

The Artivism Intervention: Can art be used to conscientise artists (Mental Health Service Users') and audience (the general public)?

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## **Abstract**

Social attitudes can be problematic for mental health service user's (MHSU's) in everyday settings, medical encounters, at work, and within social networks. The present research 'The Artivism Intervention' aimed to generate a proactive intervention to raise awareness of mental illness by producing artwork of MHSU's experiences to exhibit to the general public. This thesis aims to understand two questions (1) can art be used to conscientise (raise consciousness) amongst artists (MHSUs) and audience (the general public), and (2) are discussions about artwork an effective intervention to raise awareness of mental health stigma and suggest possible solutions?

Artivism is a proaction strategy using art as a tool to raise public awareness of Disability and Mental Health Service Users experiences. A mixed methodological approach using a qualitative Thematic Analysis was utilised to examine MHSU's experiences in studies one (chapter four). The Workshops (study one) were undertaken at Reachout: With Arts in Mind a mental health and arts charity. An exhibition (study two) exhibited MHSU's artwork (produced by study one), at The University of Stirling Central Library. Questionnaires (study 2A) and group interviews (study 2B) were employed to gauge public views after viewing the exhibition. A quantitative analysis provided numerical findings in study 2A (the questionnaires) and a Thematic Analysis was employed in study 2B (the group interviews). The findings show that new knowledge and conscientisation was produced. However, there was limited evidence of conscientisation in practice, during the art workshop process. Overall, the present research found that 'The

Artivism Intervention' has the potential to generate positive change and raise awareness of mental illness and disability. The intervention could be incorporated into integrated care pathways providing a supportive role to aid patient recovery in their local communities after hospital discharge.

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## **Table of contents**

<b>Abstract</b> .....	ii
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<b>Acknowledgements</b> .....	iv
<b>Table of contents</b> .....	v
<b>Chapter one: Introduction to Artivism and Conscientisation</b>	
1.1 Introduction to my thesis.....	1
1.2 The Medical Model.....	3
1.2.1 Critiques of the Medical Model.....	4
1.3 The Social Model.....	6
1.4 Community Critical Psychology.....	7
1.5 Conscientisation and Liberation psychology: Freire and Martin-Baro .....	11
1.5.1 Freire .....	11
1.5.2 Martin-Baró .....	13
1.5.3 Foucault.....	14
1.5.4 Conscientisation.....	16
1.5.5 Praxis.....	17
1.6 Definition of visual art.....	18
1.7 Artivism.....	19
1.8 Key Influences.....	20
1.9 What is Artivism?.....	22

<i>Figure 1.1. Las Meninas, by Diego Velazquez, (1656)</i> .....	24
<i>Figure 1.2. Eine, Street Art London (2011)</i> .....	26
<i>Figure 1.3. Fairey, (2009)</i> .....	27
<i>Figure 1.4. The Marxist Roots of Black Liberation Theology, (2008)</i> .....	29
1.10 Artivism and the medical model.....	30
1.11 Thesis overview.....	33
1.12 The remaining chapters.....	33
 <b>Chapter two: History and Constitution Changes in a Scottish Charity</b>	
2.1 Introduction.....	36
2.2 How the research began.....	37
2.3 The history of Reachout: with arts in mind .....	38
2.4 The evolution of the organisation.....	41
2.5 The Constitution.....	43
2.6 Interview with the founding and current chairperson.....	44
2.6.1 Founder: Sandi Luti.....	44
2.6.2 Current chairperson: Rhona Stewart (when research conducted).....	45
2.7 Founding (1995) and present (2009) constitutions.....	46
<i>Table 2.1: Constitution one (1995) and two (2009)</i> .....	47

2.8 Discussion.....	51
<b>Chapter three: a Mixed Methodology</b>	
3.1 Overview of the chapter.....	53
3.2 Being critical .....	54
3.3 Rationale of research/Intervention.....	55
3.4 Thematic Analysis Methodology – an overview.....	55
3.5 The Artivism Intervention Timeline.....	57
3.5.1 Familiarisation with mental health, disability arts charity.....	57
3.5.2 Ethnography.....	57
<i>Figure 3.1. Flow chart outlining strategic delivery of stages of research.....</i>	<i>59</i>
3.6 Study one: workshops.....	60
3.6.1 Location: research site.....	60
3.6.2 Participant recruitment.....	60
3.6.3 Workshop procedure.....	60
<i>Figure 3.2. The poster located on the notice board in the charity.....</i>	<i>61</i>
<i>Figure 3.3. Number of participants, researcher and staff per workshop.....</i>	<i>62</i>
3.6.4 Ethical considerations.....	65
3.7 Collection of data.....	65

Figure 3.4 Worksheet plan: Activism workshops.....	68
3.8 Study two: The Exhibition.....	69
3.8.1 Research site.....	69
3.8.2 Participant recruitment.....	70
3.8.3 Materials: exhibition.....	70
3.8.4 Group interviews.....	71
3.8.5 Discussion points.....	72
<i>Table 3.3: Group Interviews participants (MHSUs' and the general public).....</i>	<i>74</i>
3.8.6 Questionnaires.....	74
3.8.7 Field notes.....	75
3.9 Reflexivity: study one.....	75
3.10 Reflexivity: study two.....	76
3.10.1 Reflexivity: Group interviews.....	77
3.11 Study two: Thematic analysis.....	77
3.12 Reflexive research practice and analysis.....	78
3.13 Role as researcher: impact on analysis.....	79
 <b>Chapter four: Workshop Results</b>	
4.1 Introduction.....	80

4.2 Methods.....	80
4.2.1 Overview of workshop agenda.....	81
4.2.2 Basis of analysis.....	81
4.2.3 Analysis overview.....	81
<i>Table 4.1: Demographic details of 18 participants (Workshop members).....</i>	<i>81</i>
4.3 Produced super themes and main themes.....	82
<i>Table 4.2: Generated themes.....</i>	<i>84</i>
<i>Figure 4.1. Mind Map of super themes and sub themes.....</i>	<i>84</i>
4.4 Results.....	85
4.4.1 Lack of power and control ( <i>super theme 1</i> ).....	85
Healthcare (1.1).....	86
Diagnosis (1.2).....	86
Doctors (1.3).....	87
Medication (1.4).....	91
<i>Figure 4.2 2A. Sketches in a letter from Member M.....</i>	<i>95</i>
<i>Figure 4.3 2B. Dr. Serroc's Hat by Member M.....</i>	<i>96</i>
Emotion (Negative) (1.5), Emotion (Positive) (1.6).....	96
4.4.2 Wellbeing ( <i>super theme 2</i> )... ..	98

<i>Figure 4.4 3 A. The wall and me by workshop Member B.....</i>	<i>99</i>
Figure 4.5 3B. The wall and me by Member B.....	100
Society (2.1).....	100
Stigma (2.2).....	101
<i>Figure 4.6 Pressure by Member Z.....</i>	<i>103</i>
Support: Advocacy (2.3).....	105
Community: Charity (2.4).....	109
Art as a positive (2.5).....	110
<i>Figure 4.7 5A. Sketch by Member E.....</i>	<i>111</i>
Figure 4.8 5B. Artwork by Member E.....	112
Figure 4.9 5C. Artwork by Member E.....	113
4.5 Discussion.....	113
4.5.1 In reflection.....	115
<b>Chapter five: Exhibition and Group Interviews</b>	
5.1 Introduction.....	117
5.1.1 Overview: The exhibition (Study two).....	117
5.1.2 Participants: Engaging in the exhibition process.....	118
5.1.3 Overview: Questionnaires (study 2A).....	120

5.1.4 Overview: Group interviews (study 2B).....	120
5.2 Research questions.....	120
5.3 Methodology.....	121
5.3.1 Ethics.....	121
5.3.2 Study 2A: (Questionnaires).....	121
5.3.3 Participants.....	121
5.3.4 Participant recruitment.....	121
5.3.5 Materials.....	121
<i>Figure 5.1. The poster advertising the exhibition within the gallery.....</i>	<i>122</i>
<i>Table 5.1: Questionnaire.....</i>	<i>123</i>
5.3.6 Categorised responses to Questionnaire scoring.....	123
5.4 Study 2B: (Group Interviews).....	124
5.4.1 How participants were recruited?.....	124
<i>Table 5.2: Group Interviews.....</i>	<i>124</i>
5.4.2 Group Interviews Materials.....	125
<i>Table 5.3: Group Interviews: Discussion points.....</i>	<i>126</i>
5.4.3 Design.....	127
5.4.4 Procedure.....	128

5.5	Results: Study 2A.....	128
5.5.1	The Questionnaires: responses.....	128
5.5.2	Summary of the findings.....	134
	<i>Table 5.4: Questionnaire frequency of participant responses.....</i>	<i>135</i>
5.6	Results study 2B.....	137
	<i>Table 5: Core categories/Research questions from focus group data.....</i>	<i>134</i>
5.7	In summary.....	145
5.8	Discussion.....	146
5.8.1	The theoretical perspective.....	147
5.8.2	Exhibition: Artwork.....	148
5.8.3	Triangulation.....	149
5.8.4	Study 2A: Questionnaires.....	149
5.8.5	Study 2B: Group Interviews.....	151
 <b>Chapter six: Discussion</b>		
6.1	Aim of research.....	152
6.2	Research questions.....	153
6.3	Summary of the research strategy and setting.....	154
	Figure 6.1: The Psychologist Magazine.....	155

6.4 Study 2B: Group Interviews.....	158
6.5. Outcomes.....	158
6.6. Contributions of the present research outcomes.....	160
6.7 Real life implications .....	162
6.8 Critical reflections and future suggestions.....	164
<i>Figure 6.2. Blue pill.....</i>	<i>165</i>
6.9 Role as researcher, artist and collaborator.....	165
6.10 Reflectivity.....	167
6.11 Conclusion.....	169
<i>Figure 6.3. The wall and me .....</i>	<i>172</i>
<b>References.....</b>	<b>173</b>

## **Chapter One: Introduction to Artivism and Conscientisation**

### **1.1 Introduction to my thesis**

“The activist uses her artistic talents to fight and struggle against injustice and oppression by any medium necessary. The activist merges commitment to freedom and justice with the pen, the lens, the brush, the voice, the body, and the imagination. The activist knows that to make an observation is to have an obligation” (Asante, 2009, p.203).

This thesis aims to answer two questions: (1) can art be used to conscientise artists Mental Health Service Users (MHSUs) belonging to a local charity and audiences (the general public), and (2) are discussions about artwork an effective intervention to raise awareness of mental health stigma and suggest possible solutions? In brief terms, Artivism involves employing the practice of art to raise public awareness about a broad base of principally social, cultural, economic and political issues. In this project, art was utilised as a tool to generate critical thinking and discussion among MHSUs and the audience at an Artivism exhibition. By employing the concept of conscientisation, this research aimed to raise MHSU and audience awareness of the social, political, psychological and economic conditions that can oppress people in disadvantaged minority populations (Nelson and Prilleltensky, 2005).

In this thesis, the researcher explores the concepts of Artivism and conscientisation in the context of collaborating with MHSUs. The Artivism Intervention is a participatory action research project developed within a community critical psychology ethos. The researcher liaised with MHSUs who were members of a mental health and disability based arts charity (Reachout:

with arts in mind) located in Scotland. The charity empowers members to seek solidarity through using art as a tool to pro-actively challenge stigma. Numerous MHSUs have experienced stigma surrounding their mental illness from various sources, including social interactions, medical institutions, and the way in which MHSUs are often positioned within a biomedical framework (Willig, 2005). MHSU experiences are often the result of a 'top down' approach to practices, procedures and policies. Moreover, the very labelling of difference can cause stigma itself and negative attitudinal responses from the general public (Link, Struening, Rahav, Phelan, and Nuttbrock, 1997). For example, Bickenback, Chatterji, Badley and Ustun, (1999) suggest that "disabilities exist because of social expectations of normal performance" and that handicaps are socially constructed. They also cite the World Health Organisation:

"Disadvantage accrues as a result of [the individual] being unable to conform to the norms of his universe. Handicap is thus a social phenomenon, representing the social and environmental consequences for the individual stemming from the presence of impairments and disabilities" (World Health Organization, 1980, p.29).

The social constructs and attitudes in society function in such a way that the individual must conform to society rather than society changing to incorporate and enable the individual (Fox and Prilleltensky, 2001). The strict application of a medical framework to understanding disability can therefore be disempowering; for instance, a medical diagnosis is necessary in order to access disability benefits, housing support and medical treatment. However, there are also possible negative outcomes related to medical diagnosis within a medical model approach. When an individual has a mental health diagnosis there are cultural conceptions of mental illness and stigma (Kroska and Harkness, 2006).

## 1.2 The Medical Model

The medical or biomedical model of health is the term cited by psychiatrist Ronald D. Laing in his book 'The Politics of the Family and Other Essays' (1971), for the "set of procedures in which all doctors are trained to label" (Laing, 1971, p.57). The importance of diagnosis and the categorisation of illness symptoms into diagnostic categories are central to the medical model. A patient's symptoms enable the physician to select the correct diagnostic category which enables them to help the patient. This is because, according to the medical model, accurate diagnosis can provide the physician with clinically useful information as well as treatment plans. However, a problem arises in the form of what Zola (2005, p.51) terms the over-medicalisation of society. The medical model is utilised as a way to standardise, for example, a disabled person's or MHSUs participation in society rather than exploring alternative approaches.

In the United Kingdom, the National Health Service (NHS) defines people by their illness or medical condition (Liberating the NHS, 2010). The medical model is sometimes referred to as the 'individual model' because it promotes the concept that it is the individual ill person who is required to adapt to the way in which society is constructed and structured (Markova and Farr, 1995). Thus, the patient's position (within society) is fostered within a biomedical framework and discourse that is constructed according to this approach (Willig, 2001). As such the patient's "body becomes an object of legitimate interest to doctors ... invaded

in the process of treatment" (Parker and the Bolton Discourse Network, 1999, p.17).

Evidence-based practice is at the core of the medical model (Shah, 2007). In Shah's (2007) view, the medical model is encapsulated in Hippocrates' dictum 'first, do no harm', as this "assumes the doctor has specific knowledge and expertise (evidence) that an intervention causes greater benefit than harm" (Shah, 2007, p.376). In relation to the present research, a person's mental health and consequent medical treatment encounters are conceptualised as being affected by family, work and government. For example, when a MHSU visits a psychiatrist they are entering into a medically-dominant framework, which supports the authority and knowledge of the medical practitioner, which in turn works to reinforce the medical model. This form of ideological authority constrains medical professionals to treat patients within set parameters that do not provide opportunities for developing a more social approach (Waitzkin, 1989).

### **1.2.1 Critique of the Medical Model**

The critique of the medical model points to the ways in which medicine has been associated with keeping people in their place, and controlling people and their mental illness via pharmaceutical dependency. According to this perspective, the economic structures and the immense business of the pharmaceutical industry create incentives towards and aids social control. Habermas (1970) argues that

by deflecting critical attention from the problems found in society, the medical model also serves to legitimise the societal status quo (in Waitzkin, 1989 p. 222).

Critiques of the medical model are central to the anti-psychiatry movement, for example, through the Hearing Voices Network (Dillon, 2010), and the work of individuals such as Laing, Szasz and Johnstone. Lucy Johnstone worked in the psychiatric system, and after becoming disillusioned with the dominant medical model approach she wrote a book entitled 'Users and Abusers of Psychiatry' (Johnstone, 1989). In Johnstone's critique, it is noted how medications and ECT (Electro Convulsive Therapy) are often practiced as treatments instead of emotional and practical support. The validation of such practices lies in the medical model which, according to Johnstone, often lacks a firm evidential basis, "leaving traditional psychiatry with no justification for either its theories or its practices" (Johnstone, 1989, p.201).

This is not a new observation as many academics and physicians have cited and critiqued the dominance of the medical model. For instance, in the 1970s disability researchers, Miller and Gwynne (1972) defined being disabled as 'a social death', highlighting the oppressive definitions that can be constructed within medical-model based research. Deleuze (1995) suggested that medical model-based practice does not inspire individuals to challenge for change. He stated that, "Creativity has always been something different from communicating; the key thing may be to create vacuoles (little compartments) of non-

communicating, circuit breakers so we can elude control and challenge for adjustments in alternative approaches” (Deleuze 1995, p.175). As Deleuze (1995) noted alternate approaches to the medical model can prompt an ability to facilitate creative thinking reflexivity, aiding a framework to aid social change.

### **1.3 The Social Model**

In relation to mental health, Thomas Szasz (1961) and others began to question the effects of social constructs and attitudes surrounding the treatment of categorising individuals, and the negative social attitudes that could result. The term ‘social model’ arose in the 1960s-70s, stemming from the politicisation of disability rights by Paul Hunt (1966). In the 1970s the Union of the Physically Impaired against Segregation (UPIAS) published Paul Hunt’s work and the social model was accepted. The social model argued for a move away from the dominance of the medical model practice of individualising a person’s impairments, disabilities and mental illness; a process which resulted in the individual being labelled and ultimately positioned outside of ‘normal’ society. The social model is therefore a reaction to the domination of the medical model in healthcare and wellbeing, and provides a different framework within which to understand a model of treatment (Carson, 2009). From this perspective, disability is the product of the physical, organisational and attitudinal barriers present within society, which lead to discrimination. The removal of discrimination requires a change of approach and thinking, beginning with a recognition that society has been socially constructed (Burr, 2003). For example, being in a wheelchair is not in itself restrictive, but it becomes so because of the built environment around the

user. In addressing limitations associated with 'disability', the social model would therefore advocate (for example) that all buildings are accessible to everyone. This contrasts with the medical model which locates the source of the problem within the 'disabled' individual (Makin, 1995).

The remainder of this chapter will introduce the key influences that have shaped this research and then explore the main concepts and contexts used throughout the thesis. The aims of the research will be explained by detailing how Artivism is conceptualised. Also the process of conscientisation will be discussed, which refers to the general process whereby people gain a discerning awareness of social, political, economic and psychological circumstances in changing his or her reality (Aron and Corne, 1996). This awareness can affect individual's daily life whilst also having the potential to transform people's social reality (Prilleltensky, 1994).

#### **1.4 Community Critical Psychology**

The Artivism Intervention was developed within a community critical psychology framework. Community psychology, which is "a practice for liberation with responsibilities" (Duggan, Holloway, Kagan, Knowles, and Lawthom, 2000), is concerned with understanding people within their community environment and aims to uncover new ways to tackle oppressive structures in society by being proactive. Critical psychology looks at progressive ways to enable social change,

to challenge dominant policies and institutions that reinforce oppressive structures (Fox and Prilleltensky, 1997).

In this section we will explain what community and critical psychology brings to theorising the Artivism intervention. Critical psychology is described as having developed from a broad array of ideas from social constructionism, post-structuralism and discursive approaches to analytical theory based on the post-Marxist theorising of Foucault, Martin-Baró and Freire (Burton, 2003). As Fox and Prilleltensky argue, community critical psychology, “unlike traditional applied psychology, uses multi-level perspective, is sensitive to social context and diversity, and focuses on people’s competencies rather than deficiencies” (2001, p.166). Likewise, Burr (1995) argues that critical psychology focuses on where a person is positioned within society “in relation to difference, inequality and power and has provided alternative readings on a range of psychological phenomena, such as mental illness, intelligence, personality theory, aggression and sexuality” (Burr, 1995, p.16). In the present research, the focus is therefore upon activists and/or artists who want to be proactive in raising public awareness about a broad base of social, cultural and political issues (see Baigorri, 2003).

A key principle in community critical psychology is to aim to understand individual well-being and liberation, by understanding people within the context of their everyday social systems. Therefore, community critical psychology acknowledges the effect that living or working in an oppressive environment can

have on an individual by socially and physically disabling people. As a result, community critical psychology concentrates on promoting community well-being by understanding how people function within their environment and how the environment relates to them (Nelson and Prilleltensky, 2005). In the context of this thesis, the implication is that MHSU have the potential to think radically and creatively to challenge their position by employing visual and creative practices to help represent their experiences and self-expression through their art work (Howarth, 2011).

While community critical psychologists often “criticise psychology’s mainstream norms for reinforcing an unjust status quo, but we sometimes use those same norms to benefit members of relatively powerless groups” (Fox and Prilleltensky, 1997 p.7). It is therefore also important to note that the medical model treatments and pharmaceutical requirements can be necessary for a patient’s recovery in certain circumstances. In the field of critical psychology there is often resistance to a biomedical position. However, Cornish and Gillespie note that “biomedical knowledge serves the everyday interests of patients when it cures an illness, relieves symptoms or helps a person to avoid a serious medical condition” (Cornish and Gillespie, 2009 p.807). While it is important to empower people to fight dominant systems, to question ideological structures that mute resistance from often disadvantaged groups (Waitzkin, 1989), this does not imply a total or complete resistance to psychological and psychiatric practices in mental health (Prilleltensky, 1994).

Nelson and Prilleltensky (2005), propose critical psychology emphasises that society is made up of interdependent social systems. Initially it was a community psychologist, Jim Kelly, who developed The Ecological Metaphor, which comprises of four principles: interdependence, cycling of resources, adaptation and succession (Kelly, 1966; Nelson and Prilleltensky, 2005). For example, before the 1950s, Western society advocated that people with serious mental health conditions be removed from the community and placed in institutions. When deinstitutionalisation began in the 1950s, people were placed back into society thus generating a ripple effect and impact on local communities (Nelson and Prilleltensky, 2005). Prilleltensky, Nelson and Peirson (2001a cited in 2005) provide an overview of how an effect in one social system will impact on the other social system and so forth (Waitzkin, 1989). The Ecological Metaphor provides insight into the systems that govern human interactions. Thus, deinstitutionalisation put a huge strain on local communities from the individual, to the family, to school, and government and social policies (Nelson and Prilleltensky, 2005). This extra burden on a community can lead people to be stigmatised and rejected by society due to a person's mental health diagnosis. Thus, individuals needing support for serious mental health problems struggled to achieve a good quality of life (Nelson and Prilleltensky, 2005).

According to Prilleltensky et al. (2001a cited in 2005), there are three interconnected levels in society: the Macro, Meso, and Micro-systems. The Macro-system identifies policies and social norms, the Meso-system identifies work and school systems, and the Micro-system, concentrates on the family, social networks and the individual (Nelson and Prilleltensky, 2005). In this

research, Kelly's (1966) ecological model can be applied in the following way: cycling of resources identifies that the government reconstitutes resources from deinstitutionalisation back into society to aid MHSU's relocation back into the community. Adaptation is the communities adapting to support local MHSU after deinstitutionalisation. Finally, looking to the future succession explains how MHSU's are supported long term and how society can prepare for future community changes and challenges (Nelson and Prilleltensky, 2005). The Ecological Metaphor is important because as a society people live both within community and social systems. If an environment is positive and supportive it can generate a feeling of well-being. Cowen (1994) states "oppressive qualities of human environments ... can create problems in living" (cited in Nelson and Prilleltensky, 2005 p.73). This is relevant to the research as MHSU's medical and social encounters are affected by family, work and governmental policies. This form of ideological hegemony of dominant social attitudes may well assist medical professionals to treat patients within socially dominant structured constraints. This can be problematic as they often do not challenge or inform any social change in society (Waitzkin, 1989).

### **1.5 Conscientisation and Liberation Psychology: Freire and Martin-Baró**

"[T]he more radical the person is, the more fully he or she enters into reality so that, knowing it better, he or she can transform it. This individual is not afraid to confront, to listen, and to see the world unveiled. This person is not afraid to meet the people or to enter into a dialogue with them. This person does not consider himself or herself the proprietor of history or of all people, or the liberator of the oppressed; but he or she

does commit himself or herself, within history, to fight at their side" (Freire, 1971).

### **1.5.1 Freire**

Another important theoretical and ideological input into the present research comes from the tradition of liberation psychology, and particularly from the perspectives of Freire and Martin-Baró. In Marx's view the proletariat (citizen) is oppressed via class systems and the power of capitalism leads to exploitation (Mayo, 2004). It is the proletariat who need to displace and revolutionise this system. Martin-Baró's (1996) liberation psychology was developed from Marx's theory, while Freire and other theorists developed the idea of conscientisation; becoming involved in consciousness-raising to challenge personal and social oppression and to engender social change (Parker, 2007). For Freire, society does not consist of autonomous individuals with no social consciousness. Instead, people are capable of working collaboratively together with a social consciousness towards liberation within oppressive structures. The aim is to have a society characterised by solidarity, pro-action, and engagement in critical thinking (Freire, 1973). Freirean pedagogy advocates that the oppressed should work side-by-side to challenge and raise awareness by generating new knowledge to transform their social reality.

### **1.5.2 Martin-Baró:**

"In your country it's publish or perish. In ours, it's publish and perish" (Martin-Baró, 1983a).

Ignacio Martin-Baró was one of six Jesuit priests who were murdered in 1989 for their beliefs in a liberation psychology (Galeano, 1998; Toomey, 2001). Martin-Baró once said if we speak out and gain international visibility in fighting oppression it would “make it harder for them to kill us” (Martin-Baró, 1994, p.13). His liberation psychology, which had emerged from and focused on oppressive systems in Latin America, emphasised the process of conscientisation through praxis. This refers to how a community can become aware of the power structures that made them submissive through action and reflection, gaining new information on and ultimately transforming a community’s reality (Martin-Baró, 1994). In his own words, he sought to “propose a scientific endeavour committed to historical reality and the problems and aspirations of the people” (Martín-Baró, 1989 p.584-587).

Applying these principles to the present research, MHSUs experience oppression personally, socially, economically, psychologically, politically and via pharmaceutical dependency. It has been highlighted that “in many countries, individuals, who are affected by neuro-psychiatric disorders, endure double suffering, namely from the conditions themselves and from the social stigma and discrimination attached to them” (WHO Director-General, 1999, p.67). It is within this context that the Artivism intervention was developed with the aim of generating knowledge and public awareness of the often oppressive structures and attitudes experienced by MHSUs – in other words, developing the potential for change through conscientisation. The emphasis on action and praxis in the present research reflects Martin-Baró’s view that, “In many respects reality is

opaque, and only by acting upon it, by transforming it, can human beings get information about it” (Aron and Corne, 1996).

### **1.5.3 Foucault**

”The work of an intellectual is not to mould the political will of others; it is, through the analyses that he does in his own field, to re-examine evidence and assumptions, to shake up habitual ways of working and thinking, to dissipate conventional familiarities, to re-evaluate rules and institutions and to participate in the formation of a political will (where he has his role as citizen to play)” (Foucault, 1991).

Michel Foucault worked at the intersections of both philosophy and psychology throughout his academic career until his death in 1984. A key theme in his work is how knowledge is produced concerning mental illness, punishment, sexuality, and the links between power and knowledge (Gutting, 2005). Foucault wrote extensively about social structures, power knowledge and how we as a society are controlled as submissive citizens. In ‘Discipline and Punish’ (1991), Foucault discusses the birth of prison, crime and punishment in Western sovereign powers, emphasising the shift from overt, brutalising control, through acts of reform to an emphasis on rehabilitation (Foucault, 1980). In the past the majority of society found it acceptable to imprison people in mental health institutions and/or prisons. The new rehabilitative approach aimed to integrate people back into the community and offered talking therapies, treatment plans, and medication as a way to bring behaviour back into a normative range in medical model terms. Foucault argued that categorising people allowed them to be

diagnosed and thus, reformed “to make it possible to know them, to alter them” (Foucault, 1991 p.172).

