# An Autoethnological Study of Art as a Tool of Empowerment

By

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# Abstract

Empowerment is important for those with mental illness as they are often stigmatized and/or experience self-stigma. This thesis examines the connections between art and empowerment for people with mental illness through a Disability Studies lens. I Adopted a social model perspective and used Crip, Disability and Feminist theories as the theoretical framework; artmaking is explored as a key element in gaining empowerment and reducing stigma. Using autoethnography this thesis examines the author's experiences with mental illness through memories, personal journals and artwork dating back to childhood. As most research into the lives of those with mental illness is not written by those who have mental illnesses, this thesis differs as it does just that, which is important so that people with disabilities can add their perspective and experiences to the literature available to provide a more accurate and complex description of mental illness.

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# Preface

This thesis examines my personal experiences with mental illness, stigma, art and empowerment. I was diagnosed with major depressive disorder and borderline personality disorder as a young adult and have been hospitalized as a result over the years. When I was first diagnosed it was very difficult to accept my situation. While it was comforting to know that there was a name and explanation for what I was experiencing, I felt as though this diagnosis would dictate how the rest of my life would go. By meeting other artists who had been diagnosed with mental illness who were leading productive and happy lives I began to see that this could be an option for me as well. Having positive role models with mental illness was very important for me as I began to accept my diagnosis.

This thesis was an opportunity for me to study my experiences with mental illness, the good and the bad. I was able to see that art was a valuable tool for me to combat the stigma and shame I felt because of my disability. Art allowed me to express my feelings and experiences in a manner that was beneficial for me. Meeting other women artists with disabilities through my work with MAWA (Mentoring Artists in Women's Art) and AANM (Art AccessAbility Network of Manitoba), I noticed that other artists who had similar experiences as me also used art as a medium to express their experiences.

I felt that it was important to add my perspective and journey to the mental illness literature because there is a lack of academic research done by people *with* mental illness *about* mental illness. While there is more and more being written about disabilities by those with disabilities ((Jago), (Klein), (Fraser)) there is still a significant gap to fill... it is my hope that this thesis will add to the literature of disability and help address this gap.

# Introduction

All my life art has been a tool I have used to help express feelings and emotions. From the time I was a small child to this day, art has been a positive force in my life. I have had a challenging time speaking to others about what I feel. Art allows me to illustrate what I am feeling instead. Most times when I am feeling depressed, I will draw a self-portrait, such as Figure 1 on this page, *Silent Sorrow*. This image is a charcoal drawing of a woman crying with her mouth closed tightly. Sometimes I will draw myself with words attached to the image to express the thoughts going through my head. At other times I draw myself with injuries to illustrate the internal pain I feel. With my art piece, *Silent Sorrow*, I wanted to illustrate the difficulty of trying to hold my emotions within myself. In my journey of mental illness, art has played a critical role in aiding me with symptom management and connecting me with other artists with disabilities who have used art in empowering ways and encouraged me to do the same. For example, my work with artists with disabilities through the Arts AccessAbility Network of Manitoba (AANM) has opened my eyes to how art can be used in a political way by creating a space within the art world for disability art (disability art being a way to explore the conceptual ideas and physical realities of what it means to be disabled through artwork).

Fig. 1 (Shaw, *Silent Sorrow)*

Before I began to write about my experience and journey, I examined numerous research studies related to art, mental illness and empowerment (Garland-Thomson), (Hessling), (Abbott), (Driedger), etc. By examining this I was able to gain a better understanding of current knowledge within this area of study. I also noticed that many of the articles that examine mental illness or disability appear to be written by those who do not have mental illness or disabilities. Because mental illness can at times be hidden, it is difficult to say whether the literature written about mental illness was written by those with mental illness or not. Given mental illness's past and current stigmatization it would not be surprising to learn that professionals in the mental illness sector had mental illnesses themselves yet chose to remain silent. However, I believe that it is important now to break that silence. It is important to break that silence so that those who will be diagnosed with mental illness will not feel as though they must hide this part of themselves as I did. This silence represents a gap in the literature, one that I hope to address by writing about my experiences of mental illness from the perspective of someone who lives with mental illness. Next, I examine key theories such as feminist theory, disability theory and Crip theory, which form the basis of my research. All three theories provide key definitions and methods that aid me as I do my research. I then provide relevant research for autoethnography, which is my chosen methodology. Autoethnography is a research method that uses authors' experiences as their data source. It was important for me to find a methodology which would allow me to examine my experiences with mental illness and art in an academic manner without silencing my voice. Finally, I relate my experiences in three parts: the early years, the learning years, and the empowering years. By organizing my thesis in this manner, I was able to create a timeline which reflects my journey from childhood and learning to cope with me mental illness to becoming empowered as an artist with disabilities.

## Literature Review

Searching the University of Manitoba digital databases, I used the following key words in different combinations: “mental illness”, “art”, “stigma”, “symptom management”, and “empowerment”. I found numerous links between the articles about the stigma associated with mental illness. In addition, I found connections between creativity and mental illness. Finally, I looked at the use of art as therapy, and the politics of disability art. I examine these relationships in the sections below.

