy teachers are not simultaneously people with Lived Experience negotiating diagnostic locations that can themselves be usefully critiqued.

Like Roots and Roses (2020), we respect an art therapist's right to choose. This is individual, based on very real evidenced professional challenges and can only be made on the basis of choices that are in the individual's "best interests" (p.84). We are not asking students, art therapy teachers or art therapists to disclose Lived Experience where they do not feel – and are not – supported. Ironically, by disclosing Lived Experience and finding allies in art therapy practice and education, stigma and discrimination can shift, and be handed back to where it belongs – in social–political–economic discourses on mental health. Stigma and discrimination become internalised, despite not originating in the individual (Corrigan et al., 2009). By modelling the very thing that is so challenging we bring about change.

A creative education (Leigh, 2020), art therapy education contains sites where, supportively and responsively, students and teachers can co-create art therapy practices to include peer art therapy and becoming peer art therapist. Art therapy pedagogy is being challenged regarding inclusivity in spite of the difficulties asked of art therapists and training programs (Eastwood, 2020; Gilroy et al., 2019; Talwar 2019; Zappa, 2016, 2017). This capacity can be brought to art therapy education regarding an explicitly articulated peer art therapy model and becoming peer art therapist. In doing this, art therapy education can begin to tackle issues of equity and representation. Art therapy education can take up critical pedagogies that openly support and create opportunities within educational sites for new generations of becoming art therapists, who are trying to shift generations of disadvantage and stigma towards mental illness/mental health diagnoses that lead to poverty and wider marginalisation (Holttum, 2013; Krishnan, 2015).

Art therapy education and art therapy practices have many issues to address to make spaces for diverse people to enter the profession, and we have far to go (Eastwood, 2020). The below recommendations hope to provide some ways forward in peer art therapy in Australia.

Movement 5: Recommendations – *"we are here"*

Here we shift narrative gears and acknowledge this assertive move into a different tone. It reflects our sense of urgency and passionate need for change. These recommendations emerge from the above evidence in our article. They are not hierarchical; ecologically and strategically, they work together to influence all aspects of art therapy as a field and as a profession. Given our Australian professional context, there are suggestions that are more Australian oriented.

Confronting stigma and discrimination

We join Roots and Roses (2020) in challenging art therapy as a profession, and specifically its practitioners, to rigorously examine their/our beliefs about mental health diagnosis and Lived Experience within the profession. This includes confronting our beliefs about our colleagues who have Lived Experience and are simultaneously art therapists, as well as actively challenging all sites where stigma and discrimination about living with "mental illness" (Roots & Roses, 2020, p.81), are visibly or subtly active. We know that this professional reflexivity and activism is hard work. Happell et al. (2014) highlight the importance of speaking up and out where there are identified equity structures in place in institutions that are not upheld, as this leads to more intense stigma and discrimination for those with Lived Experience, who often report feeling negative impacts of tokenism and hypocrisy.

Review of current art therapy programs by peer art therapists and people with Lived Experience/peer workers

We suggest a review of current Australian art therapy programs using co-design or co-production reflection processes (Ford et al., 2021; Springham & Xenophontes, 2021) and/or the BAAT model (Huet & Holttum, 2016). This would align art therapy education with wider mental health disciplines that actively include people with Lived Experience in curriculum design and implementation (Happell et al., 2004; Roper et al., 2018). In New South Wales, this would ground the health guidelines discussed in Movement Two. In saying this, we acknowledge that we have not researched all art therapy training programs in Australia beyond web-based curriculum searches. We recognise that any changes at this level may then impact the program accreditation processes with accrediting bodies in ANZACATA and other program-specific accrediting bodies. In Australia, is there the will for this in our profession?

In the UK, BAAT now have a Dual-Experience Adviser as a co-opted board member, for art therapists who are also Service Users (UK)/have Lived Experience (Australia). This reflects the work done in the United Kingdom and included above, in Movements Two, Three and Four. We cannot comment on art therapy training and Lived Experience in the UK, beyond the discussion in Movements Two and Four of Huet and Holttum's (2016) study.