Foucault (1995) also discussed the medics’ gaze in the panopticon in *Discipline and Punish*. In the panopticon, the prisoner would not see the 'inspector' who conducted surveillance from the privileged central location, with the inmates housed in a circle around this central point. Thus, the prisoner would feel permanently visible; assuring the automatic maintenance of power (Foucault, 1995). Foucault found that this disciplinary discourse is the archetypal model for many schools, hospitals and in medical treatment today (Foucault, 1995). As evident in community critical psychology approaches, Foucault was aware that power is present in all psychological and social interactions and practices. As he put it, power is everywhere and in everything (1980). Foucault conceptualised power not simply as being delivered in a top down manner onto disadvantaged groups; rather, power is simply everywhere, as is discourse (Rose, 2007). Discourses are “practices which form the objects of which they speak” (Foucault 1972, cited in Burr 1995 p.64). Foucault states that power and knowledge are interlinked and that one cannot exist without the other (Fox and Prilleltensky, 2001, p.278). Relating power and control directly to medical practice and wellbeing, Foucault argued that “the first task of the doctor is ... political: the struggle against disease must begin with a war against bad government. Man will be totally and definitively cured only if he is first liberated...” (Foucault, 1991). The power dominance and construction of a patient fitting into a biomedical discourse thus positions the patient as the recipient of treatment (Willig, 2004).

Foucault has influenced and informed many community critical psychologists, inspiring reflection on 'power knowledge', mental illness and disability (Laing, 2008). [For example, Deleuze proposes what counts in such processes is the extent to which, as they take shape, they elude both established forms of knowledge and the dominant forms of power, even if they in turn engender new forms of power or become assimilated into new forms of knowledge (Deleuze 1995, p. 176)]. Foucault realised that individuals react to situations in different ways. He wrote that power "reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives" (Foucault 1980, p.30). Although the theories of Foucault, Freire, Marx, and Martin-Baró amongst others do not rigidly define the current research, they nevertheless give it a theoretical underpinning.

#### **1.5.4 Conscientisation**

Freire developed the concept of conscientisation after reading Marx's analysis and ideology combined with readings on liberation theology (Mayo, 2004). Conscientisation is the process "by which individuals become aware of the socio-political and psychological conditions that oppress disadvantaged groups" (Nelson and Prilleltensky, 2005. p.22). Conscientisation consists of an increasing awareness of social, political, economic and psychological circumstances in challenging lived social realities (Aron and Corne, 1996).

Conscientisation is also about being transformed through changing an individual or group's reality (Scott-Smith, 2015). By slowly decoding an individual's or group's environment the aim is to demystify and "grasp the mechanisms of oppression and dehumanisation" (Aron and Corne, 1996, p. 40-41). For instance, the practice of graffiti art (known as tagging) can be viewed as a political action in itself. It could be seen as having two dimensions. Firstly, that you create an alternative name for yourself, something of an alternative identity, which you cultivate through increasingly expressive designs. The graffiti artist's tag makes a stamp on a particular territory but the territory does not belong to the tagger. So, to whom does it belong? Secondly, people who begin to become familiar with certain tags might be 'conscientised' both through a process of identifying with the desire to be creative with one's own name, signature, tag, symbol whilst also sympathising with the more politically audacious act of defying false claims to property and the attempt to define the limits of a creative space.

### **1.5.6 Praxis**

Praxis is a process of action, reflection and generating new knowledge by being pro-active, for example by challenging MHSU's self-understanding and position, and then reflecting on that action. This enables the generation of new perspectives and epistemologies through a 'bottom up' approach (Aron and Corne, 1996). A 'bottom up' or grass roots approach engages activism with individuals working together with a joint cause. Praxis is therefore key to understanding how the Artivism intervention might aid the generation of new knowledge from MHSU's experiences.

## 1.6 Definition of Visual Art

Firstly, as previously discussed this project is understood within the context of community critical psychology as “a practice for liberation with responsibilities” (Duggan et al., 2000). Secondly, the research explores the process of ‘conscientisation’ which is precisely an articulation of such a practice. In the context of this research, the “Visual Arts” is a modern but inexact term for a broad base of artistic disciplines. In the current research it is defined as a painterly art form using paint and mixed media on canvas. Art is employed as a means to enable individuals to express their expressionistic views on canvas, of a participant’s inner world views and experiences rather than external reality (<http://www.tate.org.uk/learn/online-resources/glossary/e/expressionism>).

Edvard Munch is a classic example of an expressionistic painter who often painted his internal view, for example, his 1893 painting, entitled ‘The Scream’ which depicted an individual screaming. There are also artists who believe that all art should have the function of awareness-raising or social change, for example, Diego Rivera. Rivera was involved in ‘The Chicano art movement’, which focused on the equal opportunity for social mobility, an awareness of people’s ability to have a collective voice, history, and culture ([https://en.wikipedia.org/wiki/Diego\\_Rivera](https://en.wikipedia.org/wiki/Diego_Rivera)). The aim of current research is to enable individuals to produce art that is an expression of human experience,

subjective emotions and the human responses to that society (<http://www.artmovements.co.uk/expressionism.htm>).

### **1.7 Artivism**

Artivism is a portmanteau word combining both "art" and "activism" (<http://www.urbandictionary.com/define.php?term=artivism>). The background of the term Artivism has grown initially by an online presence of artists in example Eine and Shepard Fairey documenting their artwork and experiences of social injustices via acts of art and political activism. In this context Artivism (activism by means of art) has developed into an international social movement as a voice against injustice (<http://www.aociyc.com/artivism-panel/>). Within this research Artivism is employed in two stages; study one the art and discussion based workshops and study two, the exhibition. Thus, Artivism involves employing the practice of art and proaction to aid public awareness around social representations to engage in a process of praxis (a cycle of action, reflection, and new knowledge) thus challenge the cycle and reflect on the knowledge gained.

### **1.8 Key Influences**

Present research highlights projects that have employed a similar design to The Artivism Intervention. Comparable influences can be seen in the work of Brydon-Miller's (2014) evaluation of the theoretical frameworks within community based participatory action research (PAR) projects. Freire (1970) influenced Brydon-Miller (2014) in developing theory to aid critical understanding by engaging in

conscientisation to understand how societal factors can shape individual experience.

Brydon-Miller examined the work of Kildea et al. (2009) who worked with maternal and infant health initiatives with young females located in an Aboriginal community. This PAR project gave the participants the ability to share their knowledge and experiences with researchers with an aim to counteract high infant mortality and improve the healthcare of mothers. The successful outcome of this project was based on the high levels of trust between the participants and the researchers. The young mothers shared their experiences which were made available via modern technology to health care workers, improving knowledge in healthcare. This benefited both mother and infant health within the Aboriginal and wider community (Kildea et al. 2009). In similarity The Artivism Intervention was based on the relationship of trust built between the participants and researcher to enable individuals in a community to share their experiences and voice. By using a PAR process it enabled a practice of praxis; of action, reflection and gaining new knowledge to generate greater well-being within the membership. Further, The Artivism Intervention exhibition benefited the community by sharing members experience via exhibited artwork to the general public challenging social awareness of the effects of mental illness and disability.

Wang, Kun, Wen Tao, and Carovano, (1998) developed a project entitled, Photovoice in rural China. A PAR project with 62 'village women' all members of

All-China Women's Federation (ACWF). The project aimed to empower Women to understand their own reproductive health requirements, thus to alert local policy makers to inadequate healthcare. This photographic methodology was employed which asked participants to document their limited healthcare via photography and group discussion (Wang et al. 1998). The outcome of the project conceded that local policy makers set up a midwifery programme and scholarships for underprivileged females. In visually documenting women's experiences it proved knowledge and gave value to participant's experiences. Oppression can be divisive by reducing confidence, self-belief and wellbeing. The Artivism Intervention documented MHSU experiences, consequentially generating friendship, laughter and knowledge exchange in the Artivism workshops and challenged the public's awareness in the Artivism exhibition. Using art to engage in understanding their health condition thus, employing art as an intervention. Art can be a powerful vehicle from viewing and creating art to engaging with community members asserting a collective story and voice.

Current literature explores the use of creativity in developing new concepts of generating creative and critical thinking to challenge social attitudes by understanding the local community and its members. An examination by Murray (2012) found that practices of art and social action to challenge forms of social oppression, with an aim to improve quality of life are beneficial. In a study by Camic (2008) found that art can be used within healthcare treatment by challenging patients to document personal experiences by using art to contest dominant negative social representations. The Artivism Intervention utilises art to

engage MHSU to verbally and visually express often shared experience of negative societal representations and encounters. Praxis, art through creative practice (action), exhibiting (reflecting on art produced) and generating new knowledge (from audience viewing the artwork). This provides an account of community member's experience. In terms of practical implications, the research suggests that community support groups and in particular those that provide a forum for making sense of and expressing one's experiences can be vital to getting people back into society, not least through making society itself more receptive to discussing these issues. Drawing on their insights, the remainder of this chapter focuses on how Artivism might be used to conscientise MHSUs and provide positive pathways in recovery.

### **1.9 What is Artivism?**

By placing an image into a public arena it can invite inquiry as the image is representing a story. Presenting an image and telling its story can raise public awareness of the issue it is addressing by employing Artivism. Informed by community critical psychology, Artivism is intended to be a thought-provoking and proactive practice. Foucault in particular suggested that art can provide information and raise consciousness in the audience. His book ,*The Order of Things* (1966; original title 'Les Mots et Les Choses') opened with a discussion of *Las Meninas* by the artist Diego Velázquez (1656), included below. The painting is structured to reflect and highlight information about wealth, power, differences and beauty. Foucault highlighted three 'observing' functions:

“The painting's complex arrangement of within that reality itself it cannot not be invisible. And yet, that reality is projected within the picture - projected and diffracted in three forms to three functions of that ideal and real point. They are: on the left, the painter with his palette in his hand (a self-portrait of Velazquez); to the right, the visitor, one foot on the step, ready to enter the room; he is taking in the scene from the back, but he can see the royal couple, who are the spectacle itself, from the front; and lastly, in the centre, the reflection of the king and the queen, richly dressed, motionless” (Foucault, 1966).

Foucault suggests that *Las Meninas* (see figure 1) (1656) breaks up the conventional ‘absolute’ image of a person which would often represent a person or family’s wealth, power and status. In this painting the viewer can see behind the canvas of the artist at work encompassing his social world, the artist with the family. Through reflection and refraction, representing the young princesses, their symbolism is distorted via their parents (in the mirror at the back of the painting). The interplay of what the princesses see and what they represent of wealth and power is highlighted by the artist. The economic order is dependent on the artist doing the commission and what the artist represents in the artwork. The artist or labourer has been employed to create a representation at the request and payment of the king and queen.

How does this relate to Artivism? It is making the creation of a painting or artwork more self-conscious in its production. *Las Meninas* (1656) identifies how art in principal can express, thus is a basis for Artivism. In the process of creating art, the artist is either representing the aesthetics of beauty and nature or creating an art work that conveys the artist’s perspective or experience. The artist in this instance needs to earn a living, this is Velazquez’s role. The result makes a statement that the nature of art is not purely aesthetic but each painting has a different reality dependent on the commissioner of the piece.

Taking the position that art can be self-expressive and can change an audience; artists are artists who aim to be proactive in raising public awareness about social, cultural, economic and political issues. Artists use art to push political agendas forward and to raise social awareness and inform social change. The linguistic blend of 'art' and 'activism' does not mean that the art is necessarily political in subject matter. Rather, it allows the artist to express social issues to a wider public.

Figure 1.1. Las Meninas, by Diego Velazquez, (1656)



Acts of Artivism are often aimed at reclaiming public space. Activists frequently engage in raising political awareness, for example by changing public advertisements in urban areas with a slogan such as ‘Buy Nothing’; a practice known as Subvertising (<https://www.adbusters.org/>). Artivism and being an activist is a centuries-old practice. This modern term for graffiti art is an age old practice for self-expression. For example, in Athens political graffiti art – especially during the Nazi occupation in World War II – was found on neo-classical buildings and is often seen as providing insight into societal attitudes during this period (<http://www.athensguide.com/art/graffiti/>). Graffiti has nevertheless experienced negative media coverage and has faced a legal clamp down and a greater conviction rate for artists caught producing graffiti in illegal environments. This lead to The Anti-Social Behaviour Act (2003) being introduced and updated in the United Kingdom (KET, 2007) [Artistic self-

expression of this type in public is a criminal act in the United Kingdom and artists repeatedly face prosecution (KET, 2007)]. Activism in this thesis is understood as a reflexive, bi-directional process. It involves an interaction between the group member (artist) and the audience (the public) because of the viewer's own varied perspectives and associations. The objective of Activism is to put an image into the public domain for people to see and experience, in turn generating discussion and awareness.

For example, graffiti artists writers or taggers as they are known often have political and social messages. Artists can express personal insights through visual narratives found in, for example, street art and graffiti. Certain activists want to challenge specific social attitudinal responses by producing images that can make people question what they see. For example, a young male was stabbed in the same locale as a local graffiti artist Ben Eine. Eine created a piece of street art where this incident occurred (Hackney, London) that said 'CHANGE'. This image alerts people to look and possibly ask what has changed. In the local community many people will be aware that a young male was stabbed and died at this location. This image could be asking society to take more of a social responsibility for a growing culture of knife crime, thus the image itself may raise public consciousness and a political awareness that government legislation needs to improve.

Figure 1.2. Eine, Street Art London, (2011)



Another example is the work of Shepard Fairey, an American poster/graffiti based artist who has been showing his work since 1989. Fairey's artwork focuses on consumer culture, and involves putting images and text into the public domain to publicise and provoke discussion (Fairey, 2006). Fairey hoped that his 'Obey the Giant' campaign would make the public question everything. Fairey's poster on the giant is about consuming and obeying society and its class structures, without consideration, just following the masses (see figure 3.). As an artist, Fairey became aware through his own campaign by creating a poster and generating a demand for it, thereby exploiting and demonstrating the process of public consumption that the poster criticised (Fairey, 2009). The posters over a 20 year period became a symbol of cool, political activism and rebellion especially for the youth of America. The campaign became a symbol of demand and of a right for political change during a period of the Bush administration (2001-2009). An example of Fairey's 'obey' campaign is provided below.

Figure 1.3. Fairey, (2009)



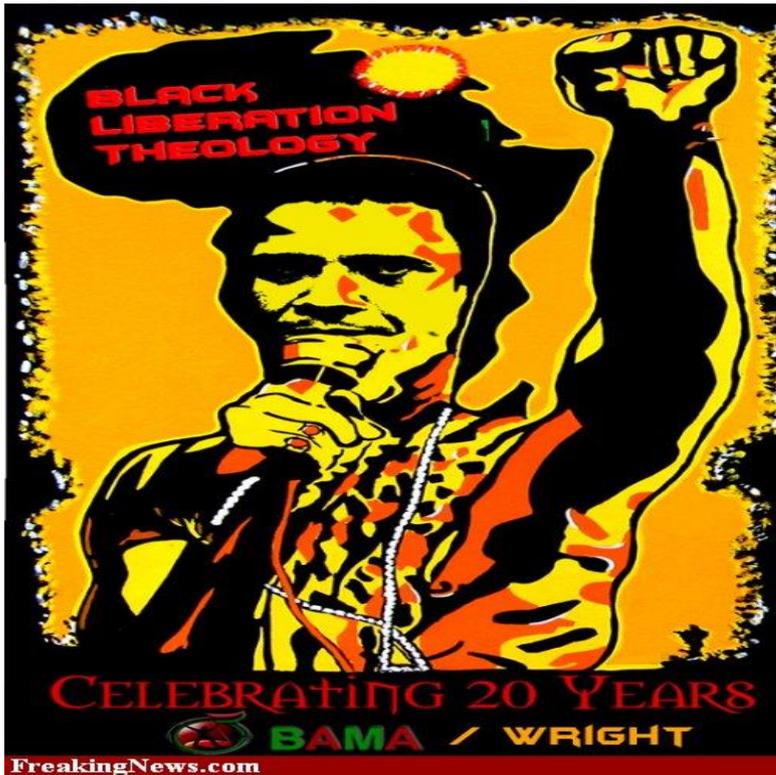
In society, we are constantly confronted and inundated with images and text. Fairey (2009) suggests that street art can likewise interrupt and send a message to people in their everyday environment. In an interview, he stated how dominant structures are changing and challenging our autonomy and human rights.

“less privacy, less civil liberties, the war, the herd mentality that allows the government to push its agenda through without too much resistance, the connection between governments and corporations that allows corporations to get away with whatever they want to get away with. On the other side it’s celebrating the people that think independently and resist. ...as form to put a philosophy across – it’s a tool for social change whether it’s reggae, hip hop or the Sex Pistols a lot of artists have used it as a platform for their political ideas” (Fairey, 2007).

This is echoed when Freire (1973) said “the fact that certain members of the oppressor class join the oppressed in their struggle for liberation”, thus moving from one pole of the contradiction to the other (Freire, 1973, p.42.). However, the reverse can also occur, with individuals freeing themselves from oppression only to then join the oppressors. In the context of MHSUs experiences, a medical

model approach requires that MHSUs free themselves from the stigmatising label, only to become part of the category that once stigmatised them and denounced their voice (Freire, 1973). As individuals, the need to be transformed from oppression to be proactive and challenging the status quo is imperative. Freire stated “The solution is not to “integrate” them (the oppressed) into the structure of oppression, but to transform that structure so that they can become “beings for themselves” (Freire, 1973, p.55). This process is a form of conscientisation; the process whereby people become aware, challenge their own viewpoints and become transformed by the social constructions that previously confined them. Fairey’s (2009) interest in guerrilla graffiti street art can be seen to be influenced by a Marxist view of liberation theology, as is the poster below, developed in 2008 in relation to a Marxist Roots of Black Liberation Theology group.

Figure 1.4. The Marxist Roots of Black Liberation Theology, (2008)



Artivists like Fairey, Eine, and MHSU's are often pushing against power-laden boundaries with an aim of liberating and/or challenging problematic structures. Graffiti art can be classified as an act of Artivism, to the extent that it is a self-conscious expression of a perspective designed to challenge an audience.

### **1.10 Artivism and the medical model**

The potential for Artivism to have an impact on MHSUs' experiences and social position is signalled by how Artivism has been used to challenge other facets of medical model-based health care practices. Regina Holliday became a leading advocate for health-care reform in the United States of America after her husband died in 2009 from kidney cancer at the age of 39 (Barr, 2013). With no health insurance Mr. Holliday could not pay for the tests that would have saved his life.

An interesting aspect of Regina's story is that she is using street art as a means to tell her story and to bring attention to the problems of the current American health care system. Regina Holliday has since gone on to develop a networking medical advocacy blog where art, medicine, social media and pop culture are brought together to create a patient voice. She is currently working on a series of paintings and blog posts depicting the need for clarity and transparency in medical records. Regina's artwork expresses the Holliday family's nightmare journey through the medical system during her husband's cancer treatment (see figure 5.). The painting became part of the national healthcare debate in America, and provides an excellent example of why Artivism is undertaken and the effect it can have on society.

Regina's Artivism was particularly important in stimulating debate and awareness of the American health care system's weaknesses (<http://khn.org/news/regina-holliday-patient-advocate/>). It has prompted Regina to launch her own website to encourage people to get involved in social awareness. This echoes Freire's assertion that "Liberation is a praxis: the action and reflection of men upon their world in order to transform it" (Freire, 1973). An example of Regina's street art regarding her husband's plight is in the image below.

Figure 5. Regina Holliday by here public artwork, (2009)



In community critical psychology there has been little research produced in the field of Artivism, and little that focuses on its potential for conscientisation in relation to mental health. The aim of the present research was therefore to examine whether and how an Artivism intervention amongst MHSUs could conscientise both the artists and the audience of their art (other members of the public). The researcher worked with a group of MHSUs from a Scottish-based mental health and arts support group. The group focused on giving voice to mental health service users via art and creative practices. The researcher became aware whilst working with this group that art could further engage the group in critical discussion about their personal experiences of mental illness. The development of the research was from a 'bottom up' approach collaborating with group members to give voice to their experiences, with the aim of establishing solidarity through joint decision making and collaboration with community members.

### **1.11 Thesis Overview**

The aim of the present research was to generate a proactive intervention for mental health service users to create awareness of and to challenge their social position. The next chapter provides some context for the research by introducing the history and changing constitutions of the charity within which the research was conducted. Chapter three presents the methodology of the research. Chapter four presents the findings from the first stage of the research, involving collaborative critical discussion and art-based workshops. Chapter five then presents findings from the second stage of the research, which involved a public exhibition of MHSU/charity members' art and its effect on the audience in terms of conscientisation. Finally, Chapter six presents a general discussion of the research and findings. The focus of each chapter is discussed briefly below.

### **1.12 The remaining chapters**

Chapter two examines Reachout: with arts in mind history and selected constitutions. It provides an insight into the charity's history and the changes in the constitution over a seventeen year period. As an established mental health, drama and arts organisation members are free to challenge problematic social and attitudinal barriers towards mental illness and disability. Chapter two highlights the changes found in the charity's constitution's [thus examining evolving power structures, how the membership is overseen and the direction of the charity]. The specific aim of this chapter is to ascertain how the charity has evolved into a member led organisation, with a management committee,

chairperson and staff members. To increase its membership base with a management committee of directors, chairperson and staff this is subject to review and monitoring by both internal and external agencies. The charity aims to both empower its members and the community in promoting the benefits of a 'bottom-up' approach community mental health and disability organisation.

Chapter three: This chapter will provide information on how the data was generated. The research was undertaken within the context of community critical psychology. A mixed methodological approach using a qualitative thematic analysis was utilised to examine MHSU's experiences in study one (chapter four). A quantitative analysis provided numerical findings in study 2A (the questionnaires) and a thematic analysis was employed in study 2B (group interviews).

Chapter four: The first empirical chapter will provide an overview of the workshops and the analysis of the workshop data. This chapter will demonstrate who the workshops were aimed at, how the workshops were facilitated, funded, advertised, and the overall intention of the workshops to explore the group process of consciousness raising. Each workshop attendee produced one piece of art work (painting on canvas) over a three month period.

Chapter five: The second empirical chapter examines the responses of the audience 'the general public'. The Artivism exhibition was held at The University

of Stirling Central Library Gallery one space. This chapter will demonstrate the aim of the exhibition, in gaining public feedback on the artwork exhibited via questionnaires and group interviews.

Chapter six: This chapter will discuss the thesis findings and the future possibilities for 'The Artivism Intervention'. The aim of the research was to discuss the findings in relation to the two research questions. (1) Can art be used to conscientise artists Mental Health Service Users (MHSUs) belonging to a local charity and audiences (the general public), and (2) Are discussions about artwork an effective intervention to raise awareness of mental health stigma and suggest possible solutions? Further findings are reported about the positive impact of the relationships formed between members and health (wellbeing) impacts of 'The Artivism Intervention' as a possible patient pathway.

## **Chapter Two: History and Constitutions Changes in a Scottish Charity**

### **2.1 Introduction**

“The way people think about themselves and represent their experience to themselves and others is dependent not upon some pre-existing essential human nature but upon the particular social and economic arrangements prevailing in their culture at that time” (Burr, 2003, p.34).

Chapter two provides the historical background to the research location; a mental health and arts charity ‘Reachout: with arts in mind’ based in Scotland. An evaluation of the organisation was undertaken to research the history of the charity and detail how it was founded. This chapter will explain how this research developed from an engagement with fellow researchers and charity members. The charity has a unique approach in challenging prejudice via praxis (reflection, action and generating new knowledge) within mental health and disability. The charity, founded in 1993, is an established mental health, drama and arts organisation, where group members can challenge social representations and attitudes via creative practices. Through a ‘bottom-up’ approach the charity aims to challenge the negative effects that social representations and attitudes can have “which deprive so many people from the opportunities to be healthy” (Stephens, 2008, p.239).

Members experiencing, or in recovery from mental illness can engage in the visual and performing arts to challenge the reality of the social attitudinal constructs encountered. The main proposal that stimulated the development of the charity derived from an interest in being proactive by practising drama.

Members of the charity include interested associates, mental health workers, academics, artists and individuals who share a joint interest. Interviews were conducted with the founder and chairperson of the charity and will be discussed later in this chapter. All charity members and staff abide by a code of conduct, and a constitution. This chapter analyses two of the charities constitutions (produced in 1995 and 2009) to evaluate the evolution of the organisation and the changes that have occurred and their affects.

## **2.2 How the research began**

The research developed from working with David Fryer (a community critical psychologist) from The University of Stirling's psychology department, where the researcher was an assistant tutor on a psychology undergraduate degree programme. David Fryer had an existing partnership with the mental health and arts charity via mutual learning schemes between MHSU's and psychology undergraduate students. The researcher met with charity members before starting teaching on the mutual learning project in 2006. From weekly visits to the charity it became clear that the MHSUs at the charity were gaining confidence and a sense of achievement from partaking in proaction projects. The members voiced that the charity had become less politically proactive, with reduced involvement from academic institutions and less member driven. David Fryer noted that an examination of the charity would be beneficial to understand the change in direction of the charity.

From the researchers previous undergraduate inquiries on challenging awareness of disability, Freire, Wang, and Foucault were examined and illustrated pathways to challenge stigma. The concept of conscientisation to survey a change in direction of the charity, and how to utilise art to raise awareness, could generate constructive knowledge. The charity and the membership enabled the researcher to develop The Artivism Intervention. This was supported by the researcher joining the membership and getting to know members before, during and after the research period (Estacio and Marks, 2010). It was important the members were aware that the researcher was invested in the charity and its continuing development post research.

The Artivism Intervention invited members to take part in a three month series of workshops to critically dialogue and engage members' experiences of mental illness. Freire states that a "true dialogue cannot exist unless the dialoguers engage in critical thinking" (Freire, 1970, p.73). The art work members produced expressed personal experiences using discussion and critical thinking during the workshops. The work was exhibited to the public to publicise and generate reflection on the artwork produced employing art (praxis) to engage in dialogue highlighting the attitude's people with mental illness can experience.

### **2.3 The history of Reachout: with Arts in Mind**

The charity is a registered mental health and arts charity, (Office of the Scottish Charity Regulator, 2009). It is a member run organisation employing five

members of full time staff who undertake project organisation, charity finances, funding applications and secretarial duties. The charity has a management committee of elected members who meet monthly to discuss the management of the charity. There are between four to six members on the management committee. The members of staff take part in documenting the monthly management committee meetings, advising on upcoming projects and funding opportunities. The continued maintenance of the constitution is part of the management committee's duties, updating policies and practices.