### Mental Illness and Stigma

Historically, people with disabilities have experienced stigma and it remains so today (Corrigan et al.), (Thornicroft et al.) (Hasson-Ohayon et al.). Stigma has been defined as, “a ‘mark’ that signals to others that an individual possesses an attribute reducing him or her from being “whole and usual” to being “tainted and discredited”” (Pescosolido 3). This phenomenon occurs in diverse ways in varying degrees and is dependent on many factors. First, stigma affects those with invisible disabilities differently than those with visible disabilities. At times, people with mental illness can chose to “pass” as non-disabled by not disclosing their medical history (Davis 154). “Passing” is when someone with a disability can pass as able-bodied by not disclosing their disability because there are no outward or physical signs of the disability. This can be a double-edged sword for those with invisible disabilities. While “passing” as non-disabled may allow an individual to avoid being stigmatized or stereotyped, it is a battle to convince others that you do indeed have a disability. Davis states, “those whose disabilities are invisible may also have to convince other people that they really are *disabled,* not seeking some special—unfair—advantage” (154, emphasis in original). Secondly, there are many different forms of stigma. I have chosen to focus on two types of stigma that affected me as an individual with mental illness; public stigma and self-stigma.

Public stigma refers to “individuals being categorized into a particular group (e.g., mentally ill) and once categorized, the general public comes to devalue the group and interpret all characteristics in terms of this categorization” (Brown 534). This categorization can be viewed in the stereotypes of mental illness that exist. What do these stereotypes look like in terms of mental illness? Corrigan and Watson explain that there are three common misconceptions of mental illness: that those with mental illness are homicidal, childlike or rebellious and free (36). In terms of homicidal, or the violence associated with those with mental illness, a review of media and mass communications illustrates and perpetuates the pervasiveness of this thinking.

Media and mass communications is one of the ways in which we can examine public stigma. Corrigan et al. explain, “mass communication sources including the news provides fundamental frameworks through which most Americans and Westerners come to perceive and understand the contemporary world” (483). Therefore, the stories which are highlighted on the news have a major impact on how certain individuals are categorized and viewed. Corrigan et al. examined numerous studies and surveys that focus on the stories told and written about people with mental illness. They found that “survey analyses in several English-speaking countries have shown that newspapers frequently frame mental illness in a stigmatizing manner. Most articles discuss people with mental illness in terms of dangerousness or violent crime” (483). While they do acknowledge that these types of stories are becoming less prevalent, there are still many stories that deal with the threat of people with mental illness and very few positive stories about mental illness. Media plays an important role in public thought as “viewing media material relevant to mental illness is believed to influence stigma in a predominantly negative manner” (Brown 534).

This stigmatization can affect the public's understanding of mental illness and of individuals who are living with it. Corrigan and Watson found that "Research has shown that even well-trained professionals from most mental health disciplines subscribe to stereotypes about mental illness" (36). It is disheartening to note that even those who know and interact with people with mental illness daily are susceptible to the influence of stereotypes and stigmatization.

Another issue that people with mental illness face is that they are viewed as being personally responsible for their mental illness. Corrigan and Watson explain "Unlike physical disability, persons with mental illness are perceived by the public to be in control of their disability and responsible for causing them" (37). I have experienced this misperception myself. There have been many incidents when I have shared with others my feelings and experiences with depression and they have told me to "pull myself out of it" or they believe that all I need to do is "move forward" when it is not so simple. Furthermore, the stigma of mental illness can be internalized causing further harm to the individual with mental illness. I personally have dealt with self-stigma and continue to do so. When I was first diagnosed with mental illness, I had a tough time accepting my diagnosis because I was ashamed. I felt that if I was only strong enough, I would be able to deal with my issues on my own. I felt that I was of less value to others and myself because of my diagnosis. While I have worked hard over the years to overcome these feelings of self-stigma it is an issue that I continue to struggle with to this day.

Self stigma is defined as "The process in which one internalizes the public stigma of mental illness over oneself" (Hasson-Ohayon et al. 802). In the case of self stigma, the individual can suffer from low self-esteem and diminished self-efficacy (Corrigan and Watson 47). Those that endure self-stigma will think less of themselves and believe that they are incapable of success. At times, especially when dealing with negative emotions and thoughts, I am much more susceptible to stigmatizing thoughts and words. For example, when I am feeling depressed, I often have negative thoughts such as “I am worthless” or “I am not good enough.” This combined with the low self-esteem that accompanies self-stigma makes it that much harder to control my negative thoughts and feelings. This means that it often takes me longer to get out of my depression which means that I suffer more than I would normally if I did not experience self-stigma.

Usually at these times I try to focus on reading positive stories of mental illness or interacting with others with mental illness to counter balance the stigma I feel within myself. When I need an uplifting story, I often read *Maternity Rolls: Pregnancy, Childbirth and Disability* by Heather Kuttai. In this book Kuttai explains her journey growing up in a wheelchair after an accident as a child. Although she meets much adversity, she grows up to become an Olympian in the Special Olympics as well as a mother. Her bravery in telling her story, with all the gritty details, good and bad, has helped empower me to write my own story.