Literature by peer art therapists, people with Lived Experience in art therapy curricula, and supporting co-produced research

Art therapy literature depends on the generosity of participants with Lived Experience, yet few participants are co-authors. Throughout this article we draw on art therapy literature explicitly authored by dual-experience art therapists, art therapists with Lived Experience or articles co-produced with art therapists by people with Lived Experience/Service Users (UK) (Ford et al., 2021; Haeyen, 2018; Morgan et al., 2012; Roots & Roses, 2020; Springham & Xenophontes, 2020; Woods & Springham, 2011). During art therapy training, the inclusion of related peer art therapy and co-produced literature in required course literature can inform and stimulate students, while modelling another way of doing academic research. Given the limited art therapy literature in these areas, drawing on literature from other areas in the Australian mental health context can demonstrate the value of Lived Experience inclusion, for example, Palmer et al. (2019).

Identified peer art therapist academic in art therapy programs

This one may well be challenging. We suggest establishing an academic peer art therapy position in art therapy programs. This would require employing a peer art therapist, or having existing academics with Lived Experience who choose to be identified in this way, undertake peer support training. Huet and Holttrum (2016) indicate the potential benefits of this visibility for trainee art therapists. This identified position would enable teaching opportunities, and clinical peer art therapy placement supervision, by a program peer art therapist. Importantly, having an identified peer art therapy position in art therapy programs can actively support prospective students with Lived Experience. It may also encourage those that meet entry requirements within the peer worker community to join the profession, knowing they will be proactively supported in their training without fear of stigma and discrimination.

Peer art therapy experiential learning in art therapy training

Leigh (2020) confirms the prevalence and importance of experiential learning in art therapy education. Providing lectures and experiential workshops in peer art therapy would give becoming peer art therapists an opportunity to learn about this model. Offering students a peer art therapist facilitator in a peer art therapy training group could demonstrate this model. Students could learn about peer support principles, as well as have demonstrated: safe and appropriate sharing of therapist and participant Lived Experience and how to make art with/alongside the training group participants. Critical theoretical reflection and modelling facilitator reflexivity in this peer context could also be included. Having these training opportunities would grow peer art therapists in the profession.

Growing a peer art therapy network

As discussed above, many art therapists have Lived Experience despite not openly identifying (Huet & Holttum, 2016; Roots & Roses, 2020). Establishing identified peer art therapist sites may encourage

art therapists who feel comfortable identifying themselves as having Lived Experience, as they would be surrounded by art therapists also identifying in this way. This could help build pride in the Lived Experience skillset and experience. Identifying with 'people like us' has been proven to decrease self-stigma, and increase advocacy and open acceptance of people with Lived Experience (Barr et al., 2020a; Edan et al., 2020; Roper et al., 2018). It also provides the opportunity for mentoring art therapists as peer art therapists and completing peer worker training. Growing a peer art therapy network could ensure peer art therapists have clinical supervision with a peer art therapist. It could also ensure the safe uninterrupted continuation of their peer art therapist practices, for example, by group, guest or co-facilitation. Here we are curious to see the outcomes for UK art therapists who have this dual experience, now that BAAT have this identified co-opted role on their board.

Mandatory personal therapy

Undertaking personal therapy during art therapy training is not a mandatory requirement across all Australian art therapy training programs.[3] In 1993, the BAAT Annual General Meeting agreed to therapy being a mandatory part of art therapy training (Waller, 1994, as cited in Woods & Springham, 2011). This requirement simultaneously acknowledges the need for personal therapy for art therapists arising from life and/or psychological challenges, and that this endeavor is a resource in art therapy training and art therapist practice, as well as normalising therapy. In the North American setting, Moon (2015) advocates strongly and clearly for personal therapy while in art therapy training and as a practising art therapist. For peer art therapists, ongoing access to effective personal therapy is crucial and necessary during their training and future clinical work.