The charity is aimed at people aged sixteen and over who have experienced mental ill health and hold an interest in the creative and performing arts. Charity members travel across Forth Valley to visit the base which typically holds a membership of between 70 to 100 members. The ethos of the charity is to support awareness of the social attitudinal barriers that mental illness can promote by employing creative practices, developing new knowledge and challenging negative practices, procedures and policies. Paulo Freire (1970) found that being critically reflexive in activism enables people to have the ability to transform their lives. The critical activism or Artivism engaged with by the charity members challenges attitudes and stigma in an effort to be transformatory and raise awareness. Praxis is necessary to the research as "critical social research should be reflective, so part of the analysis should be a reflection on the position from where it is carried out" (Chouliaraki and Fairclough, 2005). The Artivism Intervention aims to generate new knowledge, and an awareness of the wider

social representations and consequences of being diagnosed with a mental illness (Montero, 1994).

The local Council Service Legal Agreement accounts for 25% of the Charity's annual funds from the arts and education budget. This pays for the employment of core staff and premises. However, the Charities projects are funded separately which can constrain radical activism; thus members are requesting further funding to be made available for educational members run projects. High levels of funding can enable wider project budgets to explore and develop proaction projects. The charity has received funding from The Big Lottery Fund, Lloyds TSB Foundation for Scotland, The Robertson Trust, and Fairer Scotland Fund. Members also carry out fund raising activities by undertaking multiple strategies to raise money and awareness.

The charity did not have a permanent location until 1998 and in 2010 moved to a new location with full disabled access, café and is now central to the town centre. The charity has moved from being a critical to a therapeutic proactive project. Several academics have undertaken research within the organisation, for example, Paul Duckett, Steve McKenna and Adele Laing engaged in community critical psychology research as part of their PhD studies. David Fryer collaborated with members on the 'Creative Banner' project and was part of a members group visit to New Zealand. The project highlighted members involvement with creativity as an icon of enablement. It won the Engage Scotland Visual Education Arts

Award in 2005. The multiple phases in the charity's history of critical activism and a therapeutic art phase are in part due to management, chair persons and interested academics contributions.

Members are positioned by their own subjective experiences and mental health. Social barriers can categorise people into certain groups as well as can impact all who hold a label and diagnosis (Martin-Baró, 1994). The Medical Model, for example, places the power and knowledge often with the doctor and the patient as the recipient of this knowledge and power (Willig, 2004). By contrast, the Social Model aims to remove physical, structural and attitudinal barriers to create accessibility.

## **2.4 The evolution of the organisation**

Member led organisations are by nature dependent on a membership for making decisions which are overseen by a board. The charity is comprised of a two-tier structure where the board is elected by, and accountable to, a wider body of members. Thus, the evolution of any organisation is affected by changes in the membership, funding and the objectives of a charity. As with all funded organisations, funding is key to establish longevity. Therefore, funding has an important role in the evolution of a charity in targeting funder friendly projects. A participatory action research (PAR) project based on a social model approach may receive less funding than a therapeutic medical model based project. These are points to consider in the evolving constitution. In addition the charity reflects

its membership. There have been periods with very politically active members leading activism, and when they have left due to recovery or relapse the organisation has become less pro action based.

'The University of Stirling' community psychology course within the psychology department was also discontinued during this period. This accumulative effect generated a loss of proactive external allies working with the charity thus, funding for mutual learning projects via the community psychology group was ceased. The charity helps members with chronic long term illness to utilise its services and the workshops as a vital stepping stone in preventing relapse, maintaining wellbeing and finding a pathway to recovery.

The Management Committee or Board of Directors is created from invited interested supporters, academics, and charity members, who go through an election process. Once an individual has been elected they will serve on the board of directors and attend monthly management committee meetings. The executive and company secretary attend all meetings, with support staff reporting on current projects. The membership of the charity is generated from a referral process, whereby 38 external agencies forward mental health services users to the organisation (<http://www.reachoutwithartsinmind.org.uk/#!/page4/cfvq>). The aim of the charity is to be a collective voice, to encourage its members to express experiences via art and activism, and thus raise awareness of mental health within the local and wider community (charity constitution, 1995).

## **2.5 The Constitution**

As a member led charity it must abide by a code of practice (a constitution). The constitution is enforced and updated by the Management Committee (MC) which incorporates elected charity members, academics and interested parties. All changes within a constitution are raised at the Annual General Meeting (AGM) held once a year, where members are elected to serve on the MC. The constitution was initially devised by the founder of the charity in 1993. The first constitution became an enforceable document and circulated to all members in 1995. The constitution's overall objective is to oversee membership, to assert the aims of the charity and to abide by a code of conduct to protect members and staff.

All UK Charities are regulated, in Scotland the charity's constitution is regulated by the Office Scottish Charity Regulator (OSCR), established in 2003 to increase public confidence in maintaining Scottish charities. Previously the Inland Revenue issued charities with a specific number to register the charity and what it promoted. OSCR established the charity regulators act which was put into good practice in 2005 (10 years after the first constitution was drafted). It was in 2005 that OSCR became fully operational as an independent regulator.

## **2.6 Interview with the founding and current chairperson**

### **2.6.1 Founder: Sandi Luti**

The charity was originally founded in 1993 as a drama mental health group. The Charity was then known as a mental health and community arts project. Sandi Luti envisaged the Charity as a way to alleviate the negative effects of people living with mental illness by connecting people to share collective experiences. Luti envisaged a mental health support group after viewing the play 'MAD' at the Edinburgh Festival in 1992. The play was part of a trilogy of plays entitled 'MAD', 'SAD' and 'GLAD'. The play 'MAD' expressed the difficulties of living day to day with a mental illness. All the actors in 'MAD' were played by people experiencing or in recovery from mental illness. The audience feedback highlighted feelings of hope, solidarity as a collective voice. It was at this point Luti realised that drama could help people in the mental health system. In an interview conducted with Sandi Luti in 2010, she discussed the history of the charity:

“Yeah and this one was called 'MAD' and it was predominantly acted by people who were in the psychiatric system and it was a depiction of their own lives...of their own route to that...to being in the system”

“my husband and I who were there went to the pub afterwards and some of the actors were there and we talked to them and you know, the one, er, comment that I remember in particular was one of them saying, em, that in the two years for her in the psychiatric system this play had done more for her”

Luti secured funding from the local council to establish an outreach support group. The charity was open to persons experiencing mental health difficulties and/or people with an interest in mental health. The charity commissioned a play funded by the local council 'DO YOU MIND' enacted by charity members and written by the screenwriter Steven Greenhorn and directed by Guy Hollans. This was the first of many activism projects of challenging awareness of the mental health system, stigma and offering support to members. The play empowered the group to come together and challenge stigmatising attitudes of negative

social representations and power structures. The Charity gave people the voice and support to do this. Luti continued:

“So it really was from that that I started to think about how could this be done, you know, this drama...drama project and erm, started to ask about, you know, around whether people who were interested”

The initial drama project enabled the members to group together, to form solidarity and to challenge the systems that can oppress. During her time with the charity, Luti was critical in engaging members in activism and sourcing funding for the charity to continue.

### **2.6.2 Current Chairperson: Rhona Stewart (2011)**

The current chairperson, Rhona Stewart, acknowledges the charity has evolved and proceeded through transitional periods. The historical changes that have occurred through the charity’s history have shown a move from a drama production based approach, to a creative therapeutic art focused approach. An example of these changes is expressed in a conversation with the current chairperson:

Interviewer: “Right and do you think it’s from speaking to people that it’s (charity membership) kind of taken over partly from there, you know interaction with the mental health services at all?”

CP: “I don’t think so; I think there’s been a change from maybe being a bit more radical and challenging the system from an out there kind of way, em, to being more about feeling good and confident in your own community and being able to do something and produce stuff and say that makes me feel better”

Interviewer: “Yeah, so a sense of satisfaction almost it’s giving people”

CP: “Yeah and I think people will have gripes about the system but I think the system but I think the, well from my experience, the system has changed for the better”

The charity and members have been affected by changes in the current mental health system. A reduction in both NHS and community funding has impacted upon many community organisations and community nurses. People benefit from the collective creative strategies and activities running in the charity.

## **2.7. Founding (1995) and Present (2009) Constitutions**

The founding and current constitutions (from when research was conducted) are available to members of the public and are part of public record. The first constitution produced in 1995 covered the initial drama critical activism phase. The 2009 constitution was produced during the therapeutic art phase. Both constitutions examined were formed during transitional periods for the charity.

Initially, the charity was developed, conceived and funded as a politically proactive drama based group by the creative energies of Sandi Luti. The charity's initial aim was to be proactive and engage with radical activism to stimulate social justice by challenging dominant and problematic epistemologies. The charity's engagement with acts of Artivism and radical critical activism incurred a decline. This could be due to multiple factors, changing membership (less radical members), reduced funding, and academic involvement. The chart on the following page identifies the differences highlighted between constitution one (1995) and constitution two (2009).

**Table 2.1: Constitutions one (1995) and two (2009): ‘Objects and Aims’**

**Points 2.1-2.6**

<b>Objects and Aims(Points)</b>	<b>Constitution One (1995)</b>	<b>Constitution Two (2009)</b>
<b>2.1</b>	2.1 To raise awareness of mental health issues and reduce stigma through community arts.	2.1 To enable therapeutic activity and encourage opportunity for exploration of members views and needs.
<b>2.2</b>	2.2 To examine attitudes and improve understanding of user experience thereby contributing to better service provision.	2.2 To examine attitudes and improve understanding of member experience thereby contribution to better service provision.
<b>2.3</b>	2.3 To enable therapeutic activity and create opportunity for exploration of Users views and needs.	2.3 To engender collective decisions/involvement in the project thus generating a sense of equal participation and ownership.
<b>2.4</b>	2.4 To engender collective decisions/involvement in the project thus generating a sense of equal participation and ownership.	2.4 To raise through expressive arts increased awareness of broad and specific mental health issues and to promote the work of the project in the local and wider community.
<b>2.5</b>		2.5 Provide a community based mental health information and educational resource responding to local needs.
<b>2.6</b>		2.6 The projects activities will be subject to review and monitoring by both internal and external agencies.

In both constitutions, social and individualising discourses are found. In constitution one (1995), the focus is on fighting and challenging stigma in society and in constitution two (2009), the focus is on art and therapeutic practice. Thus, the changes found within the object or aim section identify constitution one (1995), changing from a social to an individualising discourse. By examining the discourse the analysis highlights that constitution two (2009) holds six points in

the objects and aims section. In constitution two (2009) points 2.1 to 2.3 are the same as constitution one (1995) but in a different order. In constitution two (2009) points 2.5 to 2.6 are new, in point 2.4 is a diluted version of point 2.1 in constitution one (1995). This last point is important.

A change in the content and order of the object or aim section in the constitution has identified how one of the object and aim points have been changed. The previous constitution places importance on reducing stigma, for example in constitution one (1995) point 2.1 states:

“To raise awareness of mental health issues and reduce stigma through community arts”

In constitution two (2009) point 2.4:

“To raise through expressive arts increased public awareness of broad and specific mental health issues and to promote the work of the project in the local and wider community”

The ethos of the charity was to challenge negative social representations and attitudes towards mental illness by employing creative strategies to raise awareness in the community (Artivism). The language is less direct and focused in constitution two (2009) compared with constitution one (1995). Constitution two states about increased awareness but the direct message to reduce stigma is lost thus the ideology has been altered. Burr (1995) states how to challenge the system and how to deconstruct text which promotes and enables change. This constitution exemplifies the power of text and its meanings. The strength of constitution one (1995) has been reduced by constitution two (2009). The order of the objects and aims section has weakened its meaning. In constitution one

(1995), point 2.1 is first on the list and in constitution two (2009), the altered point 2.4 is fourth of the list. These small dialogical shifts and changes do subtly alter people's perceptions and members activism over a period of time. Thus, a simple change in the narrative of a constitution can construct a less fervent epistemologically aware and activist orientated group (Burr, 1995). The constitutions show a shift from a general social to an individualising discourse. In constitution two (2009) an individualising to a predominately social discourse in constitution one (1995) is found. For example constitution two (2009):

“To enable therapeutic activity and encourage opportunity for exploration of members views and needs” (point 2.1)

The excerpt above highlights changes in the constitution thus adapting to an individualising discourse. This switch in focus onto the individual equates to a medical model approach of treating the individual rather than society. To exemplify this claim constitution one (1995) highlights an opposing social discourse in point 2.1 below:

“To raise awareness of mental health issues and reduce stigma through community arts”

The text above from constitution one (1995) shows a social discourse about tackling awareness through the community. Point 2.1 employs a social model approach with an aim to reduce attitudinal, social and physical barriers (Nelson and Prilleltensky, 2005). The interpretation of constitution two (2009) is less critical and political. Initially, the charity's first constitution (1995) discussed

challenging stigma and challenging social views of mental health. Initially it is about challenging the individual and the process of social change is deemed less important than constitution one (1995) states. In constitution one (1995) reducing stigma was first on the list of the charity's objects and aims and in constitution two (2009) it is fourth on the list. In addition, the phrasing and language in constitution two has changed to be less focused, critically active and aware than in constitution one (1995). In an interview with Paul Duckett a previous management committee member found:

“The changes I remember are that the charity started to become less radical. While the management committee viewed the charity as having a politically active role and tended not to perceive limits on the capabilities of group members, the manager appeared to view the activities of the group more as therapeutic and imposed limits on the capabilities of members...”

“I remember one instance when there was talk of bringing a professional photographer in to help with a project documenting people's stories of living in asylums, even though charity members were more than capable of taking their own photos”

The above excerpt highlights a noticeable transition in the group. The change in the social construction of how the group operates, as members moved from a proactive phase to constitution two (2009) a therapeutic, less proactive phase. The new management may have impacted on this, going from a critical proactive drama phase to an art therapeutic phase on the group's direction of activism based projects.

## **2.8 Discussion**

This chapter aimed to understand the historical background of the charity as an organisation and provide a critical evaluation of its evolution. The researcher aimed to evaluate and interpret the two constitutions to show changes in the charity objectives and aims. In evaluating the history, documented interviews with the charity founder and current chairperson in 2011 were carried out. Evaluating the 1995 and 2009 constitutions provided an understanding of how the charity has evolved from a critically proactive drama based group to a more therapeutic art based group.

There are identified changes found within the 1995 and 2009 constitutions. The impact of these changes were evaluated and explored by de-constructing the discourse to understand the critical and historical background of the charity. During the critical drama first phase it is easy to understand the impact Sandi Luti had in creating the charity as a critically aware drama group. The changes in the constitution highlight the move away from the charity's foundation as a critically conscious engaged group. This has no doubt been affected by the closing of the community psychology course at 'The University of Stirling' in 2010. The charity was founded and was singly funded by the local council. In 2011 there were multiple funders, aiming to achieve improved results in MHSU recovery pathways. The group was focused on community activism, by challenging stigma with an aim to generate social change, utilising personal experiences of mental health via creative practices. Reachout has developed and grown into a supportive environment where members can learn new skills in a supportive atmosphere to benefit the community as a whole.

## **Chapter Three: A Mixed Methodology**

“Power is one of those things, like gravity and electricity, which makes its existence apparent to us through its effects, and hence it has always been found much easier to describe its consequences than to identify its nature and its basis” (Hawley, 1963, p.422).

### **3.1 Overview of the chapter**

This chapter provides an overview of the methodologies employed to capture the views and experiences of mental health service users (MHSUs) who participated in study one: the workshops (see Chapter 4) and the general public who attended study two: the exhibition of the artwork from study one (see Chapter 5). This chapter discusses the delivery schedule of the intervention in both studies and presents the methods of analysis. Specifically, it provides an overview of the Thematic Analysis approach adopted in relation to both Study 1 (from an action research perspective) and Study 2. Drawing on the ethos of community psychology, it will also offer a critical reflection on the role of the researcher as both an activist in and analyst of the interactions described in subsequent chapters.

This chapter provides a context to understanding the epistemology of 'how we know what we know'. Thus, by defining an understanding of this process within a community critical psychology context, the chapter aims to reflect "a practice for liberation with responsibilities" (Duggan, Holloway, Kagan, Knowles, and Lawthom, 2000). The purpose of the methodology employed within this study is to enable an understanding of participant experience, giving voice to what has taken place, while also being accountable to these participants and wider audiences. This chapter describes the process of analysis, knowledge construction and praxis. In many ways the process of analysis, reflection, action, and knowledge construction (praxis) is a fluid creative process. Potter and Wetherell (1987) state that no analytic process can be straightforward in application "there is no analytic method...rather; there is a broad theoretical

framework” to work from (Potter and Wetherell, 1987. P.169). This methodology aims to inform the reader how the practice of art and critical thinking can raise awareness (Scott-Smith, 2011).

### **3.2 Being Critical**

The term critical psychology is a perspective that looks at progressive ways to generate social change by being aware of oppressed populations and promoting human welfare (Fox and Prilleltensky, 1997). Critical psychology is an alternative to a mainstream psychology approach and, purports “to raise questions about what we and others are doing, to be agents of social change rather than agents of social control” (Fox and Prilleltensky, 1997, p.5). In this study, critical psychology is used to inform how mainstream psychology practices can be used by researchers to become reflexive agents of change and diversity. Critical psychology has been influenced by Marxist ideology of understanding people in terms of how they are positioned in relation to power structures and hierarchies (See chapter one, p.7). Prilleltensky highlighted that the “status quo pertains to the power structure of the present social system” that society abides by (Prilleltensky, 1994, p.15). Fox and Prilleltensky suggest that “critical psychology would not exist without the status quo, but mainstream psychology would not grow and change for the better without a critical input leading to improved methods and practices” (Fox and Prilleltensky, 1997, p.69).

The process and practice of critical thinking is intended to reveal and challenge dominant social frameworks by challenging issues that can disrupt the status quo. The Artivism Intervention aims to bring a critical thinking approach to understanding stigma, power and the insidious effects of social attitudes towards MHSUs. In this project, art was utilised as a tool to generate critical thinking, through discussion among MHSU and the audience (general public) of the art exhibition. Being reflexive in relation to the current research involved being proactive, with participants being asked to reflect on particular life experiences. From engaging in critical thinking and discussion with participants, emerging themes and categories were identified via a Thematic Analysis, described in more detail in this chapter.

### **3.3 Rationale of research/Intervention**

The artwork in the study was not analysed as data. The art was used as a tool to create and to enable greater expression of member's experiences. Often a visual image can aid verbal expression especially when dealing with sensitive topics. Employing the practice of art can reduce anxiety and can also help reconcile and express emotional conflicts (Malchiodi, 2005).

### **3.4 Thematic Analysis Methodology – an overview**

A Thematic Analysis (hereafter referred to as TA) was employed in study one. TA was initially developed by Braun, and Clarke (2006) as a process to detect patterns within the data producing an analysis. A TA approach has the flexibility

to allow data to be analysed 'top down' in terms of pre-determined themes – guided by a priori research questions – while also allowing for 'bottom up' analysis of themes and subthemes that emerge from the data to complement, elaborate, or even contradict pre-determined themes (Brooks et al. 2015). In the present case, the research questions outlined in Chapter 1 meant that the focus of the analysis was on themes broadly relating to wellbeing, the medical profession, power, and the impact of the Artivism project on participants. In turn, while these themes guided initial stages of data coding, there were no a priori expectations regarding the different ways in which these themes might emerge from the data or relate to one another. In this sense, the organisation, content, and structure of these themes was inductively derived from the data based on the emerging – and sometimes unexpected and contradictory – experiences of participants during the project.

To facilitate the analysis in Study 1, the transcripts and audio video footage were transcribed and entered into NVivo software. The researcher looked at the themes and categories being identified within the transcripts. The analytic strategy and interplay between researcher and participants is important as the researcher and participants may have different explanations or responses of the same text (transcript) (Daly, 2007).

Study two used thematic analysis in a collaborative manner between the members and researcher (Braun and Clarke, 2006). The members and researcher developed a 12-item list of questions and/or points to be covered with members of the general public during the exhibition. The researcher presented

the list of questions and/or points during seven group interviews with the general public and MHSUs. A further 5-item questionnaire was developed in collaboration with members and the researcher. The questionnaires were distributed, collected and collated for data analysis at the close of the (5 week) exhibition period.

### **3.5 The Artivism Intervention Timeline**

The timeline flow chart below (see figure 1.) details the Artivism intervention in practice. The chart documents the time line from the initial familiarisation with the participants to the culmination of data collection in studies one and two.

#### **3.5.1. Familiarisation with Reachout: with arts in mind (A mental health and disability arts charity)**

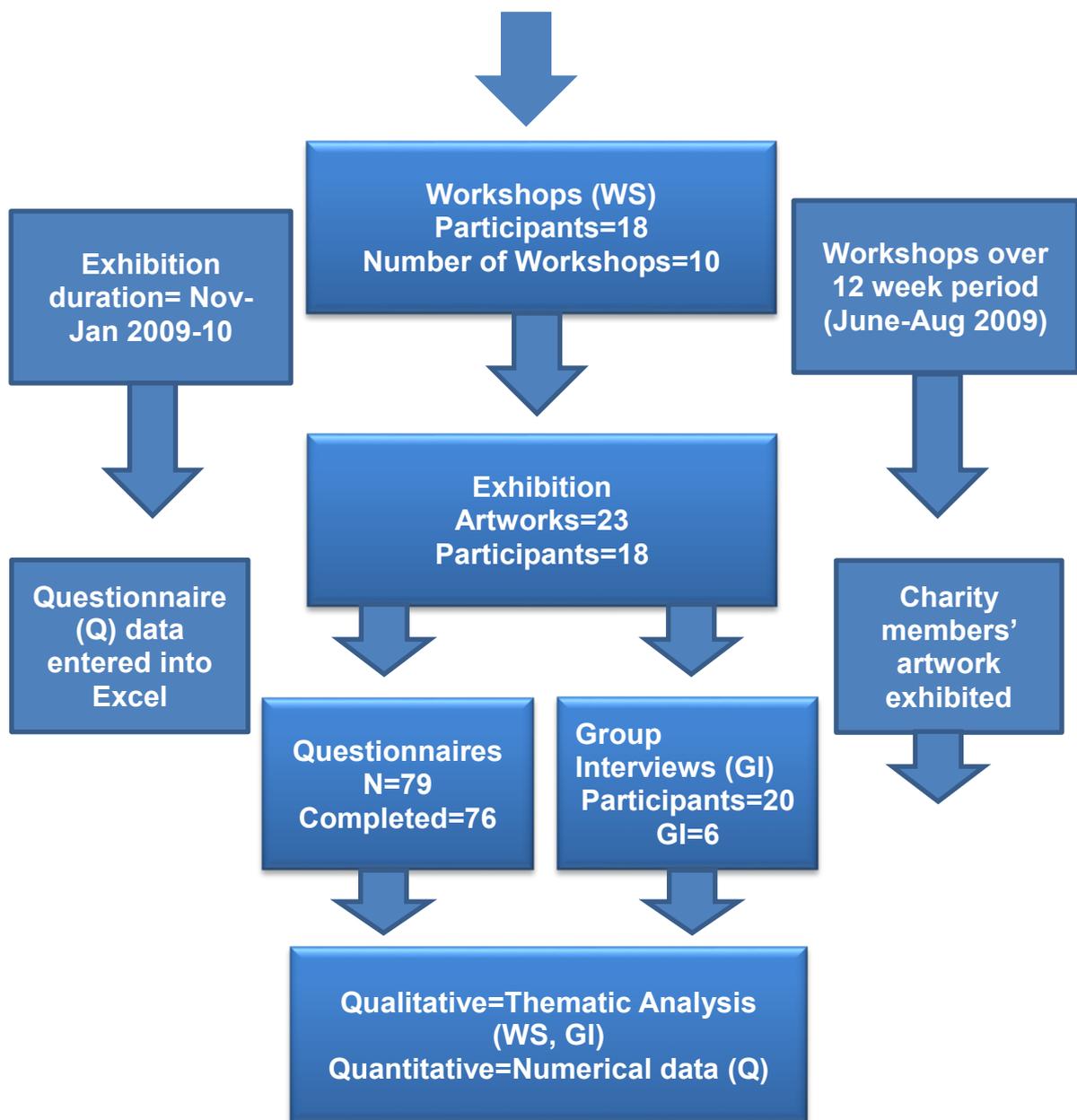
#### **3.5.2 Ethnography**

The participants who engaged with the intervention were members of a mental health, disability, and arts organisation. This included individuals with mental ill health, in recovery, and/or with a disability. The organisation is supported by local community groups, academic allies and NHS sectors. Gaining involvement from members of the organisation was integral to this research project. These members have a wealth of experience of living with mental ill health and/or disability, but also of belonging to a proactive creative organisation. Ideally community members would be enabled to “undergo a process of conscientisation by appropriating simple social scientific techniques for analysing their local

realities” (Morrow and Torres, 2002, p.55). Multiple members have previously been involved in community research pro-action based projects both nationally and internationally. The membership has a history of engaging in mutual learning based projects with academic institutions, engaging in theatre productions and national community events.

**Figure 3.1. Flow chart outlining strategic delivery of stages of research**





### 3.6 Study one: Workshops

#### 3.6.1 Location: Research site

Study one was undertaken with an arts and mental health charity located in a town in central Scotland, with a population of around 20,000. Like many locations

in central Scotland, heavy industry declined during the 19th and 20th centuries, with the retail industry as the current dominant employer. A decline in heavy industry has been recognised in the relationship between unemployment and mental health and wellbeing (West and Sweeting, 2007).

### **3.6.2 Participant Recruitment**

Participants were recruited by a poster invitation (See figure 2) within the charity's monthly newsletter sent out through email and/or postal delivery to all the charity membership (totalling around 110 members). The workshops involved a maximum of 18 participants (members) per session (see figure 3) engaging in discussion, critical thinking and personal reflection of social attitudes. Members were of mixed gender, aged between 17 and 72 years.

### **3.6.3 Workshop procedure**

The workshops incorporated 10 sessions, covering a total 30 hour period (three hours per workshop). The workshops included two breaks, during weeks three and seven due to pre-existing commitments at the charity base. The workshops were recorded via a static video camera, and aimed at the large workshop table. The dialogue between group members and the researcher from all 10 workshops were transcribed at the end of the three month workshop period. The word count for transcripts totalled 60,077 words.

During the workshops, members were encouraged to create one piece of artwork that expressed the impact (positive or negative) of their mental illness. Thus, during the workshops all members were encouraged to engage in critical thinking and discussion about their personal experiences of living with mental illness. For instance, the participants disclosed personal experiences from interacting with psychiatrists, psychologists, societal stigma, pharmacological interventions and the outcomes of these experiences (Brooks, McCuskey, Turley, and King, 2015).