## Connections Between Creativity and Mental Illness

I noted during my research that Prinzhorn, Vernon and Baughman, Glazer, and Fink et al. all use the term “madness” (in a negative manner), and that this usage remains prevalent. For example, while discussing Vincent Van Gogh, a Dutch Post-Impressionist painter from the 1800s, Prinzhorn states, “the madman painted a series of pictures of grandness unparalleled in contemporary art” (20). While this is an example of the use of the term “mad” from the 1930s, its use continues today, although in an increasingly positive fashion. Toronto’s Mad Pride website for example, explains that “Mad Pride emerged out of many historical movements for self-determination and dignity, including Black Liberation, Women’s Liberation, ‘Mad liberation’, anti-psychiatry, ex-psychiatric patient, self-reliance, anti-poverty, consumer survivor, service user and other movements" ("History"). Mad Pride works to reclaim the words "mad" and "madness" including the use of these words in festivals and marches. For example, every year Toronto holds a week-long event called Mad Pride which includes many events such as performances as well as key note speakers ("History"). Schrader et al., state "these celebrations of a shared mad culture, like the reclamation of terms such as 'craziness' and 'lunacy,' have helped solidify madness as a culturally meaningful and active sociopolitical minority identity" (62). While many organizations, such as Toronto Mad pride, have done much to reclaim these words, I prefer the term "mental illness" versus "mad". This personal preference reflects growing up with a mother who was a psychiatric nurse who helped me to understand what was happening to me when I thought I was "going crazy". My mother helped me to identify what was happening and to not be embarrassed to have a mental illness. For example, when I was reluctant to take my medication my mother would often remind me that mental illness was like any other illness or condition. She would tell me that taking medication for depression is just like taking medication for anything else, like diabetes, and that there was nothing to be ashamed of. She would remind me that it was more important to be healthy and stable then to try to do without the medication. As a result, I prefer the term "mental illness" and will use it throughout this thesis, even though the articles I examined sometimes use the term "mad".

When looking at the connections between creativity and mental illness there is a widely-held consensus that a link exists. As Glazer notes, "the knowledge of a link between creativity and madness has persisted throughout history. Socrates and Plato were both aware of the association, while over the past century questions of creativity and madness have entered the world of scientific research, fueling debates about the nature of this association" (755). To study the link between creativity and mental illness, the articles reviewed took different paths and angles. For example, Veron and Baughman consider how mental illness is reflected in the artists' work. Cardinal analyses the category of Outsider art or "art brut" and *who* fits into this category. Outsider art is defined as "a mode of original artistic expression which thrives on its independence, shunning the public sphere and the art market" (Cardinal 1459). Nelson also examines the term "Outsider art" and its connections with Deaf and disability art. The articles by Fink et al, Acar and Runco, and Neihart probe the issue more scientifically, by conducting different studies.

Veron and Baughman examine different artists and how their disability affected their work. For example, when speaking of Jackson Pollock, an American painter who was a major figure in the abstract expressionist movement during the 1940s and 1950s, his disability (depression and alcoholism) is seen in "the regression and internalized rage which are dynamic formulates of the disease [which] are characterized by the violent themes in his art and his unprecedented painting techniques" (416). They claim that you can perceive his disability through his work. Veron and Baughman use examples of three other artists' work (Vincent Van Gogh, Edvard Munch, and Paul Gauguin) to prove that the artists' works are "often non-verbal manifestations of these unconscious affects or feelings" (420). They do acknowledge that when the artists' psychological disabilities are at an advanced stage, their work is no longer of the same high quality. Veron and Baughman state "It is only when primary process and affectivity overwhelmed them in psychosis and their cognitive powers disintegrated that artists become unable to mobilize their technical and formal skills to the expression of their feelings" (420). Psychosis or psychotic symptoms is defined as follows; "the narrowest definition of psychotic is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A slightly less restrictive definition would also include prominent hallucinations that the individual realizes are hallucinatory experiences" (*Diagnostic and Statistical Manual of Mental Disorders 273)*.

Vernon and Baughman seem to suggest that there is a limited time between when the artist is beginning their psychosis and can express themselves artistically in new and liberating ways (by using their experiences and feelings during psychosis) and when their psychosis advances to the point where they are no longer able to create artwork. For example, because a psychosis is a condition that can progress to the point in which the individual cannot know if the reality, they experience is the same as others are experiencing (see definition of psychosis) they may not be able to create artwork at all. From my personal experiences, I believe all artwork created, regardless of the artists' state of mind, can be good art and do not agree that there are periods when art creating is not possible.