In the Australian university setting it may be that art therapy programs can negotiate accessibility via free university counselling services.

Coda

Returning to our narrative voice/s, we come to a resting place on this page. As lifelong activists and changemakers, we know the work involved in changing systems and ways of seeing. It takes determination, resilience, hard work and passion, and it has a toll on physical and mental health. It cannot and should not be done alone. It requires active allies. We acknowledge how far the art therapy profession has come, the leaders from the margins, the loud voices and changemakers in this space. We are grateful for, and humbled by, everything you have done.

In response, and true to our rigorous conversations, Mahlie returns to the space she found her well-being, Dialectical Behaviour Therapy, which deals in the world of dialectics – the ideology that two opposite things are true at once. *"You have done so much and I am grateful AND you must do more and I am expecting. We have come so far AND we still have much further to travel. I expect you to learn AND I am not responsible for your education. We must celebrate what sets us apart AND work together as one."*

Catherine, *"My next step is training in Intentional Peer Support (IPS) and handing back residual personal and professional shame and stigma to where it belongs, in mental health discursive practices. Yes, I'll probably discover discursive practices in IPS that invite critical conversations – there are already things I'm curious about given our own story. No doubt, these critical conversations will then trouble peer art therapy for me, and open up more of its critical edges. I'm a beginner in the peer space and the peer art therapy space, and there's a lot to learn. What I do know from many years of related social-political-ecological change work, is that the personal and systemic and structural is political; and the political is personal and systemic and structural. Putting ourselves on the line as you and I have done here Mahlie, is one hard-won way that change happens."*

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3. Catherine, *"In my transpersonal art therapy training at the College of Complementary Medicine in Sydney, NSW, all applicants were asked to disclose any mental health challenges. For me, this meant in addition to the group interview during the application process, I had a one-on-one interview. This interview was supportive and encouraging, teachers were interested in how I supported myself including my network of support. During training, all students were required to have two signed-off therapy/ supervision sessions per teaching module. This meant 24 sessions during the course. Having these mandated enabled teaching staff to openly support students where necessary knowing this support was there as a course requirement. It demonstrated a strong duty of care and respect for all students and for the therapy training in which we were involved."*

We return to our Grandmother Tree on Wangal land, saying *"thank you"* – thanking her for how she has grown, honouring how she survived a cut-off trunk by finding new ways to grow, her many limbs generously spreading, a refuge for creatures large and small, limbs strong enough for generations to climb including us, as we spoke passionately about peer art therapy. Catherine moving fearlessly along branches, Mahlie anxiously asking her to come down to 'safety', simultaneously admiring their ability to play.

Mahlie and Catherine: we step forward, seeking community in the wider art therapy profession, proudly locating our Lived Experience and its value for those we work with and hoping that other art therapists will join us and others, t/here. It is time to focus on what we can create together (Roots & Roses, 2020; Springham & Xenophontes, 2021; Woods & Springham, 2011) and find new ways that include peer art therapy and embrace peer art therapists; inviting their energy, their dual-located and dual-experience knowledges, perhaps finding inspiration. We step forward, naming peer art therapy and locating peer art therapists: essential in the art therapy profession.

Figure 5. Mahlie Jewell and Catherine Camden-Pratt, *Grandmother Tree honours the whole*, 2021, digital photograph with mixed media.

Catherine, *"It's good to name my multiplicity in this article. Yes, our brilliant, creative and intelligent order is called, by some who hold a located power, a Dissociative Identity Disorder (with Complex Post Traumatic Stress Disorder) (APA, 2013). And gosh, this way of being is so much more than those words or the paragraphs that follow it in the Diagnostical and Statistical Manual (2013). I/we have to critique it… and the literature around it. Yes we recognise us there AND it sells us so short. We climb you Grandmother Tree and you return our gaze. Thank you."* Mahlie and Catherine, *"We step forward honouring the whole; proudly locating our Lived Experience and its value for those we work with, and hoping that other art therapists will join us and others, t/here."*

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