Figure 3.2. The Poster located on the notice board in the Charity

## Outreach Charity



Banksy "Monkey" 2007

A series of art workshops, held once a week for 12 sessions, Thursday 11-2 pm. The workshops use paint, pencil and mixed media together to produce exciting effects on canvas to explore and express everyday experiences of mental health services user's medical treatments (pharmacology). This project aims to challenge social attitudes of stigma and oppression. All were welcome – No previous experience of art

Workshop artist Emma Scott-Smith: [emma.scott-smith@stir.ac.uk](mailto:emma.scott-smith@stir.ac.uk)

Figure 3.3. Number of participants, researcher and staff per workshop

Workshop Number	Participants	Researcher
1	10	1
2	8	1
3	9	1
4	10	1
5	4	1
6	7	1
7	8	1
8	8	1
9	6	1
11	6	1

The workshops incorporated the usage of art materials and canvases. The canvases ranged from small (10x12 inches) to large (48x34 inches). A range of paint brushes, pencils, paint, rubbers and china plates for mixing paint colours were utilised. A budget of £250.00 from membership fundraising was actioned by members to fund art materials for the workshops. The members often hold car boot sales and coffee mornings to aid funding for specific projects. The video and audio equipment was provided by The University of Stirling Psychology Department. The equipment included:

- a video camera on a tripod with multiple blank video cassettes
- a mini disc player with microphone including multiple blank mini discs
- a large note book to write down personal notes of the researchers

reflections on the workshops; the researcher noted attendance and what ideas participants had considered for their artworks

- a small note book to write down people's names and the canvas sizes they wanted to use for their art work
- a large folder with magazine images and art books were utilised to provide members with ideas of colour use and examples of self-expression
- a selection of members' sketches and ideas had been formed in artwork

In a typical session the researcher set up the recording and camera equipment directed at the large workshop table, set out all relevant art materials and distributed the outline discussion sheet (see Figure.4). Members set the principal themes for discussion from the workshop outline and were very proactive in generating personal stories for group discussion. The researcher facilitated the discussions, gave artistic guidance in the form of setting examples of how to position, draw and paint on canvas. This included, for example, working on sketches on paper before members finalised their paintings. The researcher provided encouragement to members to be proactive in expressing their personal views about mental health, medications, pharmacology, disability and Mental Health Services.

### **3.6.4 Ethical considerations**

Participants were asked to sign a form providing consent for data collection. Participant consent forms were provided to all members taking part in the project. The researcher discussed all aspects of the project and was available for any individual queries about the project. Members were advised they could stop the project at any time without explanation. The final thesis draft can be viewed by members at their request. All members signed and dated consent forms and agreed that only the researcher and current university supervisors would have access to the initial non-anonymous data. A transcriber was employed due to the researcher's disability under SAAS (Student Awards Agency for Scotland) funding. The data incorporated the original video, audio log, and the transcribed dialogue from the workshops. The project was granted ethical approval by the Stirling University Psychology Department's ethics committee in 2008.

### **3.7 Collection of data**

Art was used as a tool to enable individuals to express their views. A workshop outline (see Figure 4) outlines the workshop activities during the three month programme. In week one members and the researcher/artist were formally introduced (although the members had met the researcher informally on previous occasions). Members were introduced to each other (not all members had met) and the researcher/artist were familiarised with the timeline for the project. All members received a copy of the hand-out providing an outline of each workshop session. In following the timeline, session one focused on discussion and

generating ideas. This was completed by going round the table with each member (if comfortable) outlining their mental health diagnosis and an example of their personal experiences of stigma. The most prominent discussion points included everyday interactions from being in the local community and interactions with medical professionals. This led the members and the researcher/artist to discuss how personal experiences could be reflected in a piece of art. It is however, important to clarify that it was the process of generating art that was important in Study one and that the art itself would not undergo analysis.

Each week the researcher would indicate what the current session would focus on in relation to the timeline (see Figure 4.). In session two the researcher sat down with members around a large work table to discuss what each member wanted to express. The researcher had ordered a large collection of art materials. The members began to discuss the size of canvas they each would require to support their self-directed art. In session two members began discussing the outcome of having a diagnosis and being on benefits. A positive point was made that members in receipt of benefits due to a mental health condition have free access to local sports amenities. Members discussed the therapeutic benefits of swimming and discussed the possibility of creating an art collage depicting cuttings from magazines of certain sports.

In week seven members decided to work on a collaborative piece of art. The researcher had asked members to bring along empty medication boxes with their

personal details removed. Members began to discuss how medication affected them and reflected on how this may give insight to others about their experiences. It also highlighted how members were beginning to build relationships with each other and were interested in how other members expressed their experiences. This provides an example of how the workshops promoted discussion about personal experience in relation to everyday life and visually expressing oneself. It also reveals how, through critical discussion, reflections of day to day experiences can be related to a visual representation of the experience. This can then reflect how that image can be presented to express a member's experience. It is important to clarify; there were two breaks during weeks three and seven. The expectations of work from week three was moved into week four and week seven merged into the plans of week eight (See Figure 4, work sheet).

Figure 3.4. Work sheet plan: Artivism workshops

## **Artivism: Art, activism and being heard via the visual image**

**Week 1** - Introduction (who's who), Ideas/discussion? Sketching, Ideas on paper, mental health? How to keep brushes clean and fresh?

**Week 2**- What canvas size do you feel good about, will it help express your, message? Let's get started, expression, challenge, pro-action?

**Week 3**- How can we challenge, change, and be critical thinkers, the power of the image.

**Week 4**- Works in progression – exploration?

**Week 5**- Half Way Point – discussion, how is it going?

**Week 6**- Reflections so far? Critical thinking – Impact of power, differences, minority groups in e.g. mental illness and/or disability?

**Week 7**- Joint collaborative work (empty medication packets), what can we explore and express?

**Week 8**- Continue with own and collaborative projects.

**Week 9**- Aim to be finishing up work.

**Week 10**- Title, ideas behind work, write it down.

**Celebrate, we've done it!**

### **3.8 Study two: The Exhibition**

The aim of study two was to provide verbal and written accounts after viewing the Artivism exhibition. The exhibition was completed by members of Reachout (a mental health, disability and arts focused charity). The exhibition was generated to highlight social awareness of mental illness and thus to shed light on the social attitudes people can experience. The exhibition was completed as a way for members' artwork to tell a visual story and raise awareness. It asks members of the public to question dominant social constructions of what it means to be diagnosed with a mental health disorder. Study two aimed to access insight into the general public's awareness of mental health disorders through questionnaires (study 2A) and group interviews (study 2B). The psychology ethics committee at the University of Stirling granted ethical approval for Study two and accompanying data.

#### **3.8.1 Research site**

Study two of the intervention was held in the city of Stirling, with a population of 41,000 (<https://www.stir.ac.uk/about/city-of-stirling/>). Stirling is a university city, with vibrant retail and farming industries. The exhibition was held in the University of Stirling's Central library which has a high number of visitors utilising the facilities.

### **3.8.2 Participant Recruitment**

Study two was located in a library exhibition space which received high footfall. Participants in this study were members of the public who attended the exhibition and invited members. The participants from study one were invited to view the artwork on the exhibition opening night. The exhibition invitation list for the opening night was generated from the collaboration between participants and the researcher. A total of 250-320 Invitations were sent out via email, post or hand delivered postcard to invitees. Members and staff of the mental health and arts charity, academics from the psychology department at the University of Stirling and varying members of the local council and local art organisations accepted invitations. The exhibition was entitled 'Artivism' and was formed as part of the 2008 Scottish Mental Health Arts and Film Festival (SMHAFF). The exhibition received wide publicity via SMHAFF, local news and radio coverage throughout Scotland and local media outlets (Newspaper and radio interviews). A five point questionnaire was available to the public for the duration of the exhibition.

### **3.8.3 Materials: Exhibition**

The exhibition ran over a five week period. A small table was placed along the wall at the entrance of the library, at the start of the exhibition space. Above the table, were two posters, one publicising the exhibition, the Artivism project. Poster two (see figure 2) provided detailed information about the collaboration between the charity members who had produced the art work on display and the

researcher. The table included 100 questionnaires, a sealed box to place completed questionnaires and further information about the Artivism Intervention.

The exhibition included 19 charity members' artwork, and the artwork completed by the researcher comprising four pieces created (in preparation for the workshops). The four artworks completed by the researcher/artist provided members with examples of how the researcher had expressed her own disability and experiences on canvas. On the opening of the exhibition the general public and members of the charity were invited to take part in small group interviews after viewing the artwork on display. The researcher used an audio recording device with a microphone, a laminated sheet with 12 discussion points and provided group interviews members with the exhibition poster (see figure 2) after the group interview activity.

#### **3.8.4 Group Interviews**

Attendees and passing members of the general public were invited to take part in seven group interviews that also included workshop participants whose artwork was displayed at the exhibition. Each group interview was run with a mix of participant members with a 10-15 minute break between each group. The flow of conversation dictated the themes that were brought up into the discussion and the order in which they were discussed. Themes ranged from "what did you think of the work" displayed at the exhibition to 'Do you know a friend with mental ill health'? This provided a 'comprehensive record of participants' words and

actions' (Willig, 2001 p. 16). All discussions were audio recorded and transcribed at a later date the themes are evaluated in chapter five. The group interviews were undertaken in a side room off the gallery space where chairs, tables and soft drinks and snacks were available. Each group interview consisted of two to five people. This equalled a total of 20 people participating in the evening's group interview discussions, not exceeding 25 minutes for each session. The audio recordings were transcribed within one week of the group interview, by a PhD student within the field of health psychology. The seven completed group interview transcriptions totalled 7,087 words (group interview one was not transcribed due to poor sound quality).

### **3.8.5 Discussion Points**

1. What do you think of the work?
2. Are we (the general public) trapped into certain ways of thinking (about mental health)?
3. Does it remind you of anything?
4. Do you have a friend with mental ill health?
5. Does the mental health service work for people?
6. Someone mentioned the work expressed negative views of the NHS,  
What do you think?
7. Can the NHS be improved?

8. Should we look at the frameworks of how we understand mental health?
9. As a society are we trapped into certain ways of thinking?
10. Are we made to think of dominant frameworks and discourses?
11. For example the oppressed may have internalised society's view of mental ill health. People with mental ill health may feel negatively about themselves due to stigma and oppression in society, why?
12. How can we change and by what means?

It was acknowledged by the researcher that the types of questions asked would influence the answers generated. The group interview discussion points in study two were formulated from group discussion within the workshop sessions in study one. MHSU engaged in critical thinking about chosen personal experiences that affected a person's daily living. The participants explored the points that were raised with the researcher and created the discussion list of points for the group interviews in study two. The researcher transcribed the list and presented the questions/points on an A4 piece of paper printed with questions 1 to 12.

Table 3.1: Group interviews participants (MHSUs' and the general public)

<u>Group Interview</u>	<u>Number with in each group</u>	<u>Gender</u>	<u>Members (M) Public (P)</u>
1	2	1 Male, 1 Female	1 M, 1 P
2	5	2 Male, 3 Female	3 M, 2 P
3	3	1 Male, 2 Female	1 M, 2 P
4	4	2 Male, 2 Female	1 M, 3 P
5	3	1 Male, 2 Female	1 M, 2 P
6	3	3 Female	0 M, 3 P

### 3.8.6 Questionnaires

Questionnaires were available for the general public and members to complete during the exhibition period. The questionnaires consisted of five open questions:

1. What did the exhibition make you feel and think?
2. What effect has this exhibition had on your awareness of mental health?
3. Do you now think differently (after viewing the exhibition) about mental Health services?
4. Do you now think differently about the experiences of mental illness?
5. Do you think Artivism can bring about change and challenge oppression, and society's views?

The questionnaires aimed to gauge public feedback on ideologies of attitudes towards mental ill health and mental health services. All five questions were open

ended. The researcher handed out questionnaires at the exhibition opening and participants placed completed questionnaires in a sealed questionnaire box located at the entrance of the exhibition space. The researcher randomly choose three occasions (during the duration of the exhibition) to visit the library and asked any persons viewing the exhibition to fill in a questionnaire and to place it in the sealed box after completion. A total of 79 questionnaires were received and placed into a sealed questionnaire box located at the entrance to the exhibition space. A total of 76 questionnaires were valid with three of the 79 incomplete.

### **3.8.7 Field Notes**

A note book was used by the researcher at the start of the research process to document points raised, visual images participants wanted to explore and events during the workshops.

### **3.9 Reflexivity: Study one**

The workshops were video recorded so the researcher could clearly see what members discussed, to reduce ambiguity in the interpretation. Firstly, it was necessary to see members' facial expressions as, for example, someone might say "The Mental Health System is absolutely terrible" whilst smiling thus inferring the opposite. Secondly, it was also important to see the member's discuss their artwork by visually identifying what the member was describing. The body language of participants was observed to identify each individual's actions when

discussing personal experiences. The workshops were designed in such a way as to allow expression and give voice to experience around mental illness, and the often challenging power structures within which individuals act. The workshops enabled exploration of members' views to turn into a form of social action. Members were aware that the researcher was also an artist running a workshop about Artivism, activism and consciousness raising. Members knew the researcher was affiliated with the University as a postgraduate psychology student. During the first work shop the art materials were placed on the table, members engaged in discussion as individuals and as a group. Members and the researcher collaborated on how we could set about critical thinking and expressing members' experiences on canvas. The researcher's role was to offer artistic guidance to guide artistic technique and to discuss what the person wanted to express of their experiences in a visual format.

### **3.10 Reflexivity: Study two**

1. An exhibition of participants' work
2. An evaluation questionnaire for exhibition attendees (members of the public)
3. Seven group interviews

#### **3.10.1 Reflexivity: Group Interviews**

Members of the charity (1 Male, 2 Female) intended to conduct the group interviews. However, the opening of the exhibition was well attended and the

three members felt overwhelmed by the number of people in attendance and expressed nervousness about discussing what their personal artwork meant to them to the audience. Members expressed a concern about feeling stigmatised, angry and/or frustrated. Thus, the researcher agreed to conduct the 7 group interviews.

### **3.11 Study two: Thematic analysis**

Study 2 (the exhibition), like Study 1, employed a Thematic Analysis of the data generated from the questionnaires and group interviews. This provided feedback of themes emerging from the data, from the audience (the general public), the group interviews and from questionnaires. The TA was approached from a bottom-up method with no predefined themes or issues of interest (Brooks et al. 2015). Thus, the analysis was guided by some a priori assumptions about themes of interest. The research questions outlined in Chapter 1 meant that the focus of the analysis was on themes broadly relating to wellbeing, the medical profession, power, and the impact of the Artivism project on participants. In turn, while these themes guided initial stages of data coding, there were no a priori expectations regarding the different ways in which these themes might emerge from the data or relate to one another. In this sense, the organisation, content, and structure of these themes was inductively derived from the data based on the emerging – and sometimes unexpected and contradictory – experiences of participants during the project.

### **3.12 Reflexive research practice and analysis**

Initially, I engaged with charity members over a 12-14 month period of getting to know the membership. After this period, a collaborative research strategy between members and I was created to deliver the project. During this time I academically engaged in a threefold process of praxis involving action, reflection and generating new knowledge. I engaged with the relevant theorists in the field of community critical psychology regarding how to generate social change within oppressed social groups. As a disabled person, psychologist and artist I had experienced positive and negative social prejudice due to a disability which resulted in 17 years of wheelchair use. I now have the perspective of having an unseen disability; and no longer use a wheelchair (except for long distances). This provided insight into the daily experiences and attitudes of people living with an unseen disability may experience. My interpretation of the data could be biased; thus, I aimed to remain aware of my own subjective, reflexive and ontological beliefs during data analysis.

It was important to build up trust within the membership over the initial 12-14 month familiarisation with the group. Members asked questions about my disclosed disability, the research and my work as an artist. The project aimed to be collaborative, with the stages of research to be discussed between the membership and myself at each stage. It is important to note that from the initial attendance at the charity, the researcher has become a director and chairperson of the organisation. This role could be seen to have implications for the analysis of the data. The research and analysis process has revealed both positive and

negative aspects to current social attitudes to mental health and mental health services.

### **3.13 Role as researcher: impact on analysis**

Part of the procedure of collating the data involved the researcher promoting critical discussion and thinking, engaging in the roles of artist and charity member and/or representative. It is also important to emphasise how the researcher aimed to be unbiased in the research process by employing practices of personal reflexivity, subjectivity, and employing a circular process of praxis. This kind of awareness is a starting point for social action, social justice and challenging the status quo. Lord and Hutchison (1993) noted “gaining awareness was often a beginning point in people’s journeys of empowerment” (Lord and Hutchison, 1993, p. 6). The process of conscientisation (becoming aware) can aid the process of Artivism by raising minority group’s awareness and being proactive within society to raise this awareness of mental illness. The linguistic blend of art and activism does not mean that the art is political in subject matter but allows the activist to express social issues to a wider public. Chapter four and chapter five provide results of the research in study one (workshops) and study two (exhibition). Chapter six discusses the research question and summarises the conclusions to the study.

## **Chapter Four: Workshop Results**

### **4.1 Introduction**

Chapter four is the first of two empirical chapters outlining the results of study one (the workshops). This chapter introduces the workshops, how discussion evolved among the membership, how art was used as a critical tool to aid discussion, and the resulting themes identified. The themes were identified using a Thematic Analysis of the transcripts from the workshops, as discussed in Chapter three. It is important to establish how themes may or may not relate to each other, if there is a shared theoretical basis or unique themes may have developed.

## **4.2 Methods**

### **4.2.1 Overview of the Workshop agenda**

The series of workshops followed a specific agenda, where each week a pre-determined plan was followed by members (Refer back to chapter 3, p. 61). In brief summary the workshops followed a weekly guide.

- Introduction to discussion of mental health experiences
- Proaction in proactively initiating discussion of ideas
- Reflections; thinking critically, collaborative exploration of work so far
- Finishing up, emerging titles of artwork and context of each piece.

The workshop discussions were recorded, transcribed and analysed using a Thematic Analysis (TA), as described in Chapter three.

#### **4.2.2 Basis of Analysis**

The analysis was undertaken by working through the video and workshop transcripts. The analysis was carried out by firstly watching the film footage of the workshops and secondly, reading the transcripts to establish initial themes developed, i.e. a reflection of reality (Braun and Clarke, 2006). Thus, codes leading into themes were identified in relation to the research question and establishing patterns of themes within the data. Nvivo software was used to categorise the themes of discourse identified within the transcripts/film footage. This allowed access to the theme, the accompanying film footage and transcript of the theme coded. Thus, the researcher moved back and forth between transcript and coded themes of patterns found within the data sets. A thematic mind map was developed showing the themes and super themes identified. Further identifying two areas showing Negative and/or Positive themes (see Mind Map, p. 85).

#### **4.2.3 Analysis overview**

Table 1 introduces the members of the workshop to the reader. General details are provided (not to identify members) to offer a representation of the characteristics of participants. It allows the reader to access which themes were raised by which members in a particular workshop.

#### **Table 4.1: Demographic details of 18 participants (workshop members)**

<b>Member (Researcher code)</b>	<b>Participant Number E.G. (P1)</b>	<b>Gender</b>	<b>Age Group</b>	<b>Workshop Attendance E.G. (WS 1)</b>	<b>Reference number*</b>
<b>C</b>	1	M	50-60	1, 2	(P1. M 50-60 WS)
<b>P</b>	2	F	50-60	1,3,4,7,	(P2. F 50-60 WS)
<b>E</b>	3	F	20-30	1,3,6,7,	(P3. F 20-30 WS )
<b>B</b>	4	F	50-60	1,3,7	(P4. F 50-60 WS )
<b>M</b>	5	M	40-50	1,4,6,	(P5. M 40-50 WS )
<b>T</b>	6	M	40-50	1,4,6,7,	(P6. M 40-50 WK )
<b>W</b>	7	F	60-70	2,3,4,6,7,8,9,	(P7. F. 60-70 WS )
<b>X</b>	8	M	30-40	2,7,8,	(P8. M 30-40 WS )
<b>Z</b>	9	M	60-70	2,3,5,6,7,8,	(P9. M 60-70 WS )
<b>M</b>	10	F	50-60	2,3,4,5,6,7,8, 9,	(P10. F 50-60 WS)
<b>G</b>	11	M	50-60	2,4,9,	(P11.M 50-60 WS)
<b>Mo</b>	12	F	30-40	2,3,6,	(P12. F 30-40 WS)
<b>C</b>	13	F	40-50	2,3,5,6,	(P13. F 40-50 WS)
<b>D</b>	14	M	50-60	2,4,11	(P14.M 50-60 WS)
<b>L</b>	15	F	40-50	2,3,4,5,6,7,1 1,	(P15. F 40-50 WS)
<b>H</b>	16	M	40-50	4,5,6,11,	(P16 M 40-50 WS)
<b>T</b>	17	M	40-50	4,9,11,	(P17 M 40-50 WS)

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<b>E (G)</b>	18	F	40-50	9,11,	(P18 F 40-50 WS)
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The researcher created a reference system to identify the demographic information of each participant. The research employed a code to identify each participant and the workshop/s attended. For example (P10 F 50-60 WS 7), translates to the participant number 1-18, their gender (F Female), their age range (Age 50-60) and what workshops each participant attended (Workshop week 7).

### **4.3 Produced Super themes and Main themes**

Produced super themes and corresponding main themes (see table 2.) highlights the progression of the emerging core concepts. The intention is to illustrate how the super themes and main themes were constructed, and how relationships between them were established.

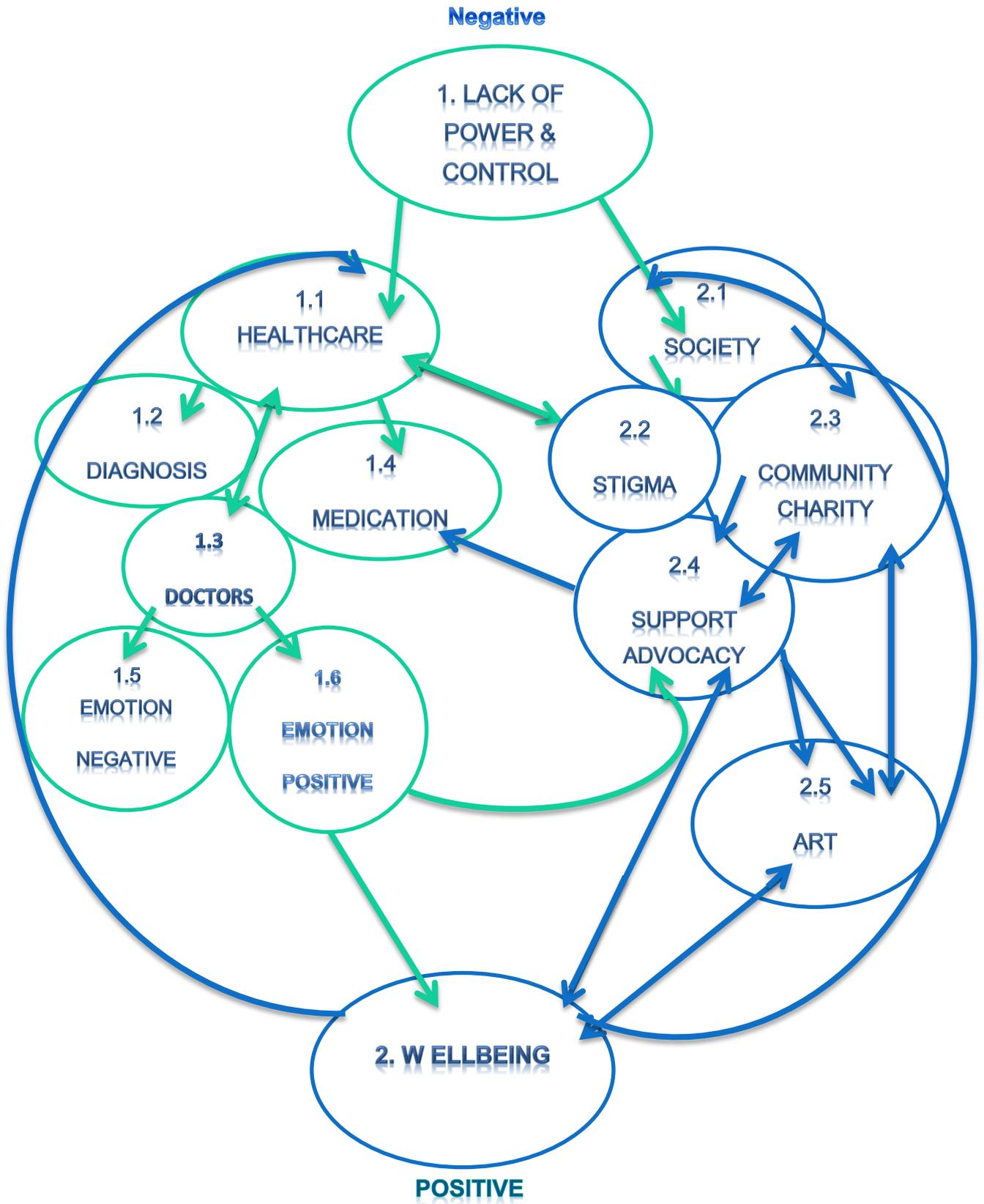
**Table 4.2: Generated themes**

Super themes	Main themes
<b>1. Power - Control</b>	Diagnosis Misdiagnosis
	Doctors
	Medication
	Emotion negative
	Stigma
<b>2. Well-being</b>	Emotion positive
	Society
	Support
	Stigma
	Art as a positive
	Advocacy
	Community Charity

Key (see Figure 4.1)

Colour	Arrows	Category
<b>GREEN</b>	Linking themes in category	1.Power control
<b>Blue</b>	Linking themes Double arrows – Dual process	2.Wellbeing

Figure 4.1. Mind Map of themes and super themes



#### 4.4 Results

The mind map (See Figure 3.) shows two super themes developed from the data: (1), lack of power and control (seen as negative effects): (2), well-being (seen as positive effects). Each super theme has developed sub-sections which share characteristics within healthcare and/or society. The analysis process identified further themes related to the initial sub-themes. These were: Healthcare related to diagnosis; doctors; medication and negative emotion, which fit under the super theme of a lack of power and control. Society related issues such as stigma, support, community, charity (name not disclosed), advocacy, art and positive emotion fit under the super theme of well-being. There are links between health care and society through stigma, with both positive and negative effects highlighted within the data. The mind map also identifies positive outcomes associated with medical care, including that medication and doctors can produce positive emotion. This is reflected within the super theme of well-being (discussed in the result section).

The identified categories highlight how participants (MHSU) are actively seeking treatment to improve their symptoms but do not want to relinquish control over their life. Thus, there is a tension between seeking treatment to achieve wellbeing, whilst still being empowered. Pharmacological treatment can improve symptoms but can create a reliance on medication. For example a reliance on medical professionals to provide treatment and medication, which can produce a problem for people of a power imbalance between doctor and patient, that requires a negotiation (Bassuk and Gerson, 1978). Essentially, the challenge

faced by workshop participants is how to achieve well-being and still be empowered within a biomedical framework.

#### **4.4.1 Lack of power and control (*super theme 1*)**

The super theme of a lack of power and control (see Figure 4.1) incorporates themes such as being disempowered when seeking medical treatment, being empowered to react against social ignorance to mental illness, experiencing a loss of control over life, and feeling like you are “playing Russian roulette” when seeking medication and treatment (P10. F 50-60, WS2). The following categories discussed are the themes identified in the mind map (Figure 4.1).