Cardinal looks at the term "art brut" or Outsider art. He states he contributed to the development of the term "Outsider art" and therefore is in a position of authority to speak on the subject. While many scholars have seen disability, especially psychological disability, as one of the mandates for Outsider art, Cardinal disagrees. He contends:

> "the criteria for Outsider Art (art brut) are sufficiently flexible to embrace not only art arising within the context of extreme mental dysfunction, but also art produced by individuals who are quite capable of handling their social lives but who recoil, consciously or unconsciously, from the notion of art being necessarily a publicly defined activity with communally recognized standards" (1459)

Cardinal asserts that the term Outsider art should not be used solely as a category for artists with disabilities. He states, "I insist that Outsider Art earns its name not because of an association with a lurid case history or a sensational biography, but because it offers its audience a thrilling visual experience" (1460). He explains throughout his article that one does not need to be disabled or lacking comforts in life to create Outsider art. He looks to the exotic types of techniques used by the artists, as well as art that looks different from mainstream art when deciding whether a piece of artwork should be considered Outsider art rather than examining the mental state or biography of the artist. Using biographies to sensationalize artwork is also addressed by Nelson as she states, "another challenge in the display of Outsider art is the ongoing fetishization of the artists' biographies rather than celebration on the artists' work" (102). In this sense, Cardinal differs from Veron and Baughman as he examines solely the work created, while Veron and Baughman examine biographies to posit how their psychosis affected their work.

The following articles examine the link between creativity and mental illness scientifically. That is, they conduct studies using populations of people to determine the links between creativity and mental illness. Fink et al. is the dissemination of one study concerning this subject. Acar and Runco use meta-analysis to examine many studies concerning the associations between creativity and mental illness. Meta-analysis is when the researcher examines many similar studies and compares their results with each other to draw conclusions. In this study, Acar and Runco found that the link between creativity and mental illness occurs only occasionally and could not be generalized. Neihart conducted a brief historical review which examined the possible links between creativity and mental illness. However, she came to a different conclusion than Acar and Runco by observing that those with mental illness *do* tend to be more creative in general.

Fink et al. recruited a total of 69 participants which included two clinical and two non-clinical of participants. For the clinical samples, they recruited a group of alcohol dependants and polysubstance dependants who were involved in long-term therapy. For the non-clinical samples, a group of actors and a group of university students participated. They then used several tests to gauge creativity, personality and latent inhibition. Latent inhibition or L.I. “refers to the capacity of the brain to screen events that were previously experienced as irrelevant from conscious awareness” (Fink et al. 11). Fink et al. state that “creative individuals are assumed to be more capable of shifting between secondary and primary modes of thinking, or to ‘regress’ to primary process cognition, which is needed in the generation of novel, original ideas” (12). This means that people who have a low-level latent inhibition (L.I.) tend to be more creative and at risk for psychosis (Chirila and Feldman, 355) than those with a high level of L.I.. Fink et al. conclude that “creative individuals do not tend to screen things from conscious awareness that were previously experienced as irrelevant” (16). This then, is thought to be what allows individuals to be more creative. In other words, what may be irrelevant to someone with a higher level of L. I. is not irrelevant for someone with a lower level of L.I., which leads to them being able to be more creative.

Acar and Runco examine the connections between creativity and psychoticism which is defined as “A dispositional variable or trait predisposing people to functional psychotic disorders of all types” (341). To do this, they do a meta-analytic review of thirty-two previous studies which examine the associations between creativity and psychoticism. Acar and Runco state that “creativity and psychopathology may have only an occasional and very specific relationship rather than a broad and general one” (347). They further stress that the role of personality traits in creativity is an area that deserves further study in the future (348).

Neihart reviews numerous past studies to draw her conclusions surrounding creativity and mental illness. After her review of historical and scientific findings in this area she makes two key findings. First, that “it appears that the potential for creativity is enhanced by the cognitive changes that occur within some mental states" (49). Secondly, that "There is a higher incidence of creatively gifted people among certain mental disorders than in the general population" (49). Taken together, these two conclusions indicate that creativity is higher among those with mental disorders and that during changes in their mental state there is a higher chance of creativity than in the general population.

The conclusion that creativity and mental illness are associated appears to be well-founded. The uncertainty lies in figuring out *how* they are related. People with mental illness may be more likely to be creative because of a latent inhibition (L.I.), or it may be a result of a fluctuating state of mind, or it could be something that we have yet to discover. Either way, the connection *is* there according to this research.

## Art as Therapy

This section examines the benefits of art as therapy for people with mental illness both in terms of symptom management and empowerment. It is important to note that there is a difference between Art Therapy and art *as* therapy. For example, while I have never participated in Art Therapy, I find creating artwork very therapeutic. Many of the studies examined in this section speak of Art Therapy, which is artwork created in therapeutic settings. Kapitan defines effective Art Therapy as requiring "collaboration between the therapeutic expertise of the art therapist and that of the clients who are experts about their priorities, concerns, and cultural traditions and values" (3). To distinguish between Art Therapy and art *as* therapy, I will capitalize Art Therapy when I am speaking about the practice of creating artwork with an art therapist.

Most of the research focused on specific disabilities such as Depression or Borderline Personality Disorder. Major Depressive Disorder is “characterized by one or more Major Depressive Episodes (i.e., at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression)” (*Diagnostic and Statistical Manual of Mental Disorders,* 317). Borderline Personality Disorder or BPD is defined as “a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity” (*Diagnostic and Statistical Manual of Mental Disorders, 629).* Many studies (Heenan), (Bar-Sela et al.), (Van Lith) explained the multitude of benefits of art as therapy for those with mental illness. Morgan et al. invited people with BPD to write about their experiences with Emergence (a user-led not for profit organization working to improve the lives of those with a BPD diagnosis) and art therapy. They explain, “interpersonal relationships are often excruciatingly difficult for people who are given a diagnosis of borderline personality disorder” (Morgan et al. 93). This difficulty causes those with a BPD diagnosis to have a challenging time when they attempt to form a therapeutic relationship (Morgan et al. 93), which is why art therapy can be very useful for these individuals. Morgan et al. further explains that art can act as a mediator between the individual with BPD and the therapist (94).

Regarding depression, Blomdahl et al. and Gussak agree that art creation helps reduce symptoms and allow for non-verbal communications. Blomdahl et al. state “The creative phase provides an opportunity to express feelings and to clarify inner experiences and beliefs” (323). Gussak explains that “art can diminish pathological symptoms without verbal communication” (446). In both cases, the use of non-verbal communication is very important. As a person who has been diagnosed with both BPD and Depression, I know from personal experience that expressing your feelings can be very difficult and often painful. The use of art allowed me to express my feelings and experiences with others when I was unable to communicate verbally. I could use my art as a vehicle to talk about and explain what I was undergoing with others by showing them what I felt through my artworks. Furthermore, art therapy allows one to forget the stresses around them and concentrate on the moment at hand (Morgan et al. 96). Many times, when I am making art I almost go into a trance, I am so concentrated on my work that the world around me seems to disappear. I always feel refreshed and relaxed after these art sessions.

The benefits of art therapy in reducing symptoms and creating communication can go even further by helping those with mental illness to reduce feelings of self-stigmatization as well as combat the public stigmatization of those with mental illness. To explore this, Van Lith, Potash et al. and Morris and Willis-Rauch all study the ways in which art therapy (both in its creation and the display of work created in this setting) can help combat all forms of stigmatization. Van Lith explains, "Artistic self-exploration saturates the image with meaning so that previously inaccessible and fragmented parts of the self find a place to become known. Thus, people with mental illness may reduce their sense of stigmatization by recovering a fractured part of self-identity" (6). By creating art that reflects one's inner self, one can recover that inner self and create a more stable and whole self-identity. Morris and Willis-Rauch echo the use of art therapy to reduce stigma by stating "Art therapy in inpatient psychiatric settings may help reduce stigma because it necessitates active engagement and decision making by participants" (29). In this situation, it is the active involvement of the individuals with mental illness, which helps to reduce stigma and create empowerment. Potash et al. state that "Art created in art therapy may be especially useful for the purpose of social change, as it is created with the intent of promoting self-realizations, communication and social experience" (736). This implies that displaying artwork created in art therapy can be used to help reduce the stigma associated with mental illness. While this may be true, it can be problematic to use art created by ‘clients’ to promote social change. Before any artwork created in these settings is used publicly, I believe it would be important to review the ethical issue of using ‘clients’ work as well as ensuring that proper informed consent was established.

To further explore the idea of using artwork created by those with mental illness to generate social change, Potash et al. recruited a group of people who were related to those with disabilities as well as those who work professionally with people with disabilities and held a workshop. Those recruited were asked to fill out questionnaires before, during, and after the viewing of the work created by artists with mental illness based on the theme “Something I want to share about my life with someone else” (Potash et al. 736). Many of the participants gave positive responses in reflection on the artwork in terms of empathy, “Participants indicated empathy through statements such as, ‘it [art] made me feel the same’, ‘the artwork and I shared something in common, it struck a chord with me’ and ‘I felt that way, too’” (Potash et al. 738). Potash et al. conclude that their study showed how creating and viewing art can be used as “an opportunity for communication, point of meeting and reflective activity” (743).

These studies illustrate how art-based therapy can be useful for individuals with mental illness in a multitude of ways. They also show how the viewing of artwork created in these settings can be instructive and create discussion about living with mental illness.

## Disability Art and Politics

In this section, I examine disability art and politics in diverse ways. The majority of research I reviewed examines the nature of disability art and who falls into the category of disability artist or artist with a disability (Eisenhauer), (Roman), (Solvang), (Nelson). For example, Eisenhauer explains that "Disability culture reflects a diverse group of people with physical or mental conditions that result in a common culture of discrimination, experience stigmatization, segregation, and medicalization" (7). Two articles examine the barriers and benefits of disability art ((Lewis), (Boeltzig et al.)). Boeltzig et al. explain "for young disabled people one potential arena for employment is the arts" (753). The remaining studies examined the representation of those with disabilities and how art can help change negative stereotypes (Sandell and Dodd), (Garland-Thomson), (Fraser), (Preston). For example, Fraser states "My practice has often been to use my own body as an intervention in society's misconceived and clichéd perceptions of Disability, especially of the identity imaging of Disability" (254).