##### ***Healthcare (1.1)***

The theme of power in the system (the mental health system) can be positive in discovering a treatment plan, or detrimental in the sense that it can lead to feeling a loss of control over decisions involving personal experiences, about physical and psychological well-being.

##### ***Diagnosis (1.2)***

The diagnosis of an individual’s disorder is an important step for a patient to seek treatment. The diagnosis provides a patient with a proposed treatment plan and the promise that the doctor will aim to benefit the patient’s quality of life (Haugli et al. 2004). The main sub-themes linked to diagnosis and misdiagnosis were:

'doctors', 'power', 'stigma', 'emotion', 'acceptance', 'anxiety', 'not being aware' and 'diagnosis'. The members below discuss how being diagnosed is a gateway to treatment and support systems.

Member G: "90% of people with any kind of illness can be wrongly diagnosed and I've learned that I just learned about it last week, it's not the illness it's the symptoms"

Member M: "yes I know you said that"

Member G: "and everybody, these symptoms affect everybody's way of life, they affect, so I think all these names that they've got, put them in the bin, it's the symptoms that affect me" (P11. M 50-60. WS 9)

Member G discusses the effects of symptoms on his quality of life and how the actual diagnosis may not affect his treatment plan if the symptoms he is experiencing are addressed. This member is positioning himself outside the diagnosis possibly due to member E's experience of being misdiagnosed with depression and subsequently receiving a diagnosis of posttraumatic stress disorder.

Member E: "I went to see him (psychiatrist) yesterday right and em we worked out all the symptoms that I feel so we were really really good, I was in for an hour, he (psychiatrist) went through one by one and I was talking to him and he was talking to me so em at the end of it he got this book out and he kept on using all these symptoms' ... 'he said you have got post-traumatic stress but you've also got it chronically" (P18. F 40-50, WS 11)

Researcher: "post-traumatic stress, so where has that come from do you think? Can you associate that to a, all to everything when you were growing up with your brother"

Member E: "but see all the 30 years I've been in the mental health system no one has ever said that to me"

Researcher: "must make you feel better, to have acknowledged, do you feel better?"

Member E: "I feel angry about it, I feel angry at how that wasn't picked up" (P18. F 40-50, WS 11)

This excerpt illustrates how misdiagnosis can have serious effect on a patient's mental well-being and treatment. Member E feels anger at not having gained the correct treatment over a long period of time. This extract identifies a mutual reciprocal relationship of telling and listening, of trust, between participants, respect and mutual understanding of each other's role. It emphasises how important it is for a patient to fully express their symptoms and gain the 'right' diagnosis i.e. a diagnosis that makes sense of their symptoms for them.

### **Doctors (1.3)**

In workshop three, the researcher and members discussed the mental health system and the maintenance of power within this system.

Researcher: "How would you express your experiences visually?"

Member M: "I feel like a chess set, as we are all pawns, being directed about the system, Mental health system" (P10. F 50-60, WS 3)

The discussion above demonstrates how the member sees him or herself visually (in relation to the art workshops) as being part of a chess game. Chess is a two player board game which is undertaken for pleasure in a person's free time. It is a game of strategy with strategic skilful tactics employed with an aim to remove the other player's pieces from game play. This can highlight the imbalance of power between one player and another or between a patient and doctor in a medical encounter. A power imbalance is conveyed of the patient being powerless in negotiating their own healthcare choices. Within mental health care,

the role of the doctor is to collaborate with the patient to aid treatment and patient wellbeing (NICE, 2014). Members discuss this point further:

Member C: "Ok but how are you going to do it?" (P13. F 40-50, WS 3)

Member M: "I didn't I just made, set an example, there, you play chess, you've got a chess board, right, and you've got the pieces, the king, the, all the main pieces and then you've got the pawns, right and I saw us being, in mental health, the pawns. When you play chess, you use the pawns to enable the main pieces, to protect them, I used Liquorice Allsorts as the pieces and in a way it showed you that it is how they manipulate you ... could be incorporated to mental health because you've got the main pieces, you could go across society, the government and then you've got the law and then you've got the doctors, psychiatrists and all the others, and they could take on a role of these pieces, right? And we slot into being the pawns" (P10. F 50-60, WS 3)

Member C: "Because you'll never do it by making sweeties, you've got to stand up and talk about your sweeties, standing up and arguing your case"

Member M: "but can you see I'm trying to, break it down"

Member C: "you're telling it to me though, you should be telling it to them (psychiatrists)"

Member M (participant 10) refers to 'being a pawn in the system'. A pawn is seen as the weakest piece in a game of chess, as the pawn is used to be directed, managed or controlled. This language is used as a powerful device in positioning a person into an oppressive framework and/or context from the MHSU's viewpoint (Burr, 2003). It places the patient as other, not in control of their reality, not being able to move their position and/or treatment or have power over their own reality and medical treatments. Member C (participant 13) positions Member M as a child (referring to sweeties) and the system as the parent. This locates the child with little or no power (the patient) and the parent (The mental health system) in the power.

Medical professionals from Community Psychiatric Nurse (CPN), (GP), Psychiatrist, Nurse, and Physiotherapist all play an important role in a patient's care. The main themes of 'medical professionals' and sub-themes of 'distrust of medical professionals', 'disempowered', 'empowered', 'anger', 'frustration', 'not being listened to', and 'respect' are linked to the super theme, a lack of power and control. The relationship between medical professionals, patient trust, and respect emerged clearly in the transcripts. The mental health system is discussed by members in relation to improving patient doctor interactions. The extract below shows a wish to engage in a constructive process to raise awareness to challenge services.

Member M: "go to the policy makers and the bosses that make, change the way psychiatry works, the people who decide that the policy makers developers ... you've got to be constructive and say why people with mental health problems are being treated the way they are" (P10. F 50-60, WS 2)

The individual wants to be protected and seek treatment for his mental health diagnosis but highlights themes of distrust. This is linked to sub-themes relating to social attitudes towards mental illness in society which also can lead to a mistrust of medical professionals. Multiple members individually discussed their experiences of medical professionals during workshop two.

Member C: "You're frightened of saying what you believe and how you think and feel because you know you're going to be stigmatized for it" (P13. F 40-50, WS 2)

Member X: "They've (doctors) have their own preconceptions" ... "it's like trying to convince somebody that there are trees in a wood" (P8. M 30-40. WS 2)

Member M: "you've got to play them at their own game you're little game" (P10. F 50-60, WS 2)

Member M: “you’re really playing Russian roulette” (P10. F 50-60, WS 2)

Member C: “you learn how to lie, to play the system” (P13. F 40-50, WS 2)

The above examples are listed to highlight how members see themselves in relation to doctors accessed through the mental health system. These extracts discuss distrust, of being frightened to say how you feel in fear of social attitudes and stigma. The term ‘game’ is referenced in multiple member exchanges. As stated by member M (P10. F 50-60, WS 3), she felt she was being ‘played’ in the system in the metaphor of playing a game of chess, being a pawn in the system, with little or no power. A game can be a way to manipulate (a situation) or out-think an opponent for advantageous results. These extracts all depict power of one person over another. Members challenged these experiences, by participating in the Artivism workshops.

Member D: “I thought I couldn’t trust the mental health system”...”I want to know I am being protected” (P14. M 50-60, WK 7)

Researcher: “do you feel the charity have made you more... (aware)”

Member D: “the charity is making me more aware of mental health in society”

Raising awareness is an important part of the process in The Artivism Intervention. The extracts above highlight a perception and experience of stigma which can be found within society, in medical encounters and the charity. The label of a mental illness diagnosis can affect an individual’s confidence and feelings of social rejection (Link, Struening, Rahav, Phelan and Nuttbrock, 19997). In challenging members’ discussions of their personal experiences, it has allowed a forum for members to engage and educate themselves about

mental health. In generating awareness, members can express these experiences into their artwork to raise awareness (e.g. the exhibition audience, see chapter 5), by making MHSU, the local community and healthcare professionals aware of stigmatizing attitudes, MHSU's experience.

### **Medication (1.4)**

Themes relating to medical treatments and medication were raised by several members. Themes included stigma, psychiatrists, and medication, improving daily living, and being listened too, and respected. Respect is a term that should establish a positive emotion in another person providing each individual conducts him or herself with a respect for others. When receiving treatment from a medical professional in a supportive environment, mutual respect is an important dynamic. In discussion member D (participant 14) said how important it is when being prescribed medication to have trust. In the extracts of conversation below each group of members are discussing their experience of treatment describing sub-themes of trust, power, well-being, medication, and attitudes (each extract took place in a different workshop).

Member G: "when I go back and see him (psychiatrist) that my medication is to get sorted out and then I might start feeling that I am a real person" (P11. M 50-60, WS 9)

This extract describes what could be a patient's loss of reality which can be experienced within a diagnosis of mental illness. Certain psychosis-related mental illnesses can affect a person's perceptions and cause hallucinations and delusional thinking. This can severely disrupt perception, thinking, emotion and

behaviour (Morrison, 2001). It could also be interpreted as a patient wanting to be treated as an individual, seeking medication to ease symptoms and be supported. This is contrasted with the extract below.

Member M: “Surely nowadays they (doctors) see people different, as individuals” (P10. F 50-60, WS 2)

Member C: “no” (P13. F 40-50, WS 2)

Member B: “psychiatrists have too much power” (P4. F, 50-60, WS 2)

While both extracts above provides an account of individuals seeking treatment to aid their health, they identify two sides to the imbalance of power in a doctor-patient relationship. While the first extract suggests that medical professionals and medication can help one to become a whole, empowered person, the second presents them as a potential impediment because of their power. The latter theme is picked up in other extracts that relate more explicitly to mistrust.

Member C: “you get to the point where you’re frightened of actually saying what you believe and how you think and how you feel because you know you are going to be stigmatised for it. So you learn how to lie and play the system to get out of the hospital, just to be able to be”

Researcher: “mmm”

Member C: “you’re meant to have a relationship with people (doctors) who are helping you, and open and truthful as well and it doesn’t encourage that, it encourages you to keep your mouth shut”

Member E: “How can you get treatment ... if you can’t say what’s actually going on”

The extract above provides an account of member C’s (participant 13) mistrust and disempowerment in a doctor-patient encounter. A relationship based on fear and stigma minimises the opportunity for the patient to access treatment and discuss long-term goals. The Artivism intervention encouraged members to

discuss their experiences with other members who have also experienced feelings of disempowerment and mistrust. For a patient to have trust, choice, and be empowered are vital components in a medical encounter. For a mental health patient to feel unable to state how they feel due to a fear of being stigmatized or hospitalised can have negative long term effects. Patients want to foster a partnership with their clinician, build trust through patient choice and transparency in treatments (Laugharne, Priebe, McCabe, Garland, and Clifford, 2006).

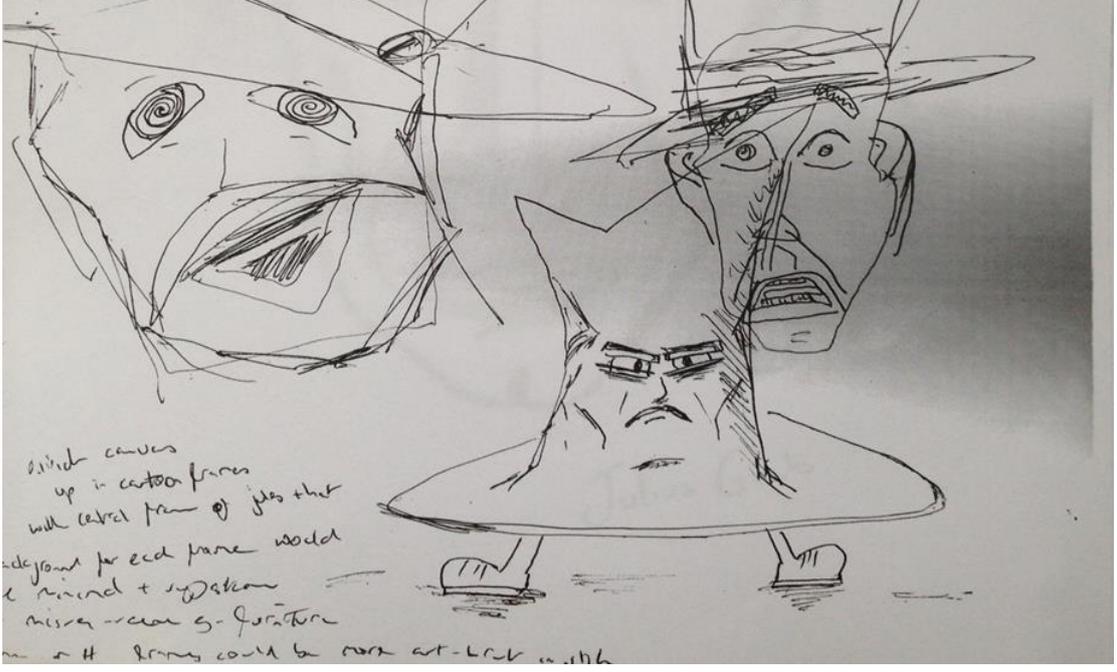
This is consistent with earlier work by Haugli, Strand, and Finset (2004). To be seen and to be believed are two of the most important points when a patient visits a doctor. To be seen as an individual person showing support and understanding of another person and not just seeing the diagnosis is important to the majority of patients when visiting their doctor/GP (Haugli et al., 2004). Multiple members discussed the balance between regaining a quality of life whilst experiencing side effects and / or alleviating their disorder's symptoms. Member M (P5. M 40-50, WS 3) wrote his experience in a letter (See Figure 2A.) and completed a painting by the end of the workshop course (See Figure 2B.). Member M described his experiences of taking an SSRI drug to treat his symptoms for depression.

Member M: "at first not much happened but then the hat (medication) started to get tighter and tighter" ... "I felt I could not breathe" ... "please please take the hat off its making it worse" ... "he was numb, just a shell no longer him" (see Figure 2A and 2B) (Excerpt from a letter given to the researcher by P5. M 40-50, WS 4)

This is consistent with a study by Pennebaker (1999), of understanding the benefits to putting a traumatic experience into a narrative, through storytelling. This allows a patient to express their experience and emotions into text which helps to organise, reflect and move forward from a negative experience (Pennebaker, 1999). The workshops enabled members to critically reflect on experiences, create ideas and engage in a form of praxis on the canvas by creating visual images which often contained words / narratives. Member M (participant 5) has constructed a story also with a visual narrative of his 'cautionary tale' (in his own words) of the possible side effects to taking an antidepressant. The extract explores personal identity being altered via medication, being numb, and no longer him, and unable to freely breathe.

Figure 4.2. 2A. Sketches in letter from Member M (P5. M 40-50, WS 3)

so tight that John couldn't breathe + he thought his eyes would pop out. Their bodies  
 were sore but John couldn't reply. He just felt all quiet and the doc gave a quick  
 + rubbed his hands.  
 The doctors followed John out but John didn't care anymore, the hot was so tight he couldn't  
 breathe or hear or just felt completely numb. When his nose his chest spoke to  
 it was like he was wearing them, like he was just a shell, he was no longer John  
 not happy either, just empty. And then something weird happened. He started to  
 a funny color and the ~~head~~ <sup>all of a sudden</sup> ~~head~~ all see-through as his face completely vanished.  
 as time passed +  
 to be honest with you no-one wanted to speak to him no more, it was like  
 going to a wall. And we stopped seeing him. But knows what happened to him as frankly  
 no-one cared as it would even have thought about him if it wasn't for the fact  
 - but your weary look exactly like his  
 at the time to see him. he wasn't in his little box, all that was there was a hole with little  
 + a ~~little~~ ~~smile~~ ~~or~~ ~~anything~~.



which comes  
 up in cartoon frames  
 with central frame of eyes that  
 independent for each frame would  
 be mirrored + symmetrical  
 mirror-image symmetrical  
 in a 4 frame could be next at last with

Figure 4.3. 2B. Dr Serroc's Hat by Member M (P5. M 40-50, WS 3)



**Emotion (Negative) (1.5), Emotion (Positive) (1.6)**

In 90% of workshops, the theme of emotion was discussed on many levels, from feeling upset, angry, frustrated, to enjoying the workshop process. The foremost theme of emotion was presented as an umbrella title representing members' experiences of trust, anger, and joy at artistic expression, vulnerability, anxiety, power, trust and mistrust, support, respect and gaining confidence. The extract

below provides an example of the anger a member felt at being asked to discuss her personal experiences of mental illness.

Member B: “no its not it’s because its prying into our private lives and it is very private what we’ve been through in our illness our illness is only experienced by us and they can’t imagine what it’s like” (P4. F 50-60, WS 2)

Member W: “we’re all here to help each other, not to add to your persecution” b (P7. F 60-70, WS 2)

Researcher: “don’t feel you know forced to divulge anything you wouldn’t want to, you know I can’t fully understand em but always just you know say ...”

Member B: “...depression was difficult, such a difficult thing, as you can imagine, it’s so serious and its common ... it’s lacking in research so it makes me angry even thinking about it”

Initially Member B found the workshops difficult. Opening up personal experiences and sketching them out on canvas initially made the individual emotional, angry and frustrated. Off camera the member noted to the researcher “I went home and I really didn’t like you for making me think about this” (P4. F 50-60, WS 3). In contrast, nearly two months later, the member was enjoying doing her artwork and getting her message about personal experiences relating to depression and anxiety to others.

Member B: “it’s lovely when someone comes in and also paints and you feel not alone, you feel alone in your mental health world, we all share these ...” (P4. F 50-60, WS 7)

This member’s sketches and completed artwork link the main theme of emotion, to sub-themes of anxiety, disempowerment and isolation from the normal world. In the artwork the member positions herself alone as an undefined figure

separated from the world via her mental illness and use of pharmaceutical interventions.

Member B: “Well, I’ve got a shadow picture reaching out like this (gestures putting arms out in front of her) and then I’ve got medicine boxes and then I’ve got the world” (P4. F 50-60 WS 3)

Researcher: “Where are you positioning yourself then?”

Member B: “On the other side of the medicine boxes. Because, I can’t get to the world, because of the medicine boxes” (P4. F 50-60 WS 3)

The member positions herself as disempowered trying to break the wall down to join the world but is stopped by her medication and mental health diagnosis (see figure 3A and 3B). However, when the member engages in the Activism workshops, she states “you feel alone in your mental health world” (P4. F 50-60 WS 3), set apart and, different. In the art workshops however, the member said she felt not alone, not isolated as she had solidarity and joint experiences with other charity members.

#### **4.4.2. Wellbeing (super theme 2)**

Identity and personhood plays an important part to a person’s self-definition within Western culture. An individual’s ability to distinguish oneself from another person impacts on identity, behaviour and overall wellbeing (Vignoles, Chryssochoou, and Breakwell, 2000). Personal identity has implications on how we interact as individuals and as a society with people. Foucault (1988) discusses 'technologies of the self' which refers to the behaviours people employ to police their 'selves' in society; and the ways in which they are empowered or

constrained. Stigma can lead to a negative self-view of identity, from ignorance, prejudice and discrimination (Thornicroft, Brohan, Kassam, and Lewis-Homes, 2008). This can create self-stigma; the individual internalizes society's negative view on mental illness (Pasman, 2011).

Figure 4.4. 3A. The wall and me by workshop member B, (P4. F 50-60 WS 3, 7)

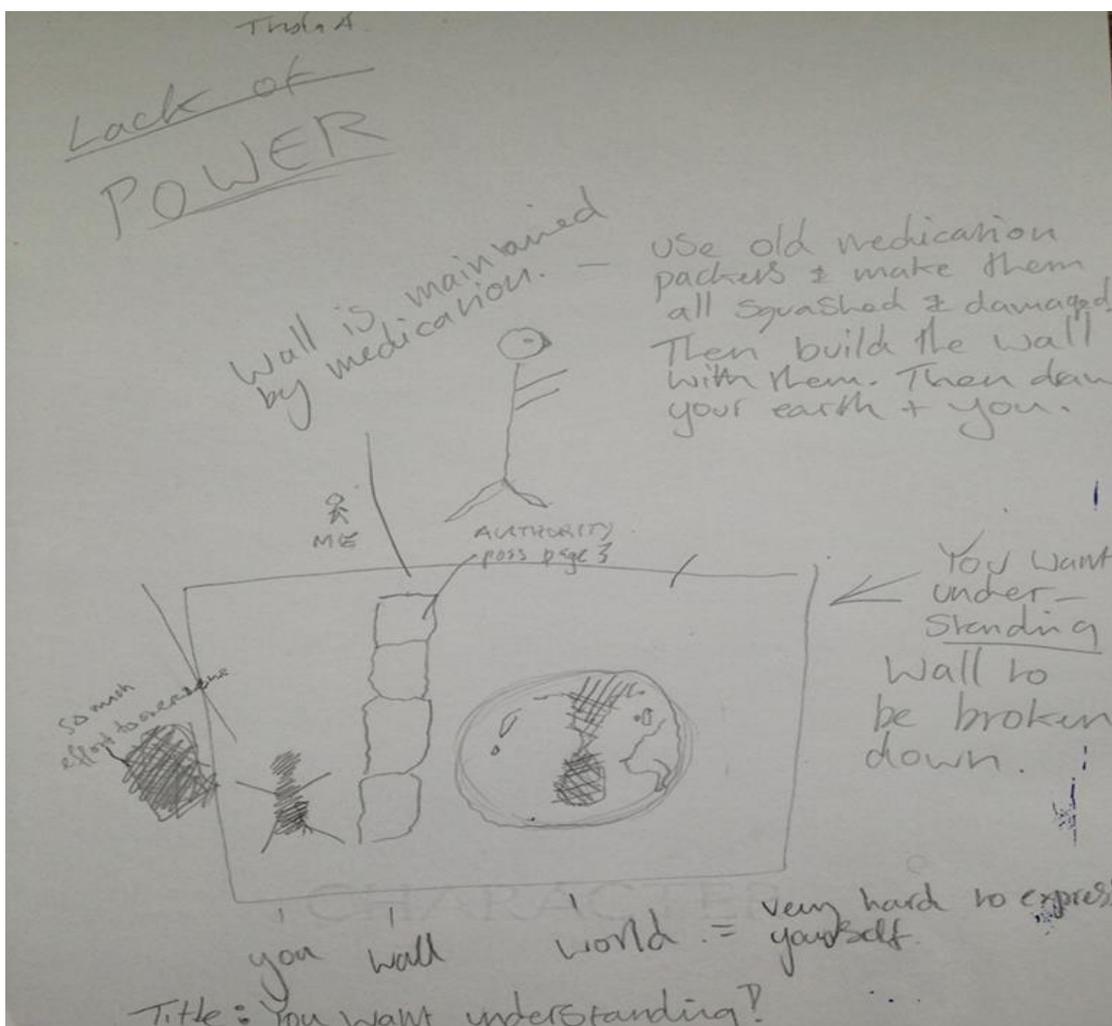
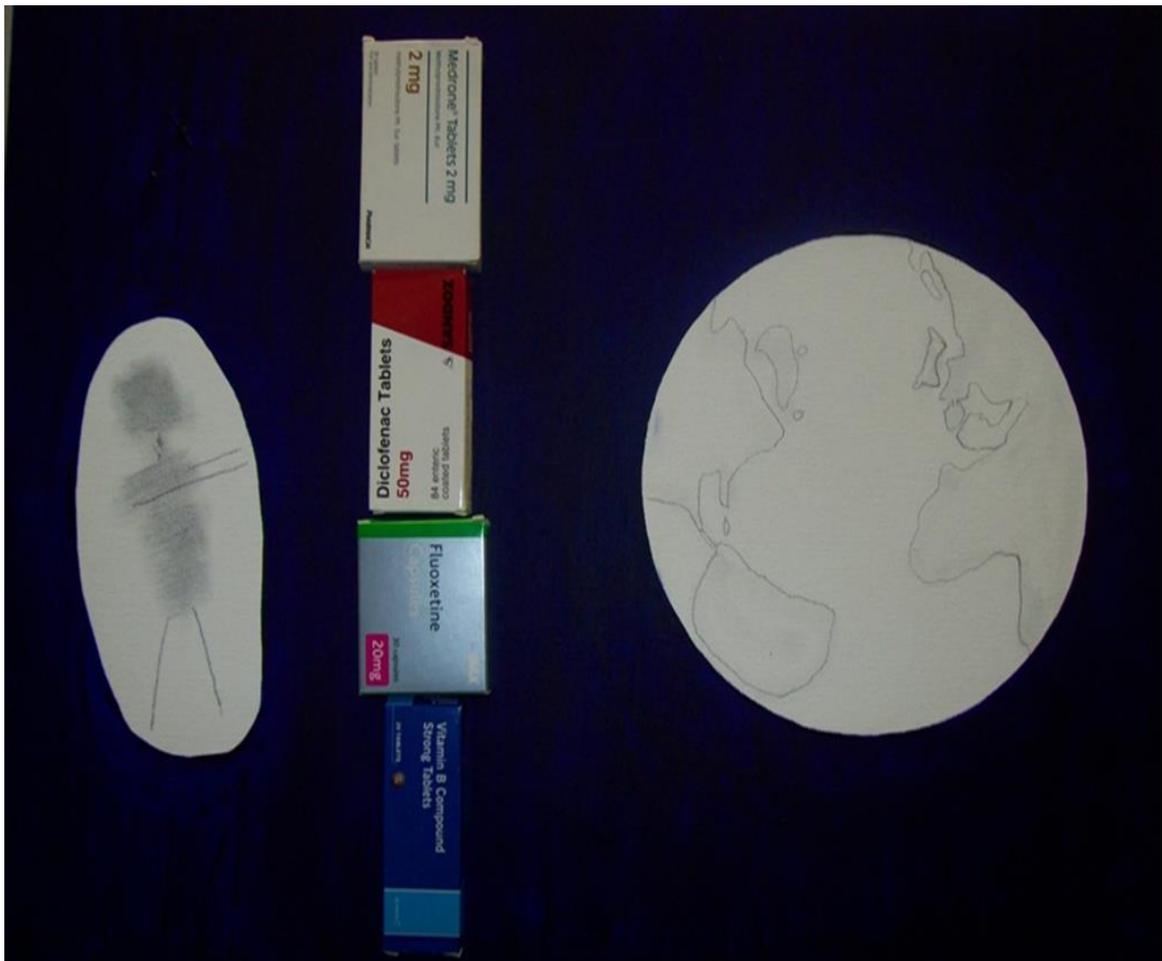


Figure 4.5. 3B. The wall and me (P4. F 50-60 WS 3, 7)



### Society (2.1)

Many members found social discrimination problematic but were also affected by attitudes socially from personal family members and/or friends. Member L notes:

Member L: "I feel completely let down" (P15. F 40-50 WK 5)

Interviewer: "who has let you down"

Member L: "I have a husband...there's nobody, I just, see all these people and they are holding hands and having a nice time, I can see it but there's this gap" ... "I need someone to be there, I've been away from people for so long and I'm frightened" (P15. F 40-50 WK 5)

The dichotomy of a patient, “feeling alone with their symptoms, of possibly not being believed” especially with unseen health diagnosis’s can lead many to feelings of stigma and vulnerability (Haugli et al. 2004, p.172).