To be a disability artist, Nelson asserts "one must create work that *represents* one or more disability cultures, or one must self-identify as an artist whose *intent* is to advance the professional status of disability artists" (105, emphasis in original). Therefore, to be a disability artist one must self-identify as disabled and have similar political inclinations as the disability art movement. Solvang echoes these sentiments stating, "Disability art originated in political movements of the 1980s…they emphasize the intimate relation between disability art and disability politics, and exclude both artists with disabilities who do not identify themselves as disabled and art as therapy…the collective experience of disability is in the forefront, and the artworks are valued for their ability to empower people with pride and solidarity" (181). This implies that to be a *disability artist* one must self-identify as a person with a disability and create work that empowers people. If one does not do this, then one is an *artist with a disability*. Eisenhauer reiterates this idea stating, "Within the Disability Arts Movement a critical distinction is made between disabled people doing art and disability artists" (9). These quotations illustrate the importance of the terminology associated with disability art. Who and what artworks are included in the category of disability art is important as disability art goes beyond the work created as it is a political movement. Therefore, an association with art therapy or with Outsider art can be detrimental to the disabled artist who is pursuing a political or professional path. Solvang explains that "Art therapy itself is not perceived as a problem, but for the artist struggling for recognition in the cultural field, being perceived as a patient seems like discrimination" (183). It is therefore important to draw a line between art therapy and disability art. When someone with disabilities is trying to make a career as an artist or is making a political statement through their artwork it is important that their work is not seen through a medicalized lens (i.e. art therapy), but for what it is, disability art.

Now that I have distinguished disability artists from artists with disabilities, let us turn to the term "disability art" and what exactly is meant by this term. Nelson explains "Deaf and disability arts incorporate the distinct experiences and perspectives of people living with disabilities. Disability artists not only are responsible for creating art but must simultaneously consider the ways in which their art *represents* disability culture" (104, emphasis in original). In this definition, disability art is political in that the art represents disability culture and the disability perspective. Solvang agrees with the political nature of disability art stating, "Disability art has been defined and developed in close relation to disability activism" (180). Therefore, disability art is political art. One of the ways in which disability art is pushing the political agenda of the disability rights movement is through representations of disability.

Up to this point, I have focused on research which distinguishes the disability art movement from artwork created by people with disabilities. I will now examine some of the social barriers that impede artists with disabilities. Boeltzig et al. examines the barriers and benefits of an arts career by reporting on the experiences of forty-seven young disabled artists. They explain that the barriers they face include “lack of access to the arts community; architectural and programmatic barriers to participation; financial disincentives (restrictions on or loss of benefits); the misperceptions that art is not a credible career pathway, along with limited access to training and education, partly due to the stereotypes and low expectations of disabled people held by education and arts professionals” (754). Lewis uses her firsthand experiences in attempting to attain professional theatre training to illustrate barriers that existed in the past. She states, “The school would not, could not accept me as an acting student. Childhood polio had left me with a pronounced limp and an atrophied leg. They said I would never work as a professional actor. If I wanted to seek medical advice and somehow eliminate the disability, they might reconsider” (29). This is an example of social barriers that existed/exist for people attempting to enter and develop a professional arts career. While this example illustrates what took place in the 1960s-70s, Lewis further explains that similar situations remain today, “The barriers are still formidable: In many cases a state's department of rehabilitation will refuse to provide financial support to disabled students seeking professional training in the performing arts” (30). Along with social/physical/financial barriers that exist, one of the most problematic barriers is the negative stereotypes of disability which create real systemic barriers for people with disabilities.

Stereotypes of disability and depictions of disability play a significant role in the lives of those living with disabilities. Sandell and Dodd state “Public portrayals of disabled people have effects and consequences which – though slippery, diffuse and difficult to trace – are nevertheless ubiquitous and capable of powerfully shaping disabled people’s lives in innumerable and very tangible ways” (3). The public portrayal of disability is also taken up by Garland-Thomson who explains “most prevalent pictures of people with disability have come to us through the genres of freak show photography, charity campaigns or medical photography” (23). These images shape the way people view those with disabilities. Fraser speaks about how the media portray those with disabilities: “Media imaging habitually uses disabled people as a warning, for pity inducing, for scare tactics, for sympathy, for schadenfreude, and in general for othering, and rendering us the eternal Outsider” (247). Preston further clarifies how portrayals affect those with disabilities by stating “I argue that popular culture enforces myths of disability based on three common myths; the hero, the villain, and the burden/child” (165). After reviewing these articles, it is clear that those with disabilities are often stereotyped in the media, in campaigns and in other forms of public portrayal. The articles also suggest ways that we can combat these stereotypes with the use of art and performance, such as Matt Fraser explains in his article.

Matt Fraser (an actor with a physical disability), uses his own body to combat these stereotypes. He states, “My practice has often been to use my own body as an intervention in Society’s misconceived and clichéd perceptions of Disability, especially of the identity imaging of Disability” (245). Sandell and Dodd examine three works of art that depict people with disabilities; in a realistic as opposed to idealized manner *Franklin Delano Roosevelt Memorial* monument by Robert Graham in Washington DC, *Alison Lapper Pregnant* by Marc Quinn in London’s Trafalgar Square, and *Black Dog* commissioned by Rethink in Norwich, England (7). In all three cases the public reaction to these statues was explosive. While many disability activists applauded the work done by the artists in illustrating the real lives of those with disabilities, others were outraged with the portrayals (Sandell and Dodd, 7-10). To better understand these reactions, it will help to examine one piece more in-depth: Marc Quinn's piece *Alison Lapper Pregnant* (Figure 2). In 2005 Quinn created a realistic statue of Alison Lapper, a fellow artist and a woman with disabilities, while she was pregnant. The statue depicts Lapper naked, who was diagnosed with phocomelia when born and therefore has no arms and undeveloped legs. This artwork was displayed in London's Trafalgar Square. Sandell and Dodd explain, "the debate which unfolded in newspapers over the following days and months saw supporters of Quinn's statue praising the quality of the art and highlighting its potential to challenge viewers' preconceptions about disabled people…Interesting several critics, and also members of the public debating the statue on the online pages of national newspapers, describing the statue as 'disgusting' and 'repellent'" (8-9).

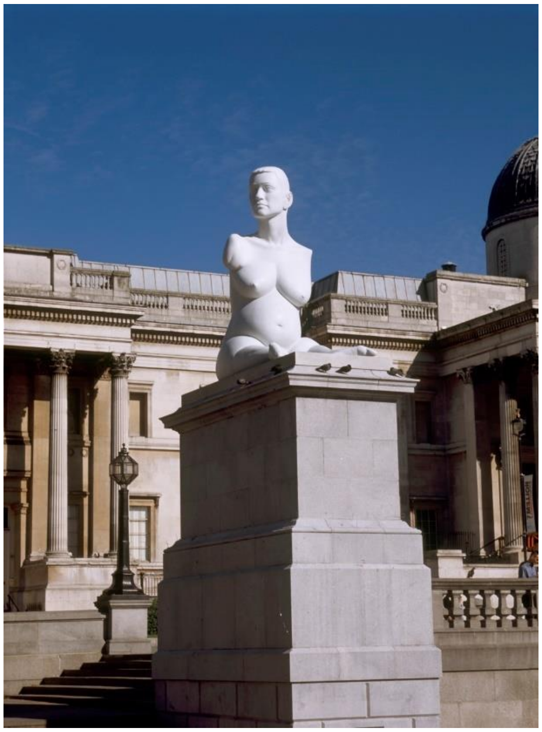

Fig. 2. (Quinn, *Alison Lapper Pregnant)*

While some reactions to controversial artwork such as Quinn's may be negative, it is important to continue to push the boundaries of disability to create a dialogue. These artworks allowed the public to begin talking about disability, which is important as disability has been and continues to be a taboo subject. Garland-Thomson examines the benefits of classical portraiture including how it can give power to the subject. She states, "A conservative representational genre can act in the service of a progressive politics of inclusion" ("Picturing People with Disabilities: Classical Portraiture as Reconstructive Narrative." 24). In these articles, the authors illustrate how art can be used to combat disability stereotypes.

### Conclusion

The literature reviewed deals with mental illness and art in different ways; mental illness and stigma, the connections between creativity and art, art as therapy and the politics of disability art. While reviewing the materials, I noted that many of these studies were written by either professionals or non-disabled individuals. While there were some authors that spoke of their own work, there is a need for more to be written from the perspective of the disabled individual. As a person with a disability and as a part of the academic world, I can address this gap. Because my research is based in my experiences and memories of living with a mental illness I can study and analyze those experiences using my methodology, autoethnography, which is discussed further in my methodology section.

## Theoretical Approaches

### Disability Theory

There are three main models of disability: the medical model, the social model, and the charity model of disability.  The medical model "focuses on the disadvantaging impact of physical or mental impairments rather than that of the environment in which they operate. The impairments themselves are thought to be disabling" (Samaha 1256). The social model "defines 'disability' as disadvantage caused by the confluence of (1) personal impairment and (2) a setting compromising architecture, economics, politics, culture, social norms, aesthetic values, and assumptions about ability" (Samaha 1257). The charity model "constructs people with disabilities as childlike victims to be pitied and paternalistically 'helped'" (Rohrer 38). I speak about the charity model in this section solely to illustrate the problematic ways that some people view disability. The charity model is outdated and can be dubious for those with disabilities as it marks them as a victim of their impairment and leaves no room for those with disabilities to empower themselves and be independent. For this project, I explore the marginalization of individuals. It therefore makes sense to use the social definition of disability as it includes the idea that disability is not solely based on a person's conditions but also is shaped by the society in which they live.

As we do not yet live in a society in which all impairments and conditions are solely disabling because of marginalization or exclusion, it is important to acknowledge certain aspects of the medical model of disability. For instance, because many disabilities require some sort of medical attention, such as my mental illness which requires medication and therapy, I believe it is important to acknowledge the medical model of disability. The charity model also gives insight into how in many cases, people with disabilities continue to be perceived. It is one of the ideas that disability activists continue to work against.

I choose to define disability with a combination of both the social and medical model, with more emphasis on the social model.