## **Stigma (2.2)**

When a MHSU receives a diagnosis; the label can enable an individual to access treatment, benefits and social support. This can empower an individual, build self-esteem and provide access to community lead support measures (Rosenfield, 1997). However, MHSUs can also be disempowered from a diagnosis by developing a dependency on the medical profession, medication, and the possible stigma attached to being labelled with a diagnosis for a mental illness. The consequences of stigma can affect MHSUs from accessing the appropriate treatment. Identifying oneself with a mental health support group may encourage people with mental illness to turn to members, family or friends for mutual support and empowerment (Rusch, Corrigan, Wassel, Michaels, Larson, Olschewski, Wilkniss and Batia, 2009). This can benefit the individual into accessing medical treatment.

Negative social attitudes and experiences of mental illness can be difficult to put into words. The artwork below (See figure 4.) entitled ‘Pressure’ is by workshop member Z (P9. M 60-70 WS 8). The work expressed the member’s sensation of being watched and judged by society, weighed down by treatments, appointments and negative social attitudes. The mind map (see figure 1.) shows

the negative links from a lack of power and control; society, stigma, healthcare, doctors, medication, diagnosis, and negative emotion. Having a voice and being heard by both society and medical professionals is important to MHSU. The Artivism Intervention provided members with a platform to discuss perceived public views of mental illness (Scott-Smith, 2013). The negative outcome of stigma can be shown in multiple links which affect members' confidence, trust, and emotions and perpetuate psychological isolation. The member below relates his experience of social attitudes and stigma.

Member X: "I think when you first get in the psychiatric system whether that's through your GP or a psychiatrist or whatever you have all these concerns about your own wellbeing ... through coming to (the charity) and you know taking part in things, you can get round that. I'm not saying you'll totally through it because you will have bad days and up days you know, but as soon as you get to the point what happens is you become aware of the outward, people out there and what they think and what their perceptions of people with mental health, so you initially have to deal with the mental health problem and then find the empowerment in yourself and the strength in yourself"

Member B: "that's right" (P4. F 50-60 WS 2)

Member X: "you know to deal with, to deal with the shit out there, I think that's a journey that as an individual you have to take yourself cos were all different" (P8. M 30-40 WS 2)

Member X recounts his personal experience of the negative attitudes towards mental illness in society. This patient took an active role in understanding the mental health system, gaining treatment and how to negotiate the social attitudes of the public. It also presents the important role of mental health charities in bringing MHSU experiences together, thus providing a way to positively challenge and work through negative social and medical experiences. The friendships that evolved from workshops weekly encounters had a positive effect

on MHSUs by improving self-efficacy and therefore reduce self-stigma and improve social integration. The artwork (See figure 4.) shows a tree producing a claustrophobic effect of a psychological weight on an individual's everyday experiences. Graffiti is scrawled onto the tree 'hospitals, doctors, ambulance, medication, listen, drugs, look at me'. The individual who completed 'Pressure' described the work as an exploration of the stigmas, attitudes and pharmaceutical dependency he faces daily. The eye in the top left of the painting depicts the feeling of always being judged and watched by society, echoing the medical panopticon of Foucault (1977). Again 'listen to me' is a comment frequently made by members during the workshops in relation to doctors being perceived as not listening within medical encounters (Haugli et al. 2004).

Figure 4.6. Pressure by member Z.



Four members (including the member who created the painting in Figure 4.) discussed how the label 'mental illness' has impacted on their lives (WS 2).

Member W: "why don't you call it mental illness?"

Member X: "because it becomes a problem for you"

Member W: "Because"

Member X: "I don't know how psychiatrists think because I'm not a trained psychiatrist but the thing is"

Member B: "it's sort of outworn"

Member X "yes"

Member B: "time we got another"

Member X: "survivors as that's what you are in the mental health system"

Member E: "It's time for you to reclaim isn't it" (P3. F 20-30 WS2)

The use of labels in language can impact on a person's wellbeing negatively and/or positively dependent on what the label symbolises (Kroska and Harkness, 2006). Society often adopts the attitude that 'they are seen as being mentally ill instead of a person having a mental illness' (Pasman, 2011. p.122). This could create a problem for MHSUs, by being inhibited to disclose their symptoms, they many not seek treatment for their condition (see extract below).

Member M: "it's like they are labelling you, you know wanting to categorise you...it's like when you've dealt with psychiatrists and you don't feel, you think well who are they to come to that conclusion...it's a prime example of how, how, psychiatry can treat people you know they just"

Member E: "stifle"

Member M: "yes"

Member C: "I think you get to the point where you're frightened of actually saying what you believe, how you think or feel...you're meant to have a relationship with people who are helping you, open and truthful as well and it doesn't encourage that, it encourages you to keep your mouth shut"

Member E: “how can you get treatment?”

Member C: “yes exactly” (P13. F 40-50 WS 2)

Members discussed (above) how stigma has affected them when needing to seek treatment. Rusch et al. (2009) discussed how self-stigma and not accessing treatment “could be associated with reduced willingness or ability to seek help” which can lead to hospitalisation (Rusch et al. 2009 p. 552). Stigma affects a person’s self-concept, the idea of the self, constructed from the beliefs an individual holds about them and the beliefs of others (Rosenfield, 1997). Stigma has affected members from accessing treatment due to the fear of being stigmatised. When a diagnosis has been delivered, a treatment plan can be made available to the patient. The Artivism workshops aimed to publicise the affects that mental illness and social attitudes can have on a person. From forming friendships benefits self-efficacy and ‘facilitate help-seeking’ to gain treatment (Rusch et al. 2009 p. 552).

### **Support; Advocacy (2.3)**

Together, the issues of support, trust, friendship, frustration, and confidence formed the theme of support. One formal system of support that was referenced by workshop participants was advocacy, which enables individuals to access information and services. An advocate is an independent person employed by the council and/or hospital to put one’s case forward and make sure one’s concerns are heard by the right people. Advocacy is intended to ensure that people, particularly those who are most vulnerable in society, are able to have a

voice to safeguard a person's rights (<http://www.seap.org.uk/im-looking-for-help-or-support/what-is-advocacy.html>). The advocate will not input a personal view; rather, they simply articulate the perspective and interests of the person for whom they are advocating.

Member B: "I was given 5 minutes by a psychiatrist ... he said I should go to bed by 11 O'clock' ...'the next time I went I took an advocate"

Member M: "has it made a difference?"

Member B: "of course I got 50 minutes"

Member B: "they can't fudge anything with this man (advocate) besides me" (P4. F 50-60, WS 11)

This example shows how a patient developed distrust and became aware of the unequal relationship of doctor and patient. The patient felt a need to have an advocate to document the meeting and an adequate amount of time to present their symptoms. Mistrust can develop when a patient receives a limited appointment time and, thus, time to discuss their symptoms. The power disparities are raised via a trivialising of the person's symptoms. Thus, a mistrust of doctors can be established from these experiences. The doctor patient role can be affected by power variances "exacerbated by the possibility of compulsory assessment and treatment" within mental ill health (Laugharne, Priebe, McCabe, Garland, and Clifford. 2006 p. 843).

Support also contributes to MHSUs ability to conduct daily schedules including seeking medical treatment. Advocacy has been employed by eight of the eighteen workshop attendees. The availability, confidence, friendships,

improvement in daily living and support from a GP are linked sub-themes in gaining support. The first extract below presents advocacy as an important resource to have an exact record of interactions with medical professionals. This is especially so in view of the lack of trust between patient and medical professional, as discussed above (Boyers, and Orrill, 1971). In this way, the theme of advocacy links the overarching themes of power/control and wellbeing through the theme of medication:

Member M: “I didn’t have confidence of going to Citizens Advice ... didn’t have the ability in my brain to sort that out” (P10. F 50-60, WS 2)

Member C: “advocacy is the best way forward, having a third party there is also having a witness ... there is a lot of psychological abuse goes on with psychiatrists and psychologists behind closed doors, who are they going to believe, you or him” (P1, Male 50-60, WS 2)

The following extract highlights more specifically how having an advocate is seen as providing the patient with time and space to digest a possible treatment plan for the future. It also suggests a patient should be treated with respect and to challenge and raise awareness of problematic aspects of the medical system:

Member M: “we’ve got to say that’s not acceptable, what can we do to change things, for us (MHSU) being on the receiving end (of treatment)” ... “I would want advocacy, an advocate with me and take it away and digest and make sense of it”

Support was also discussed in relation to the more general benefits of the charity and its members. The charity provides members a social space to drop in for a cup of tea, take part in an art project and share experiences with other charity members. On a theoretical level the charity normalises members’ experiences of mental illness, provides solidarity between members and reduces the feeling of

isolation of mental ill health. For example the extract below outlines the effect of support by other MHSUs within a drop in group setting (the charity).

Member X: “it’s up to the individual person to find their own way with guidance, but this is the great thing about, I think (the charity) that has worked for me more than any other organisation or doctor and that’s because you are sitting with likeminded people who are in the same boat but have different problems but there’s a solidarity there ... you know you’re not alone” (P8, M over 30, WS 2)

Member Z: “you’re not alone that’s right” (P9, M over 60, WS 2)

Member M: “it’s within yourself that you find the strategies of coping or not coping” (P 10, F over 50, WS 2)

Member X found it comforting and gained confidence through meeting other individuals facing a similar situation (Workshop 2). Members X, Z and M agreed that establishing mutual relationships and understanding between members has increased their sense of well-being and equate this for example to visiting the doctor.

Member D: “(the charity) making me more aware again of mental health problems within society”

Interviewer: “What (the charity) is good?”

Member D: “Yes, the therapy of it, the ideal of it’ ...’we’re all sharing here around this table from different circles of life, that’s what’s good about (the charity)”

Fellow members can provide MHSU’s with support, knowledge sharing on a basis of trust, knowing of their shared experiences of mental illness. The recurring theme of power and how it can isolate a person both physically (avoiding social stigma) and psychologically (feeling disempowered via medical model practice) can link to a mistrust of medical professionals. In contrast the

members find empowerment, by meeting individuals with similar experiences that can reduce feelings of isolation and gain empowerment through shared experiences, “you’re not alone” (P9 Male over 60, WS 2).

### **Community-Charity (2.4)**

Themes surrounding friendship, solidarity, and support enable MHSUs to engage with funded schemes. The definition of charity is an organisation set up to provide support and access funding to generate new artistic skills and knowledge. In the location of the charity, there are multiple opportunities available for people on low incomes, and the long term unemployed, including exercise classes, swimming, Tai Chi and water based aerobics. The charity runs art workshops where new skills can be learnt and tea and coffee are available. This provides joint activities where members can join friends from the charity and engage in activities outside of the charity base:

Member W: “mental health can mean quite a lot of things. You know how some of us do free activities like swimming and sports and things” (P7. F 60-70, WS 3)

Sources of positive emotions for MHSUs include the availability of resources and access to sports and outdoor activities that bolster mental well-being (Wipfli, Landers, Nagoshi, and Ringenbach, 2011). The charity has played an important role within the local community and nationally. It provides a base for individuals to seek solidarity with other people experiencing mental ill health, whilst also providing a creative hub to engage its members with new skills and enjoyable

activities. Members often engage with the charity on a daily basis, for a cup of tea and mutual support with friendships that have been established and grown through the Artivism Intervention.

### **Art as a positive (2.5)**

Art itself was also identified as a positive outlet utilised by many individuals as a hobby, tool for self-expression and/or a therapy. The images by Member E, (See figure 5A, 5B and 5C) show two sketches and the completed artwork. The individual wanted to express how being diagnosed with depression does not diminish her skills in other areas of her life. The theme of art as a positive included discussions relating, to employing art as a coping method within themes of 'depression', 'quality of life', and 'confidence'. After discussing sketch 5A (difficulties of depression) and 5B (what I still can enjoy), the member used the completed artwork (5C) as a reflection of her experience as a MHSU.

Member E: "the feeling of depression to show that in my head I can still do all the things. So I did little pictures in my head' ... 'it's a struggle and a battle and so that's what I was trying to impress is that, yes, we are good at things that could be useful" (P3. F 20-30, WS 7).

Member F: "you've got to be in the right frame of mind to do it"

Member E: "yes"

The art and Member E's discussion of it highlights the potentially positive role of art in breaking down and expressing experiences and an individual's own belief about their abilities. There can also be potential negative effects when a person's artwork is judged by others (see Chapter 5: The exhibition). Critically, the art also

provided a conduit through which members could critically discuss shared experiences. Sub-themes of self-expression, coping methods and exploring depression link members to the positive effects of the charity.

Figure 4.7. 5A. Sketch by Member E (P3. F 20-30, WS 7)

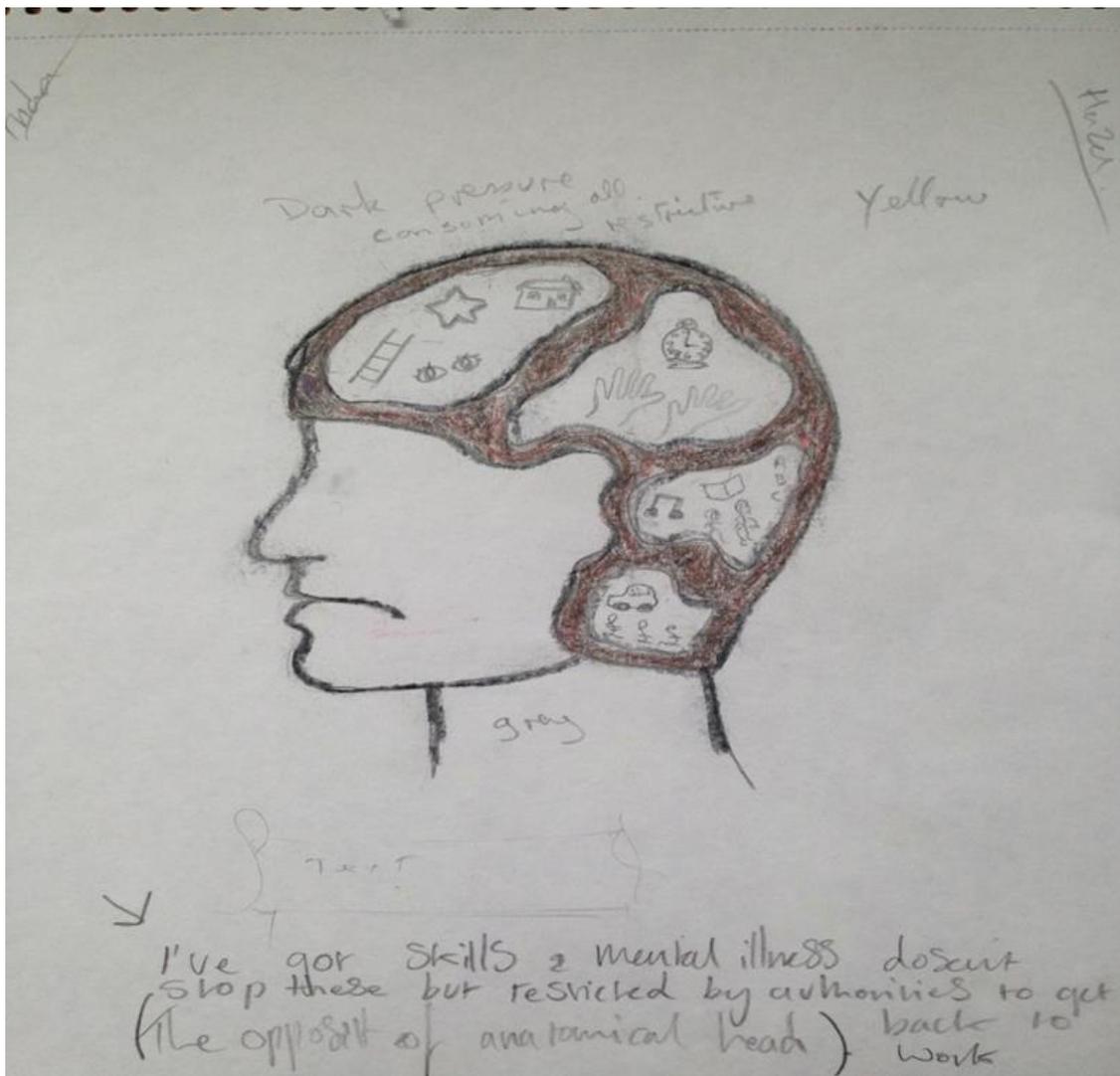


Figure 4.8. 5B. Artwork by Member E (P3. F 20-30, WS 7)



More generally, art was discussed as a beneficial tool in enabling members to express their experiences verbally through critical discussion and visually onto canvas.

Member B: "there are different ways of bringing out what you are feeling isn't there and this is one way, art is one way" (P8. M 30-40 WK 2)

Interviewer: "yes definitely"

Member X: "art is more positive because I know if I ever really got stressed years ago and built things up, especially if stress was caused by somebody else, (its) the only way I could express it" (P8. M 30-40 WK 2)

Figure 4.9. 5C. Artwork by Member E (P3. F 20-30, WS 7)



The themes analysed find art as a positive mode of expression, learning a new skill and finding solidarity with fellow workshop members. In forming friendships, completing an object that is admired by others and discussing the artwork created were cited to be enjoyable practice by multiple members.

#### **4.5 Discussion**

This chapter has presented an analysis of MHSUs experiences in relation to negative themes from a lack of power and control in both healthcare and society,

and positive themes from wellbeing, in both healthcare and society. The analysis has discussed how themes may or may not relate to each other, if there is a shared theoretical basis or that unique themes have developed. The two overarching themes of healthcare and society emerged from the sub-themes developed from the data. The main experiences MHSUs discussed were related to medical encounters within a healthcare setting and/or experiences and attitudes from the general public. The negative sub-themes developed around discussion on diagnosis, doctors, medication, stigma, support and emotion. The positive sub-themes were generated from interactions within the community/charity, support, advocacy, art and emotion. Sub-themes across both positive and negative participant extracts were shared between linked themes on advocacy, with positive links to medication.

The analysis highlighted MHSUs experiences of being and not being listened to, with discussion over medication and specialist treatment. Identified categories of power and control, and wellbeing were described in doctor patient interactions with a dilemma over maintaining good health whilst remaining empowered. Freire found that when hope becomes “hopelessness (it) is a form of silence ... resulting from an unjust order” (Freire, 1970, p.72-73). The extent and the effects of power and control are seen in multiple participant extracts. When a MHSU visits a psychiatrist they are entering into a medically-dominant framework, which supports the authority and knowledge of the medical practitioner, which in turn works to reinforce the medical model and can disempower a person (Waitzkin, 1989).

The positive effects of employing an advocate are highlighted by members' extracts. The reassurance of having another party to document events provided protection and support to MHSUs. The art workshops as a practice generated a positive outcome for members, by providing members with the opportunity to discuss their personal experiences and what has and hasn't worked for them in the Mental Health System. It allowed friendships to form from the weekly encounters over the initial three month period. Members found solidarity is discussing members' experiences of social attitudes and stigma. Unexpected outcomes from the Artivism Intervention were from members' experience of gaining friendships; enjoying creating art that would be later exhibited all emphasised positive effects of workshop engagement (Scott-Smith, 2013). The workshops also brought members together in critical discussion which provided greater understanding and awareness of other people's mental illnesses. Knowledge was exchanged in discussion over individuals' medical experiences which have had a positive effect of learning about advocacy and human rights. Themes surrounding self-esteem and confidence in relation to stigma also emerged from member discussion. This provided members with the realisation that they were not always alone in their experiences in the community, at the doctors, and in taking medication.

#### **4.5.1 In reflection**

The results from Study one (chapter 4) provides subjective interpretation of the data. It is important to acknowledge the subjective component in the interpretation of such data, and the practice of theory development more

generally (Willig, 2001). The researcher also engaged in multiple roles prior to, during and post data collection. While this crucially enabled the researcher to build up an understanding of the membership, staff and visitors, it also means that there may have been conflict from the researcher's different roles with the charity, as researcher, artist/tutor, and director within the charity. The researcher aimed to resolve possible conflicts by talking to the charity members about the multiple roles and members were able to question the researcher. Some members may have been concerned about information going back to the charity Board of Directors about members. The researcher reassured the all members present that personal information was confidential and all transcript extracts would be anonymised.

The researcher engaged in reflecting and generating proactive strategies to generate new knowledge and theory generation in the second phase of the Artivism Intervention (Chapter 5, The Exhibition). The very nature of social settings and systems means they can be challenged and changed (Burr, 2003). This is a positive point for future research to understand how to challenge negative attitudes through engaging in raising social awareness, self-efficacy and possible treatment pathways of mental illness.

## **Chapter five: Exhibition and Group Interviews**

### **5.1 Introduction**

This chapter introduces mental health service users' work (MHSUs') seen publicly for the first time at 'The University of Stirling's' library exhibition space. The artwork displayed was created by MHSUs' during study one (the workshops). During the exhibition, feedback was gained from the general public in the form of 79 completed questionnaires (completed during the exhibition period). Seven group interviews were undertaken with the public and MHSUs (at the exhibition opening). In study two (2A questionnaires and 2B group interviews) both quantitative and qualitative data analysis were employed, triangulating the data from two perspectives. The aim of triangulating the two data sets was to provide insight into gauging the general public's social attitudes to mental illness in relation to the group interview discussion between members of the public and MHSUs'. Thus, to validate the reliability of the conclusions the data provided.

#### **5.1.1 Overview: The Exhibition (study two)**

All participants from study one (the workshops), were invited to exhibit work in the exhibition. Members had the option to opt out of exhibiting their artwork, but no artist chose this option, thus all members who completed canvases were included in the exhibition. The exhibition included 23 paintings, 18 were from workshop participants and 5 were completed by the artist/researcher to show an example of creative practice. The artist/researcher completed artwork that reflected their personal experience of disability.

### **5.1.2 Participants: Engaging in the exhibition process**

The final phase of study one (finishing the artwork), focused on getting the work exhibition ready, including titles, medium of materials the artwork formed, dimensions of the work and formulating a list of invitees. The researcher assisted workshop members during the last 30 minutes of final two workshops. Each member chose the size of their artworks' at the start of the project. The mediums available of acrylic based paint, pencil, charcoal and mixed media (for example, members used medication boxes were available to use in individual artwork) were noted down by the researcher during the project. Artwork titles, were formulated by each member during the workshops, and documented by the researcher. The invitation list was developed by the members (in the final workshop), where the researcher asked who would they like to invite. The researcher gathered the contact information for sending out the invitations and the charity funded the postage costs. This was completed between study one and study two. The researcher further invited interested academics from The University of Stirling to the event.

The exhibition followed a specific programme of events located at The University of Stirling Central Library gallery space. MHSUs' artwork was on display to the public for a six week period. The exhibition exhibited 23 paintings that were labelled numerically. In which two of the artworks that included an accompanying story, which related to the artists' mental health experiences. A price list, which

detailed the title, and a chosen synonym from each artist (if requested), and medium of the artwork, was available to the general public. A private room neighbouring the gallery provided attendees with refreshments and a sign-up sheet for participating in the group interviews.

The exhibition entitled 'Artivism' was part of Scotland's mental health awareness month (in October) and the Scottish Mental Health Arts and Film Festival (SMAFF, 2008). This is a yearly festival hosted by the mental health foundation. SMHAFF is funded by multiple organisations and media outlets including; 'See Me' (Government Mental Health Campaign), NHS Greater Glasgow and Clyde, and BBC Scotland. The festival aims to provide awareness of the benefits of employing the arts to improve mental health, by presenting a programme of arts based events that explore themes surrounding mental illness. The exhibition opening consisted of invited charity membership (MHSUs' and support staff), members of the general public, invited academics and interested supporters. The exhibition provided the location to undertake two parts of research, Study (2A), a questionnaire survey of the views of the general public attending the exhibition, and Study (2B), group interviews. All participants from study one: the workshops were invited to the exhibition opening and 16 attended. The questionnaires were available for the public to complete. Thus, members of the public who may have, or had a mental health diagnosis could have completed a questionnaire. The group interviews were attended by both MHSUs' and the general public. A total of seven MHSU and thirteen members of the public took part in group interviews (see chapter 3 p 61 table 3.3).

### **5.1.3 Overview: Questionnaires (study 2A)**

Study 2A used brief questionnaires to evaluate public opinion on MHSU experiences. The aim of the questionnaire was to gauge the general public's awareness of mental illness through viewing artwork.

### **5.1.4 Overview: Group Interviews (study 2B)**

Study 2B, the group interviews provide a forum for open-ended discussion. The group interviews were facilitated by the researcher, who coordinated and invited MHSUs' and members of the general public attending the exhibition opening. The group interviews aimed to explore people's opinions after viewing the exhibition. Qualitative methods were used to analyse the group interview data.

## **5.2 Research questions**

1. What is the impact of public display of their artwork on MHSU's and the general public?
2. Can art conscientise artists (MHSU/members) and audience (the general public)?

## **5.3 Methodology**

### **5.3.1 Ethics**

Study two (the exhibition, questionnaires, and group interviews) received ethical approval from the University of Stirling's Psychology ethics committee.

### **5.3.2 Study 2A: (Questionnaires)**

### **5.3.3 Participants**

In study 2A, the participants were members of the general public. A total of 79 participants completed questionnaires, with three not usable, equalling 76 completed. The age and gender of participants were not included in study 2A.

### **5.3.4 Participant recruitment**

The researcher visited the exhibition at three random times over the 6 week duration of the show. This allowed the researcher to ask members of the public viewing the exhibition to complete questionnaires and allowed the researcher to empty the questionnaire box. The questionnaires were available for members of the public to pick up and complete at any time within the exhibition period.

### **5.3.5 Materials**

A poster advertising the exhibition and questionnaires was located in the gallery space. The researcher constructed the poster which also employed the image of a painting created by the researcher as an example of expressing experiences (the artwork expressed social experience of disability). The poster introduced the concept of and background to the Artivism exhibition (see figure 5.1.) and publicised the availability of questionnaires.

Figure 5.1. The poster advertising the exhibition within the gallery



**Artivism: Reachout**



Artivism is an inspiring exhibition from Reachout: with arts in mind, led by local artist Emma Scott-Smith and developed by local people with experience of mental ill health. The exhibition is a form of art activism and consciousness raising. The artwork explores everyday experiences of mental health, pharmacology, highlighting stigma, oppression and challenges current social attitudes.

The charity is an expressive arts mutual aid group for adults experiencing mental health problems and their allies. It is interested in using the creative and performing arts to challenge stereotypes and stigma about mental health in the community. Please complete a questionnaire after viewing the exhibition. The exhibition 'Artivism' will open on Friday the 7th of November at The University of Stirling Library and close in January.

[emma.scott-smith@stir.ac.uk](mailto:emma.scott-smith@stir.ac.uk)

Each questionnaire consisted of five open questions (see Table 5.1.). The researcher developed the questionnaire to provide information about the general public's awareness of mental health. The introduction to the questionnaire stated:

Please could you complete the following questions and leave the sheet in the box provided in the library. The questionnaire consists of 5 questions, and blank spaces for comment and/or drawing. 1. Please answer questions by writing on the sheet, 2. Write freely, as all answers are anonymous, 3. Your views will be used to understand the role of art in social action.

**The questions asked are presented in Table 1 below**

Table 5.1: Questionnaire

<b>Table 1: Questionnaire</b>	
1.	What did the exhibition make you feel and think?
2.	What effect has this exhibition had on your awareness of mental health?
3.	Do you now think differently (after viewing the exhibition) about mental health services?
4.	Do you now think differently about the experiences of mental illness?
5.	Do you think Artivism can bring about change and challenge oppression, and Society's views?

### **5.3.6 Categorised responses to Questionnaire scoring**

Five categories were identified from all of the submitted participant questionnaire responses. Themes were identified from participants' responses' to the five questions posed and the data allocated to these categories. For example:

**Question 4: Do you think differently about the experience of mental illness?**

'No, my views have always been in line with encouraging freedom of expression and challenging the barriers caused by stigma'

This response was categorised as ‘No, already aware’ (see points 1 to 5)

### Five Response categories

Key: Categories of participant questionnaire responses	
1.	Established new knowledge
2.	No increase in existing knowledge
3.	Increased existing knowledge
4.	No change in Attitudes
5.	Artivism can challenge stigma

## 5.4 Study 2B: (Group Interviews)

### 5.4.1 How participants were recruited?

The group interviews included members of the public and MHSUs as shown in Table 5.2.

Table 5.2: Group Interviews: participants

Group	Number of	Mental Health
Interviews	Participants	Service Users (MHSU)
	Gender	and Public (P)

1	2	1 Male, 1 Female	1M, 1P
2	5	2 Male, 3 Female	3 M, 2 P
3	3	1 Male, 2 Female	1 M, 2 P
4	4	2 Male, 2 Female	1 M, 3 P
5	3	1 Male, 2 Female	1 M, 2 P
6	3	3 Female	3 P

#### 5.4.2 Group Interviews Materials

The researcher employed a 12 point discussion sheet, produced onto an A4 sheet of paper and laminated. The researcher asked the same questions in each group but in a different order depending on the flow of conversation. The discussion sheet enabled the researcher to steer the discussion back to the topic being debated when needed. A total of seven group interviews were undertaken, but only six were transcribed due to poor sound quality in one group interview.

The group interview discussion sheet was developed by the researcher after completing study one. The group interviews discussion points in study two were formulated from group discussion within the workshop sessions (chapter 4). MHSUs engaged in critical thinking about chosen personal experiences that affected their day-to-day living. The participants explored the points that were raised with the researcher and created the discussion list of points as shown in Table 5.3. The questions were developed to investigate individuals' responses'

to the artwork exhibited, experience of mental health and how we as a society can perpetuate negative frameworks and attitudes about mental illness.

Table 5.3: Group Interview: Discussion Points

<b>Table 5.3: Group Interviews: Discussion Points</b>	
1.	What do you think of the work?
2.	Are we (the general public) trapped into certain ways of thinking (about mental health)?
3.	Does it remind you of anything?
4.	Do you have a friend with mental ill health?
5.	Does the mental health service work for people?
6.	Someone mentioned the work expressed negative views of the NHS, What do you think?
7.	Can the NHS be improved?
8.	Should we look at the frameworks of how we understand mental health?
9.	As a society are we trapped into certain ways of thinking?
10.	Are we made to think of dominant frameworks and discourses?
11.	In example the oppressed may have internalised society's view of mental ill health. People with mental ill health may feel negatively about themselves due to stigma and oppression in society, why?
12.	How can we change, by what means?

### 5.4.3 Design

The group interviews were designed to include both artists (MHSUs') and audience (the general public). One group (group interview 6) included members of the general public only; this was by chance, as two MHSUs' who had planned to attend felt overwhelmed by the event. Both members were keen to take part in a group interview but the public nature of the event in contrast to the interpersonal workshop environment proved difficult. The two members found the public nature of expressing very personal experiences to strangers (the public) uncomfortable. Thus, both members approached the researcher 20 minutes before the group interviews were due to begin, to eliminate them from the process. Each group included both male and female participants' no further demographic details were collected to preserve anonymity.

The MHSUs' and members of the public had not met before this event. The process of the analysis of coding the group interviews transcripts was devised by constructing meaning from group interview discussion (transcripts). A thematic analysis approach was employed where the researcher went through the transcripts identifying similarities and differences within the data. Categories began to emerge, were expanded upon and relationships formed themes. The core three themes developed from the group interview transcripts were devised after all participants had viewed the art exhibition. The group interview transcript analysis identified and generated three/categories themes (see Table 5.5 p. 128).

#### **5.4.4 Procedure**

The group interviews took place in a side room from the gallery space where chairs, tables and refreshments were available. Each group interview consisted of two to five people. The group interviews lasted from 10 to 25 minutes'. The group interviews were performed between 6.30 and 9.30 pm in the evening of the exhibition opening. The exhibition opened to invited members from 6 pm. The audio recordings were transcribed within one week of the group interviews, by a PhD student with a background within the field of health psychology. Due to the researchers' disability, transcription and assistance was provided by postgraduate students within the field of psychology.

## 5.5 Results: Study 2A

### 5.5.1 The Questionnaires: responses

The data from 76 participants were summarised in five separate categories, one for each question. The categories (see chart 5.4 p.131) chart responses to question one, reveals most participants (n=45, 59%) show an increase in their existing knowledge, thus support consciousness raising.

Table 5.4: Questionnaire frequency of participant responses

Questionnaire Question Number	Responses: Number of Participants and Percentage of data									
	Category 1		Category 2		Category 3		Category 4		Category 5	
	Number	%	Number	%	Number	%	Number	%	Number	%

1. What did the exhibition make you feel and think?	15	19	6	8	45	59	2	3	8	11
2. What effect has this exhibition had on your awareness of mental health?	32	42	19	26	22	28	0	0	2	5
3. Do you now think differently about mental health services?	32	42	32	42	9	14	0	0	1	2
4. Do you now think differently about the experience of mental illness?	34	44	22	28	3	7	11	18	1	3
5. Do you think Artivism can bring about change and challenge oppression and society's views?	0	0	3	6	0	0	1	2	70	92

### 5.5.2 Summary of the findings

In summary, the findings from study two (2A questionnaires) show, the greatest frequency of responses across questions one to five. In 59% of participants 'increased existing knowledge' overall from question one (see Table 5.4.).

Findings from question two show 42% of participants 'established new knowledge' after having viewed the exhibition. In response to question three, 42% gained mutual results between 'established new knowledge' and 'no increase in existing knowledge'. Further question four findings show, 45% of participants responded to having 'established new knowledge' from viewing the exhibition. Finally in question five, 92 % of participants noted that 'Artivism can challenge stigma' from engaging in art to challenge awareness of mental health. Further still, 'established new knowledge' had an overall high frequency consistently across all five questions responses. The pie chart provides a clear example of the frequency of participant responses across 76 completed questionnaires.

### **1. what did the exhibition make you feel and think?**

One respondent found a positive impact of viewing the exhibition.

"The exhibition made me realise how terrible it must be to have a mental illness and how vulnerable it must make you feel. I think this came across in some of the paintings, it has made me a lot more aware of the struggles people must have" (Questionnaire 5, Response 1)

This questionnaire participant reflects the majority of participants' views from viewing the artwork in the exhibition (Q5, R1). Reflection is essential to conscientisation and praxis. The circular process (praxis) of taking action (engaging in exhibition), being reflective (reflecting on artwork), and developing new knowledge (challenging awareness), in itself be considered conscientising.

## **2. What effect has this exhibition had on your awareness of mental health?**

The results for Q2 Show that participants have gained significant new knowledge after viewing the exhibition and some have increased existing knowledge.

For example, this respondent notes that the exhibition has provided an insight and established new knowledge and awareness of MHSUs' experience of being diagnosed with a mental illness.

“It has been educational. Has shown me what the experience of mental ill health can be like” (Q 21, R2)

Education through generating new knowledge is key to developing a social awareness that benefits both MHSU and society (the public). Increased existing knowledge is shown with participant 50's response to question 2.

“Knowing that the art is about mental health awareness, it makes me look at the art work again putting myself in the minds of others. The picture of the tree branching out the word hospitals makes you feel more aware and slightly sad for people” (Q50, R2)

## **Q3. Do you now think differently about mental health services?**

In Question 3 scores were evenly distributed between two categories 'Established new knowledge' and 'No increase in existing knowledge'. The results show that n= 32, 42% of participants have gained significant established new knowledge after viewing the exhibition. And n=32, 42% had no increase in existing knowledge. Questionnaire responder 44, established new knowledge from viewing the exhibition, by showing an awareness of the effects mental health services (NHS) can have on MHSUs'.

“I can’t say I had an opinion on mental health services, therefore it has changed, now that I know some of the services they provide” (Q 44, R3)

The participant shows that they have gained new knowledge from viewing the art work. As a member of the public with no mental illness, this participant is now aware of services available to MHSUs’. Participant 72 found the exhibition a possible valuable tool to challenge prejudice and negative social attitudes towards MHSUs’. This highlights a perceived perception of social prejudice, suggesting MHSUs’ can be non-functional, and not a benefit to society.

“I certainly do, (its) a highly commendable project as it makes people feel valued and creative...The exhibition has disproved much of the current social prejudice in proving that people who suffer mental illness are functional, thoughtful, and often talented members of society” (Q 72, R3)

Some responders reported no increase in existing knowledge about mental health services. Participant 7 highlights that society and MHSUs would benefit if mental health awareness is improved, thus improving services and social attitudes to mental illness.

“I have always had an awareness of mental health; in its various forms...I think being healthy mentally creates a healthy society” (Q 7, R 3)

This participant acknowledges the role of both the individual and society in recovery. Further, participant 45 noted.

“They (MHSU) rely too much on drugs? I have to say I missed the critique of this exhibition” (Q 45, R3).

No increase in existing knowledge is found in this response, however it does provide an insight on possible stigma MHSU experience.

**3. Do you now think differently about the experience of mental illness?**

The results for Q4 Show that n= 34, 44% of participants have gained established new knowledge after viewing the exhibition. And n=22, 28% had no increase in existing knowledge. Participant 17 noted.

“It has challenged some of my assumptions about self-awareness of those who have mental health problems” (Q 17, R4)

An assumption is something that is accepted as true or certain to happen, but without proof. Being Self-aware is a conscious knowledge of an individual’s own personality, emotional state, intentions, and desires. The findings show (in relation to question 4) that members of the public, established new knowledge from viewing the exhibition of artwork displayed. Participant 26 found.

“I just think it’s something very difficult to get through by that I mean, be totally cured” (Q 26, R4)

This respondent did not clearly state no increase in existing awareness, but their response shows they did not gain awareness from viewing the exhibition, rather compounded the distress of mental illness recovery.

**5. Do you think Artivism can bring about change and challenge oppression and society’s views?**

The results for Q5 Show that a majority of n=70, 92% of participants found that Artivism can challenge stigma. Most responders felt that 'Artivism can challenge stigma' and a positive change in attitudes can be established from viewing the exhibition of MHSUs work. Participant 45 noted:

"Activism always can, and why not Artivism! Maybe it takes a certain kind of person to stop and think about the art in-depth but it definitely makes a difference. Great exhibition" (Q 45, R5)

This participant understood the ethos of Artivism, being proactive, challenging prejudice and raising awareness via art. Participant 59 noted:

"I think it could if its objectives are clear to those who see it and everyone is aware of the subject matter" (Q59, R5)

This participant makes a valued point. Artivism as an exhibition can challenge and raise awareness on the small scale. Artivism as a MHSU treatment pathway would need further research and development into making this part of MHSU recovery and pathway back into the community after hospitalisation. Further participant 63 noted:

"I think so because I believe that art is a way to express what people think and what they are not able to say. So, yes, I think Artivism can bring change and challenge (out loud) oppression and society's views. Keep this going" (Q63, R5)

The Artivism Intervention and conscientisation have the ability to challenge, develop and generate wellbeing and aid recovery in the community. As participant 64 noted, funding is needed to take this researcher further into a fully functioning treatment pathway.

“I would hope so. More work and research needs to be done. But like everything it requires money. A very interesting study” (Q64, R5)

The majority of participant responses to question 5 felt Artivism is a novel practice to raise public awareness. However, there were some critical comments - multiple respondents’ noted that advertising, financial backing and clearer research aims would be beneficial in future studies.

Key 5.4: Questionnaire Key

<b>Key 5.4: Questionnaire Questions</b>	
1.	What did the exhibition make you feel and think?
2.	What effect has this exhibition had on your awareness of mental health?
3.	Do you now think differently (after viewing the exhibition) about mental health services?
4.	Do you now think differently about the experiences of mental illness?
5.	Do you think Artivism can bring about change and challenge oppression, and Society’s views?

Key 5.5: Response categories

Key: Categories of participant questionnaire responses	
1.	Established new knowledge
2.	No increase in existing knowledge
3.	Increased existing knowledge
4.	No change in Attitudes
5.	Artivism can challenge stigma

## Summary: Participant questionnaire responses

The findings of this study support the research question, “Can art conscientise artists (MHSU/members) and audience (the general public)”? The questionnaire findings suggest conscientisation can be generated from members of the public viewing the artwork. For example, findings of ‘established new knowledge’ suggest that consciousness can be raised.

Some participants found the exhibition liberating as it generated open public discussion about mental illness.

One participant, established new knowledge from viewing the art work exhibited and a positive move to challenge awareness of mental illness in society. Another, participant noted they had an emotional reaction to MHSUs’ artwork and it was a platform to raise social awareness. A further participant noted that it would not leave a lasting impression although, it raised their awareness. Employing art as a tool for discussion and raising consciousness may exclude a selection of the population. This reflection of general public responses to the exhibition provides an insight, a snapshot of social attitudes to mental illness. It also provides critical feedback which can be explored in future research.

## **5.6 Results Study 2B**

The interpretation of the group interview data (study 2B) employed a qualitative thematic analysis. A framework was established to code findings in relation to three core themes. Participants discussed themes related to the artwork exhibited, shown in Table 5 below.

Table 5.5: Core categories/Research questions revealed from group interview data

Core themes
1. Is the artwork generating awareness of mental health, for MHSU and/or the general public?
2. MHSU and the general public awareness raised from discussing artwork?
3. Can GP's, charities, and community organisations make more referrals, publicity to support MHSU (often MHSU are not aware of support in their community)?

**1. Is the artwork generating awareness of mental health social attitudes, for MHSU and/or the general public?**

Art has the ability to transcend language and express shared emotion. The group interviews reported a common theme about the benefit of expressing experiences via visual art. One participant (member of the public) noted in group interview 5:

P6: "well you come to something like this (exhibition) and you think god, you know, you can have these experiences but you still...you're able to kind of find this outlet via art to produce something that's, you know, it's quite emotional"

R: "mmm"

P6: "I think it's a really interesting way of expressing"

P4: "the focus here is on something separate also to mental illness because its art and artistic abilities and what they produce" (Group Interview 5)

The benefit of expressing emotion whilst learning new skills in a social environment can have a positive impact of creating art. In study 2 (the exhibition) the participants gain understanding of the emotions MHSUs' can experience from viewing the members' artwork. Participants found that stigmatisation and stereotyping cause negative overall wellbeing. The participants discussed this in group interview 6:

R: "it's the 'I'm fine' attitude"

P1: "Yeah, and I think the only way to change that is literally through viewing the bad bits as a positive as wellbeing, em I can't think of another way to get the message out there"

P2: "and not concealing, yeah, anything that shows like an expression, whether it's an expression of the pain that someone's in" (GI 6)

The participants discussed public awareness issues in group interview 3:

P1: "Nowadays we know a lot more about a lot of things that 20, 30 years ago you were institutionalised for"

R: "that's true to a certain extent but lots of people with mental illness can internalise society's views"

P5: "you get, there's no form of positive, em stereotype that you have of mental illness, so you can't really embrace it" (GI 3)

The findings show participants discussing and grappling with how to challenge and change the stereotype and stigma of mental health into a positive. From exhibiting the artwork members have produced and generated publicity about the

expression of MHSUs' experiences, generating new knowledge on how to challenge social perceptions. In addition findings demonstrate how MHSUs aim to break down the barriers of stigma. Participants of group interview 6 discuss:

P2: "well one of the things with having it (the exhibition) here is that hundreds of people, I think (every semester) a term there is about 4,000 people who will see your exhibition"

P4:"that's a serious claim"

P2:"Do you know what, we're privileged to have it here, because it gives everybody the opportunity to explore what you've been exploring"

P3:"it's really breaking down the barriers, it's just saying, well this is people with mental illness who've produced this work, you know, there is a lot to it and its rich substance" (FG 6)

Within group interviews other participants understood what MHSUs were aiming to express, by challenging social perceptions and stereotypes but also to aid understanding and raise awareness. By generating new knowledge and focusing on how to challenge social attitudes, you can raise awareness through a proactive intervention.

## **2. Is MHSU's and the general public's awareness raised from discussing artwork?**

Across group interviews, multiple participants reported that social stereotypes and attitudes towards mental health are problematic. This was especially evident when discussing mental illness and social preconceptions with children. Education was a key concern when being able to challenge ongoing stigma. Thus, education and educating people (society) was seen as an important step

to challenge social stereotypes and challenge social misperceptions from childhood onwards. Education in schools, the family unit, and through positive medical encounters has the ability to generate pro-active strategies and reduce stigma. Proaction strategies act in advance to deal with an expected difficulty by designing a long-term plan to deal with for example, stigma. The participants below discuss how tackling stigma about mental illness at school is key to challenging awareness by discussing it before it becomes a negative social stereotype within ones social frame of reference. Participants shared their views in group interview 4:

P1:"But it seems to be the attitude. So far she is only four so it may not have reached their consciousness highly yet"

P3: "It's just like the one (school) I'm working in just now"

P2:"it's the external; influences that make the difference"

P1:"We were saying earlier, I notice a change in my children since they've become more aware of everything and think it's harder for them to except (attitudes to mental illness), I think children are fine as long as they know... your aim"

P2:"Cos they read these signs and you're giving them mixed messages. You're saying one thing but inside your feeling another"

P2:"again, you are perpetuating the cycle" (GI 4)

Participants discussed how children from school age (age 4-5) should know about mental illness and how it can affect people. Participants noted that if parents have negative view points the child needs an external influence to challenge those views (from school). Participants shared their views in group interview 2:

P3:"like paranoia; it could never just be you"

R:"do you think you know, entrenched in dominant ways of thinking"

P1: "I think it depends how sheltered you are and what your upbringing is... I think when you're a child you ask 'what's wrong with them' or you know, 'mummy that's a strange lady or a strange man...'"

R: "Mmm"

P1: "instead of just thinking that, you know they're mad or they are not normal"

P3: "nothing is black and white is it, the older you get"

P1: "you don't know what they've just experienced that day or what they are going to experience..." (GI 2)

Participants noted that it is healthy for children to be aware and raise their consciousness, that mental health should not be stigmatised. Participants note that an awareness to challenge social attitudes needs to be addressed via proaction strategies. Participants discuss this further:

P3: "it needs to start in schools"

P2: "that's right"

P3: "talking to children about expressing... and attitudes"

P3: "I work with children and they just accept difference"

P2: "it's the external influences that make the difference"

P1: "I've noticed a change in my children since they've become more aware in everything in that I think it's harder for them to accept and see but then the opposite side of that is you are covering things up... I think children are more accepting as long as they know" (GI 4)

Participants noted how as a society Scotland can be a "put up shut up nation (GI 4). Thus, parents want their children to be aware of mental illness, rather than perpetuating a cycle of "yes, I feel fine...so it's about being honest with your children" (GI 4). Participants did however note that children under school age might find the concept of mental illness confusing. Therefore, it is important to adopt mental illness education into early tutelage.

Expressing personal experiences on canvas allows the public to view first-hand what a MHSU can experience in relation to the diagnosed disorder, daily coping, stigma, and both medical and non-medical positive benefits. Participants relate to this in group interview 1.

P2: "you're limited by how language works and how it's constructed and it doesn't really seem to fit in with how you feel so you don't get it quite right. Whereas artwork, there's no real language in artwork"

P1: "visually"

P3: "If you think of ourselves back when we first went to (the charity), I couldn't express myself, I couldn't concentrate, I didn't know what colours to choose... I thought how can I express myself, it really is difficult. It is only through confidence and as time passes that you get the ability to be more articulate through your artwork" (GI 1)

The exhibition provided the context to discuss MHSU experiences through a visual format of art. Creative strategies are beneficial in gaining an instinctive response from both MHSU and the general public viewing the artwork. Participants reported their thoughts of art as a proactive tool, group interview 2:

P2: "It's a hard thing to do"

R: "it is"

P2: "I've tried to write about mental health in words. You can't express it into words"

P2: "It's impossible and you get close to it with art"

P1: "I don't know, you can get relief through writing in words"

P2: "Maybe relief but you never get close to how it really feels, cos there aren't really words for it"

P1: "I think there's a route"

P2: "...you write but never get close to how you feel really, cos you're sort of confined by a set of..." "You can get closer with artwork" (GI 2)

The findings in relation to question 2, suggest that MHSUs' and general public awareness of mental health was raised from discussing and viewing the artwork. Visual art enables people to express themselves without language or words, which provide a person with freedom to express themselves.

**3. Can GP's, charities, and community organisations make more referrals, or provide publicity to support MHSU (often MHSU are not aware of support in their community)?**

MHSUs can be unaware of organisations that are available to support persons with a diagnosis of a mental health condition. MHSUs across group interviews reported how beneficial art based mental health organisations can be for this reason. Lack of awareness of the existence of such organisations is a factor in individuals not gaining non-medical support. Discussing non-availability of medical support participants noted:

P3:"I suffered from depression, em all last year and again I went to counselling and the GP and not once, cos you know I put it on my form I would have loved to come to something like this (the exhibition)"

R:"(the charity) used to target GP practices and give out flyers for giving to people" (GI 6)

Participants reported similar experiences and how they would have accessed support if they had been aware of such organisations in the community. This is further illustrated by participant's discussion in Group Interview 6:

P1:"I'll be totally honest I've been diagnosed with having bipolar"

R: "right"

P1: "and consider myself as a practising artist of stigma and I'm just leaving because I'm not coping very well with it..."

R: "I'm sorry to hear that"

P1: "I think it's nice to see, em, somebody else expressing themselves literally and I can totally relate to...to some of the work"

P1: "And both of us were just saying, in terms of me when I went to my GP and stuff like, they were very quick to rush you out, and I don't think its tailored in terms of, as not once has anybody said anything about this exists (the charity/art events) to me either in a sense of me coming in and being part of it or in a sense of me needing it myself"

R: "you had to find it (the charity) yourself" (GI 6)

Participants reported a lack of awareness of available funded projects in local communities. Participants noted it would be beneficial to have a link between health care providers and local organisations, so patients can have both a medical and holistic route to their well-being. Participants discussed how local bureaucracy does not help in accessing certain networks, in group interview 3:

P3: "But it's the system (mental health system) we're in, the bureaucracy"

R: "...the system"

P3: "And that's set in stone ... and it's us really floundering due to our mental state and we really can't fit into anything because we don't have the comprehension of thick and thin, you know all the other bits" (GI 3)

Findings suggest that artistic practice has encouraged MHSU expression of personal experiences of mental illness. Art as a discipline or as a tool can stimulate discussion with a positive impact on MHSU and raise awareness of the general public.

## 5.7 In summary

In summary all three questions generated from the group interview responses have often included metaphor. Metaphors were initially used to express participant views after seeing the exhibition. A selection of participants separately noted, for example, “breaking down barriers”, “to knock these walls down”, ‘they are very high and well-built walls”, “were a put up shut up nation”, “the thick and thin of it”, “brushed under the carpet” and “it is set in stone”.

In relation to question one, ‘Is the artwork generating awareness of mental health, for MHSU and/or the general public?’ participants responded noting the exhibition is “breaking down barriers”, and “to knock these walls down” of social attitudes. Question two, posed if ‘MHSU and the general public awareness raised from discussing artwork?’ noting ‘they are very high and well-built walls’ in reference to breaking down social prejudice. Group interview participants also noted, the artwork was expressing “the thick and thin of it”, and ‘they are very high and well-built walls’ to penetrate. In relation to gaining support from community based pathways ‘Can GP’s, charities, and community organisations make more referrals, publicity to support MHSU?’, participants noted “to knock these walls down” and gain support from local community organisations.

## **5.8 Discussion**

This study provides insight from MHSUs’ experiences and general public perspectives identified in relation to identified themes in study one (the workshops). The experiences of MHSUs’ in a closed workshop (study one), are

contrasted with an open, public exhibition of member's artwork (study two). Thus, shifts from an interpersonal to a public format. The context of study one was initiated in an interpersonal environment of discussion about personal experiences of mental illness between the researcher and the members. Displaying artwork in an exhibition leaves the artist (MHSU) open to judgment and debate about their artwork and the content from the general viewing public. This could have positive, negative or dual effects. The artwork produced by members in the workshops was created within an open, safe interpersonal environment whereas; the exhibition was viewed within a public forum.

In study 2B (the group interviews), participants demonstrated three core themes. The group interview findings support the research question 'Can art conscientise artists (MHSU/members) and audience (the general public)? The group interview findings suggest conscientisation can be generated from members of the public viewing the artwork. For example, findings of 'established new knowledge' suggest that consciousness can be raised. This is further illustrated in the group interview findings. The second research question "What is the impact of public display of the artwork on MHSUs' and the general public" shows group interview participants acknowledging stigma as a problem and that art can raise awareness. The artwork itself raised discussion and participant consciousness. For example, education is seen as an important step in generating awareness with children of a school age. By teaching children about mental illness it may reduce social anxiety and stigma about people with mental health issues.

### **5.8.1 The theoretical perspective**

The wider theoretical perspectives that informed the research questions were generated from a community critical psychology context. This intervention is understood from the theory that artwork created by MHSUs' about their experiences in the world will aid consciousness raising (conscientisation). This is understood from a theoretical perspective that involves certain assumptions about human social behaviour. The aim of this study was to develop an intervention that would enhance understanding of MHSUs' experiences in relation to increasing the general public's awareness of mental illness. Consequently, the research question was: 'Can art conscientise artists (MHSU/members) and audience (the general public)'?

The Artivism intervention shows an increase in public consciousness from viewing the exhibited artwork. Study 2A participant responses show an increase in awareness from questionnaire data, which highlight how greater publicity and advertising would contribute further generating awareness. The impact from displaying artwork, illustrate that MHSU's and the general public have benefited from study two. The main findings suggest that the general public have 1. Become more aware and/or conscious of the effects of mental illness, 2. Both MHSUs' and the public have become aware of community art related organisations that are available to MHSUs', and, 3. Conscientisation during study two has been identified within group interview transcripts.

### **5.8.2 Exhibition: Artwork**

When viewing art, the artwork demands to be interpreted in some way or form by the viewer. Consequently, the viewer's interpretation, personal preference and/or derived meaning can be related to events in the individual's personal life (Barrett, 1999). As previously noted the employment of art as a tool and the subsequent exhibition may exclude a section of the population who do not frequently view art. Though, when art is used as a tool it can empower people, building confidence, skills, and relationships with others and raise awareness of those marginalised in society (Scott-Smith, 2015).

### **5.8.3 Triangulation**

Triangulation of the data using different methods provided multiple understandings (Willig, 2004). The questionnaires provided a qualitative quantitative analysis of participant feedback, and this was coded into five categories. A quantitative approach was employed to provide the numerical values of categorised participant responses. The group interviews provided qualitative thematic analysis of 3 core themes.

### **5.8.4 Study 2A: Questionnaires**

The results from the analysis of numerical responses (quantitative) from the questionnaire data show agreement across study 2A (questionnaires) and study 2B (group interviews) analysis. The findings show that overall that existing knowledge and new knowledge increased regarding mental health awareness. The findings in relation study 2B, show agreement that MHSUs and the general public awareness of mental health were raised from viewing the artwork in the exhibition.

Participants showed agreement that the viewing of artwork had increased and developed their current knowledge of mental illness. Additionally, study 2 (the exhibition) would increase findings if greater publicity was achieved. Multiple questionnaire respondents noted that greater publicity and advertisement is vital to raising awareness of mental health issues via Artivism as an intervention. A referral system from community GPs' and community organisation would provide information that could benefit MHSUs' wellbeing.

An artist's journey from creating a piece, to exhibiting work, whether abstract or realist can be a daunting process, exposing inner emotions to interpretation and judgment by the viewing public. Educating society about mental illness is an important step in raising awareness in the general public as well as MHSU's (Scott-Smith, 2011). Thus, discovering sources of support and engaging in developing new knowledge to challenge problematic social attitudes is important. The benefits of employing public health campaigns about artistic practice are

beneficial in understanding MHSUs' and aid self-reflection (Stuckey and Nobel, 2010). Art as a practice and therapy is utilised 'to examine how individuals perceive and express change in themselves' (Hogan, 2003. P. 160).

Mark Rothko is an artist who lived with mental illness throughout his lifetime until his suicide in his late 60's (Ashton, 1996). Rothko was able to express his emotional content about depression, articulated through often muted and limited colour palette of dark hues of paint. Mental illness is experienced by one in four adults in the UK, throughout their lifetime ([www.who.int/whr/2001/media\\_centre/press\\_release/en/](http://www.who.int/whr/2001/media_centre/press_release/en/)). Thus, the visual arts as a practice can aid social understanding of mental health by raising public consciousness via visual expression on canvas. The visual image is a powerful tool to express emotions especially when it is difficult to find language to articulate those experiences. Thus, art can provide an anthropomorphised view of what mental illness may look like from an inside viewpoint (Cross, 2004).

#### **5.8.5 Study 2B: Group interviews**

The themes identified from the group interview analysis are comparable to study one (the workshops). A lack of power and control in relation to the links between stigma, support and being proactive are a common thread. Employing art as a proactive tool, to engineer interpersonal and public discussion is an important element in future research. It would also be feasible to generate a list of vetted support networks and community organisations for GP practices to distribute. In relation to this project a list of support organisations for individuals with mental health disorders and individuals with disabilities would be very helpful.

## **Chapter six: Discussion**

“Liberation is a praxis: the action and reflection of men and women upon their world in order to transform it” (Freire, 1970, p. 60).

### **6.1 Aim of Research**

In the practice of reflection members of society can evolve to challenge problematic social attitudes in example by viewing and engaging in projects comparable to the Artivism Intervention. Stigma is a problem for people in everyday settings, medical encounters, at work, and with friends. In Scotland, 9 out of 10 people experience stigma daily ([www.seemescotland.org/stigma-discrimination/](http://www.seemescotland.org/stigma-discrimination/)). Foucault (1980) noted that power “reaches into the very grain

of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives” (Foucault 1980, p.30). The Artivism intervention aimed to challenge specific social attitudinal responses by producing art that can make people question what they see and the effects social attitudes can produce. Power inequality in minority groups can make a person “internalise the dominant cultural narratives about themselves” (Moane, 2003, p.93). This can be problematic for people thus the process of conscientisation can aid consciousness, awareness. Conscientisation is a theoretically problematic process to define measure and induce. The Artivism Intervention held real life benefits of engaging in conscientising practices can develop social benefits in friendships, be therapeutic, aid wellbeing and laughter in MHSUs. Thus, this chapter will aim to discuss two questions posed within this thesis. Each research query will be discussed in relation to the thesis overall and in particular the two empirical chapters.

## **6.2 Research questions**

1. Can art conscientise artists (MHSU, members) and audience (the general public)?
2. Are MHSU’s and the general public’s awareness of stigma related to mental health and possible solutions, raised from discussing artwork?

To address these questions, the research assessed the Artivism intervention, and specifically aimed to assess how art and critical discussion may stimulate

conscientisation. On a wider level the positive impacts of creating art and critical discussion via consciousness raising created support through the friendships participants fostered within the project. Further social awareness was raised via members of the public viewing the exhibition (Scott-Smith, 2013). Activism is a proactive practice using the visual arts to document MHSUs daily experiences. In this research, art was used as a tool to express experiences of mental health onto canvas (Chapter four), and to exhibit the artwork produced to the general public (Chapter five). Martin Baró (1996) states that conscientisation is a response “to a situation of injustice by promoting critical consciousness of the objective and subjective roots of social alienation” (Martin Baró, 1996, p.42). Thus, MHSUs and the general public can develop an awareness of the psychological, socio-political realities that can aid oppression. In the current research conscientisation is defined as a multi-level process with an aim to raise group consciousness, public awareness, and praxis (see chapter one). Praxis is defined as action, reflection and generating new knowledge. The aim of the intervention was to conscientise, through changing an individual or group’s reality and awareness.

### **6.3 Summary of the research strategy and setting**

The background to the research included the contrast between what may broadly be termed the medical and social models of health. The medical model is sometimes referred to as the ‘individual model’ because it promotes the concept that it is the individual person who is required to adapt to the way in which society is constructed and structured in order to overcome illness (Markova and Farr,

1995). However, the social model aims to remove social attitudinal barriers that are often projected onto people with disabilities and/or mental illness. The removal of discrimination requires a change of approach and thinking. Beginning with a recognition that society has been socially constructed and thus, can be deconstructed (Burr, 2007). As this research aimed to show, there are multiple initiatives that could aid challenging attitudes which this chapter will discuss. Publicity, and providing minority groups with an intervention to enable MHSUs to get their experiences across to the public can challenge and change attitudes (Asante, 2009). A piece by a Reachout member, included below, highlights the effects of stigma (Scott-Smith, 2011).

Figure 5.1 The psychologist Magazine: The Artivism Intervention



Chapter two provided more specific background and analysis of the research setting by examining the history and constitution of the charity over a 17 year period, providing insight into changes over this period. As an established mental health, drama and arts organisation, members were free to challenge problematic social attitudinal barriers towards mental illness and disability. Chapter two highlighted the evolving power structures and agenda of the charity, and how it relates to its own membership. The specific aim of this chapter was to identify how the charity has evolved from an initial members-led organisation with collective decision making, a chair person, membership and a management committee. As a charity, it is subject to internal and external reviews and monitoring by OSCR (Scottish charity regulator). The charity aims to both

empower its members and the community in promoting the benefits of tackling mental illness and disability through a 'bottom-up' approach. The charity aims to challenge the social conditions and attitudes "which deprive so many people from the opportunities to be healthy" (Stephens, 2008. p. 239). This chapter aimed to understand the historical background of the charity as an organisation that was membership led. A documented interview with the charity founder and interpretation of the 1995 and 2009 constitutions provided an understanding of how the charity has evolved from a critically proactive drama based group to a more therapeutic art based group. The consequences of the change from a critical drama phase (1995) to an art therapeutic phase (2009) chart a reduction in political activism which had evolved over a period of time.

Chapter three aimed to provide an insight into what methodologies were employed and why. A mixed-methods approach was employed using thematic analysis of qualitative data for the workshops, and a quantitative (questionnaires) and qualitative thematic approach (group interviews) to the exhibition. This mixed-methods approach was utilised to gain triangulated data from multiple perspectives on the impact of the intervention.

Chapter four was the first empirical chapter. It provided an overview of the workshops and the thematic analysis from the transcripts. The analysis identified two overarching themes: (1), lack of power and control (seen as negative effects): (2), well-being (seen as positive effects). Each super theme contained sub

themes which share characteristics within healthcare and/or society. These were: Healthcare related to diagnosis; doctors; medication and negative emotion, which fit under the super theme of a lack of power and control. Society related issues such as stigma, support, community, 'Reachout', advocacy, art and positive emotion fit under the super theme of well-being. The main experiences MHSUs discussed were related to medical encounters within a healthcare setting and/or experiences and attitudes from the general public. Sub-themes across both positive and negative participant extracts were shared between linked themes on advocacy, with positive links to medication. The analysis highlighted MHSUs experiences of being and not being listened to, with discussion over medication and specialist treatment. Themes of power and control, and wellbeing emerged in relation to doctor patient interactions, highlighting a dilemma over maintaining good health whilst remaining empowered.

Chapter five presented analysis and findings from the Artivism exhibition, which was held in the library at The University of Stirling, Scotland. Analysis of the questionnaire (study 2A) and group interviews (study 2B) data indicated that the Artivism intervention did begin to effectively challenge stigmatising views about mental illness in society. The group interviews in particular involved discussion between artists and members of the public, in contrast to the interpersonal expression of experiences within the workshops. The analysis found that a positive increase of awareness was established from viewing the exhibition. The findings in study 2A show that existing knowledge and new knowledge increased regarding mental health awareness. The findings in relation to study 2B, confirm

that MHSUs and the general public's awareness of mental health were raised from viewing the artwork in the exhibition. One weakness identified was the relatively low numbers attending the exhibition, limiting its 'reach'. Many questionnaire respondents noted that greater publicity and advertisement would be vital to raising awareness of mental health issues via Artivism as an intervention.

#### **6.4 Study 2B: group interviews**

The findings from study 2B suggest that both MHSUs and the general public's awareness of mental illness was raised from viewing and discussing the exhibited artwork. The group interviews instigated insightful discussion among attending exhibition viewers.

#### **6.5 Outcomes**

With regard to the workshops, the findings suggest that conscientisation was not clearly evident. An emphasis instead on coping with the more individual-level dilemmas of seeking well-being through medical treatment, and remaining empowered was highlighted. Part of the reason for this effect is the workshops which involved a long-standing, proactive community group. The researcher had worked with the group in multiple previous studies, utilising innovative proactive strategies, such as a mutual learning project between undergraduate psychology students and charity members (see chapter two). Thus, the group were already an aware, proactive, political activist group. In reflection, the group may have

already been conscientised by their involvement in previous proaction projects. Charity members often attended psychology lectures that were available for the local community to attend. Future research would therefore benefit from approaching a non-proactive community group in order to examine the development of conscientisation from an earlier point in the process of awareness development.

It is nevertheless important to note that the Artivism Intervention was a six month project in two parts. Thus, the process of participating in the workshops, and the critical discussions they fostered, were vital to the success of the exhibition, which produced evidence of conscientisation. In other words, conscientisation may not have occurred within the workshops themselves, but the more general participation in the Artivism intervention ultimately generated positive effects on MHSUs and the general public.

What emerged more clearly from the workshops was that they allowed friendships to form from the weekly encounters over the initial three month period. Members found solidarity in discussing experiences of social attitudes and stigma. Advocacy was a positive theme highlighted in the findings from multiple participants in study one as a positive, proactive action in aiding healthcare and reducing the possible effects of stigma. The relationships MHSU formed were an unexpected positive outcome from the research. This process itself engendered well-being, confidence and encouraged members to actively develop friendships

as well as learning new art skills. Although not formally included in the analysis in Chapter 4, the atmospheres of the workshops themselves were full of laughter and storytelling experiences. Friendships and solidarity between members were formed and carried through into positive reactions to the exhibition of members' artwork. The workshops engendered social support and friendship which can improve self-efficacy and therefore reduce self-stigma and improve social integration.

## **6.6 Contributions of the present research**

There are limited studies available that have employed research strategies via Artivism, to explore conscientisation with MHSUs and the general public, within a community critical psychology ethos. In Wang et al. (1998) PAR project a sample of 62 non proactive village women with limited healthcare employed Photovoice (photography) methodology to raise awareness and community change. This study achieved the objective of raising awareness with policy makers who provided a midwifery programme and scholarships to improve the local women's lives. Wang et al. (1998) study worked with non-proactive women to gain change within a village with high levels of poverty and limited medical care. Further, the use of photography provided an impact to policy makers to make changes. Thus, any change in living circumstances would have benefited the participants.

The Artivism Intervention employed a PAR project with a sample of 18 politically and proactive Reachout (charity) members. The trust built between the

researcher and members provided access to the group. The relationships generated, artistic skills and knowledge gained by the workshops and the culminating exhibition had a positive effect on members. The Photovoice methodology was used as a visual tool to aid discussion between participants and researcher. This was not classified as Artivism, but it incorporates visual imagery to challenge the reality of a disadvantaged minority group.

The Artivism Intervention engaged with MHSUs to create artwork alongside discussion to shape their experiences into a visual format for the viewing public to see. Further, The Artivism Intervention participants were free to create art on their chosen experiences on mental illness. The village women in China wanted to keep good relations with their neighbours thus self-censorship occurred within their photography. The Artivism Intervention enabled voices to be heard from a novel perspective on community members challenging social awareness on mental illness and disability.

Brydon-Miller's (2014) evaluation of community based participatory action research (PAR) projects. Further, aimed to generate knowledge from the effect that negative social representations can have on an individual's wellbeing using drama and art practices. Further Freire (1970) influenced Brydon-Miller (2014) in developing an ethos to aid critical understanding by engaging in conscientisation to understand how societal factors shape individual experience. Current artists and researchers including EINE, Shepard Fairley, Caroline Wang and Bansky,

have utilised and generated their own form of Activism. To project a public awareness of specific issues related to their personal art forms and/or research (see chapter one). Historical artists including Edvard Munch 'The scream' (1893), and Diego Velázquez 'Les Meninas' (1656) produced artwork that reflected, mental anguish and pain, with Velázquez's depiction of power structures. Foucault (1966) suggests the painting is structured to reflect information about wealth, power, difference and beauty. In relation to this research, art is employed not purely as an aesthetic but that each painting has a different reality, dependent on the artist (MHSU) of the piece (artwork). Supplementary to aesthetic pleasure the artwork created from the Activism Intervention provides a snap shot of a reality other than our own. In this sense the art often depicted adversity experienced due to stigma and misunderstanding of mental illness and disability. Many contemporary artists and politically engaged artists deliberately produce art that is unattractive. Danto (2004) termed the phrase "beauty phobia" where a critical art is political art expressing topics of social injustice and political struggles. However, Asavei, (2015) states that "not everything looks beautiful is in fact beautiful" there are other layers and purposes of art and not just the aesthetic (Asavei, 2015. P1). The broad aim of this research was to understand if art (when used as a tool) could generate critical discussion about (MHSU) experiences, thus challenge awareness. This outcome was clearly evident in the paintings produced. In figure 5.2 a members expresses their experiences of medication in 'Blue pill'. The artwork is unskilled but creates a message to the viewing public.

Figure 5.2. 'Blue pill' Artwork by Member D



Artivism has been used to challenge other facets of medical model health care practices. Regina Holliday became a leading advocate for health-care reform in the United States of America. Regina used street art as a means to tell her story and to bring attention to the problems of the current American health care system (Barr, 2013). The Artivism Intervention relates to Holliday (Barr, 2013) by both projects using art exhibited in public to raise awareness of the lack of health treatment and support. The Artivism Intervention gained publicity through publications, radio programmes and being active in mental health campaigns. In using the visual arts has an immediate impact on the general public viewing the work, albeit in an exhibition, magazine, or journal article. An image tells a story, in a quick glance thus The Artivism Intervention aimed to challenge societal

preconceptions on mental illness and disability. It also provided a space to be listened to, gain solidarity, relationships, knowledge, new skills and importantly challenge stereotypes and stigma on mental health and disability (Scott-Smith, 2011).

A key finding of the present research is the relationship between lack of power/control and wellbeing in relation to mental health service users' experience within healthcare and society. Being disempowered and stigmatised by being labelled can have a negative impact on an individual. The Artivism Intervention is an example of MHSUs interpretation and public presentation of their personal experiences of daily life, medical encounters, and social attitudes to mental illness (Stirling Minds, 2015). Martin Baró (1996) understands conscientisation not just in terms of a simple change of an opinion about reality, but "that persons change in the process of changing their relations with the surrounding environment and, above all, with other people" (Martin Baró, 1996, p. 40-41). The public exhibition offered the MHSUs an opportunity to develop a shared understanding of their work and their experience of mental health issues with the general public, in the spirit of Baró understanding of conscientisation.

## **6.7 Real life implications**

In terms of practical implications, the research suggests that charitable organisations and community support groups – and in particular those that provide a forum for making sense of and expressing one's experiences. These

can be vital to getting people back into society, not least through making society itself more receptive to discussing these issues. The context within which MHSUs currently operate is important. When MHSUs are discharged from hospital within the UK, they have to undergo an assessment to ascertain they are medically fit to vacate. All hospitals within the UK have separate discharge policies, although MHSUs must be supported via an assessed care plan (<https://www.nice.org.uk/guidance/cg136/chapter/guidance>). A care plan should be supported by community care services, in the patient's local authority. MHSUs care plan should be checked and revised employing integrated care pathways (ICPs), to support MHSUs in the local community aiding recovery ([http://www.icptoolkit.org/adult\\_and\\_older\\_pathways.aspx](http://www.icptoolkit.org/adult_and_older_pathways.aspx)).

Against this background, the unique potential for interventions such as Artivism is clear. For example, the Artivism intervention could be incorporated into MHSUs care pathway in the community to aid future recovery and well-being. In the workshops many MHSUs expressed feeling isolated, vulnerable and disempowered by their diagnosis and experiences, both socially and medically (see Chapter 4). The Artivism intervention provided MHSUs an opportunity to give voice and imagery to their experiences through producing their artwork. In turn, through exhibiting their work, MHSUs were able to express these experiences to the public. Thus, the intervention has the potential for positive benefits both at the level of the individual MHSUs wellbeing, and at the more general level of societal attitudes.

In terms of process, conscientisation or consciousness raising as a process that can enable a person the opportunity to challenge his or her reality, by engaging in dialogue (Martin Baró, 1996). This process cannot be taught as such, but is dependent on engaging with other proactive individuals. Through this process individuals should become more aware of their surrounding reality and how they can challenge it from their raised awareness. If the Artivism intervention was developed as a treatment pathway it could generate greater feelings of well-being in MHSUs via building confidence and an awareness of their surrounding reality. Thus, conscientisation is an important feature to challenging greater awareness of mental illness within a community and thus can aid feeling of wellbeing and recovery.

## **6.8 Critical reflections and future suggestions**

Since the completion of this research it has become apparent that wider circulation of the exhibition is needed to raise awareness. Publicity and the general public's awareness of stigma need to be improved. The NHS in Greater Glasgow and Clyde, Scotland produced the 'See Me' campaigns (<https://www.seemescotland.org/>), which could potentially provide a vehicle for increasing the effectiveness of the intervention in terms of wider consciousness raising. That is, the conscientising effect of the intervention may have been limited by the narrow scope of the exhibition phase.

It is also the case that the research could have been approached using different methodologies and targeted different organisations. In particular, the methods employed here were not well-defined in advance; instead, they were developed opportunistically as the research progressed. This organic, collaborative approach reflected the community, liberating psychology approach that informed the project as a whole. This novel approach gained the trust and good relations between participants taking part. The downside of this approach is that the project could in hindsight have benefitted from a more extensive questionnaire using previously validated scales. For example, a more structured and controlled group interviews or larger focus group methods. This methodological pay-off should be balanced by the fact that access to and sensitivity of the Activism Intervention and the MHSUs who participated would have been incompatible with a top-down, 'external' research process. That would be imposing outsider understandings and methods that are likely to have been perceived as invasive and even potentially threatening. While acknowledging the limits of the methods employed in the project, these methods – and their sensitivity to the participants themselves were part of what made the project possible in the first place.

### **6.9 Role as researcher, artist and collaborator**

More generally, I adopted multiple roles throughout, including those of researcher, artist, and as a disabled person. These different stances and perspectives undoubtedly influenced the research through my own experiences of stigma, and of how art can challenge and be a tool within research. I aimed to tackle my own research bias by collaborating with the participants on most

aspects of the research process and immersing myself in trying to understand their own experiences while also facilitating the process of creating their art. Again, this represents a necessary trade-off between the need for subjective involvement and sensitivity on the hand, and a more detached analytic stance on the other. It is important to bear this in mind when evaluating and interpreting the findings, both in terms of the biases and subjectivities that it introduces, and in terms of how it made the research viable.

### **6.10 Reflectivity**

On reflection the overall strengths and limitations of the research process and directions for future work have been significant. Study one (chapter 4) aimed to generate conscientisation as a group process; this was limited due to working with an already sophisticated knowledgeable proactive group. Reachout: With Arts in Mind (charity) had previously been involved in both community and international proaction projects. Future research would address this, by working with a less politically proactive group. Study two (the exhibition), gained insight into the general public's views and opinions of mental illness. Study 2A (chapter 5) suggested that the exhibition had been educational and had raised awareness. Artivism as a proactive practice gained positive feedback with a possibility of future research via developing a patient pathway project with funding. Study 2B (chapter 5) gained insight into and understanding of MHSUs and the publics' opinions on mental illness and the views it generates from society. Consciousness raising was revealed via participant excerpts representing the public's view point. The chosen methodologies generated rich data, but on

reflection a more reliable methodology of developing a questionnaire and group interviews could have improved the research. However it may have lost the relationships and trust built within this research project, without which this research would not have taken place.

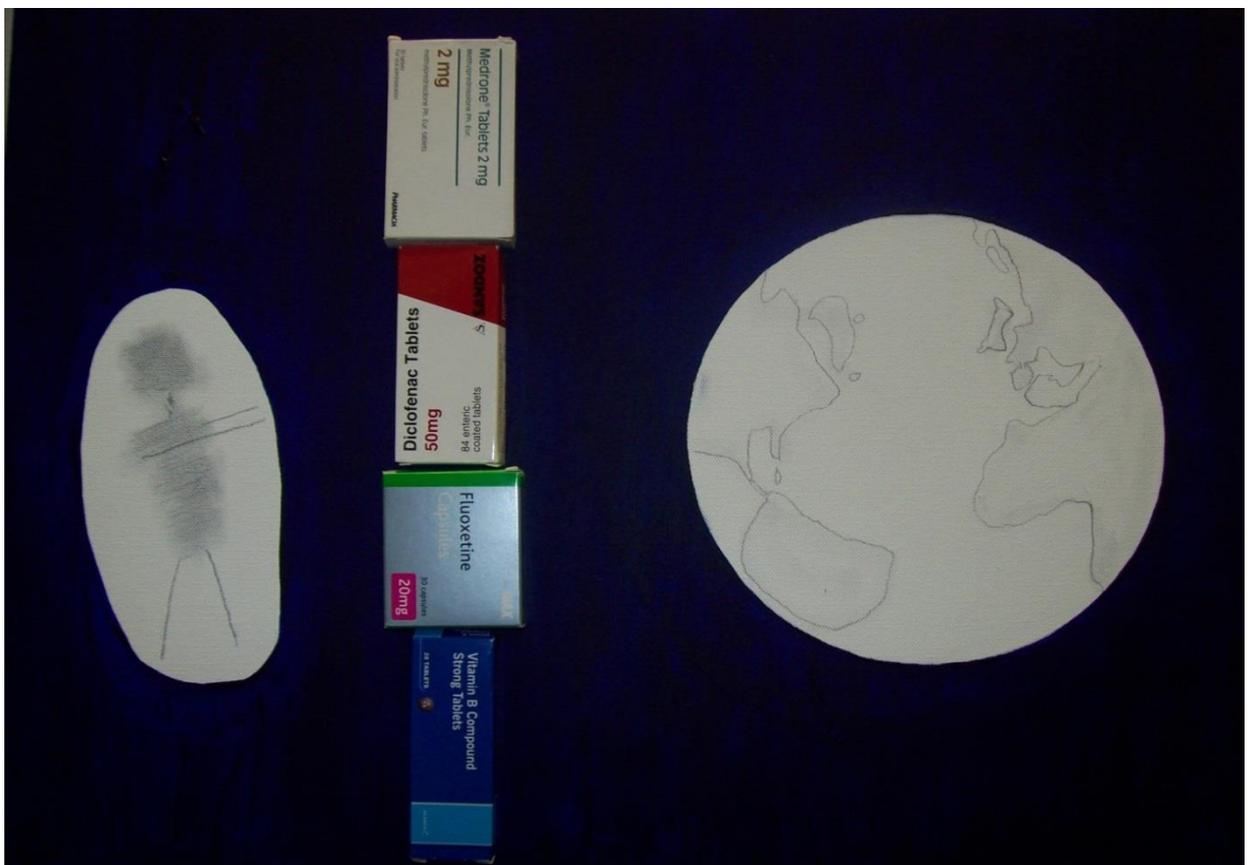
### **6.11 Conclusion**

The research presented in this thesis has provided new knowledge in a field where there has been minimal previous work. Thus, specifically the potential practices for an Activism intervention to conscientise MHSUs and members of the general public. Overall, the present research has found that the Activism Intervention has the potential to generate constructive and positive changes within mental health care. In relation to question one: Can art conscientise artists (MHSU, members) and audience (the general public)? There was limited evidence of conscientisation in practice in creating the art, it was however evident during the process of exhibiting the artwork. This is not only in terms of MHSUs awareness about and engaging with wider society, but also in terms of MHSUs engaging with each other through the process of creating the artwork. In relation to question 2: Are MHSU's and the general public's awareness of stigma related to mental health and possible solutions, raised from discussing artwork? The solidarity, laughter and self-understanding that this fostered had benefits beyond pharmacological and therapeutic treatments outcomes. In practical terms, this research has highlighted the potential for integrating 'activist' community-based groups and interventions into care plans for MHSUs. This is both, in terms of the

benefits for users themselves but also in terms of the potential to positively challenge societal attitudes.

Figure 5.3 'The Wall and me' highlights the effects of physical, psychological and pharmacological experiences of having a mental illness. There is the individual (fuzzy incomplete), the wall (the medication taken) and the World (to take part in). This member's artwork shows the power of the visual image and how she wants to be part of the World, not outside, not medicated just living with good wellbeing.

Figure 5.3. 'The wall and me'



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