One of the advocates of the medical model of disability, John Harris, defines disability as "a physical or mental condition we have a strong [rational] preference not to be in" (97). As Harris uses the term "we" in this statement he is excluding the disability voice and giving his personal opinion of disability, not a definition. While I understand not wanting to have to deal with the difficulties of impairment, I would not willingly have my "impairment" cured as I feel that this condition is part of me and has made me more aware of the marginalization of others. I have firsthand experiences of being marginalized because of my disability and can therefor easily recognize when it happens to others. While I might not know exactly how it is like for another, I can more fully sympathize with others in similar situations. These experiences have been very useful to me as a scholar as well as an activist in disability rights. I would not take back my years of depression, but I understand that this is not a condition that someone would want to be in. While this definition does have some merit, it ignores the social marginalization of those with impairments by placing the problem of the disability on the individual with the impairment who needs to be rehabilitated versus on the environment of the society that creates situations in which a person's impairment becomes a disability. Wendell explains "Social arrangements can make a biological condition more or less relevant in almost any situation" (35). As Wendell explains, it is the way we shape our environment and our practices that affect how people with disabilities live in the world. For this reason, the social model of disability offers more in terms of research into the lives of people with disabilities.

Stienstra explains that "The challenge for those pursuing disability rights is to discover the ways in which we marginalize people with impairments" (3). Woodill states "because the meaning of disability can be seen as social construction, rather than… [A] 'natural' condition, the way is open for a change in their current meaning of disability" (203). Creating new definitions of disability, especially those created by people with disabilities themselves, is one way to empower those with disabilities to been seen not as medical curiosities but real and whole people who are discriminated against and marginalized because of their disabilities.

John Harris states, "The principle which we all share, is that all persons are equal and none are less equal than others. No disability, however slight, nor however severe, implies lesser moral, political or ethical status, worth or value" ("One Principle and Three Fallacies of Disability Studies" 383). This idea is further explored by Davis. She explains that both visible and invisible impairments and conditions have certain social consequences. Those with invisible disabilities can avoid stigmatization attached to those with visible disabilities yet may encounter difficulty in having their disability acknowledged. Davis states “When individuals are not “seen” as disabled, it can be more difficult for them to secure the assistance or accommodation they need to function effectively” (154). As Harris implies with his definition, all people with disabilities should be equal to all persons; it is important to note that people with visible and invisible impairments and conditions experience marginalization in diverse ways.

O’Day and Killeen provide an integrated definition that combines both the social model and the medical model of disability: “Disability is not simply a condition characterizing individuals who have limited functioning but is also the product of the interaction between individuals and their surroundings” (9). This definition acknowledges the real lived experiences of people with disabilities in that it recognizes that they experience the world differently because of their impairments and are also impacted by how others (and themselves) view their disability.

Rohrer adds to this debate by stating, “more recently there is a growing debate about the need to revise the narrow conception of the social model to include discussions of impairment and to trouble the neat bifurcation of nature and culture” (38). By this Rohrer means that looking at the world through dualistic lenses, i.e. viewing everything as “black or white”, denies the interaction and effect of all aspects of the human experience. Furthermore, “Alexa Schriemphf critiques the social model… ‘The social model, in focusing on the social construction of disability, has amputated disabled (especially women’s) bodies from their impairments and their biological and social needs’” (Rohrer 54). Schriemphf’s observations on the social model of disability as limiting reinforces the need of disability activists to acknowledge that people with different impairments and disabilities experience the world differently not just because of social opinions of them, but also their real experiences of living with those impairments and disabilities. By combining the medical and social definitions of disability we develop a more realistic definition. Disability is both a physical and/or mental condition, as well as a socially constructed condition that causes individuals to become disabled and marginalized within a given society.

### Feminist Theory

When I first began my university journey, I knew very little about feminism. I was majoring in honours mathematics. I noticed that as I got further along into my degree the number of women versus men in the courses was unbalanced. The women in the class seemed to drop away after the first year or second year. By my third year in the program I was the only woman in most of my courses. This left me wondering why. I decided to take several women and gender courses to figure out why there was this discrepancy. This decision changed the course of my academic career. I fell in love with feminism and activism. I began to understand the gendered bias that exists in our society and wanted to help to change this bias. I changed my major from honours mathematics to honours women and gender studies to study the reasons why gender inequality exists. Following this path, I also discovered disability studies and ableism. As a woman with mental illness feminism helped me to understand the world around me and my place in it.

Feminism has played a very important role in my life. Before I give a definition of feminism it should be acknowledged that there are a multitude of different definitions of feminism as well as many types of feminist theories, I chose this specific definition because it clarifies what I believe to be the most important aspects of feminism for me and my life. Ackerly and True states that “Feminism is the search to render visible and to explain patterns of injustice in organizations, behavior, and normative values that systemically manifest themselves in gender- differentiated ways” (464). This definition resonates with me as it speaks of normative values which is something that I am especially interested in as a woman with a disability. Being perceived as "normal" is something that people with disability often face, especially those with invisible disabilities such as my mental illness. I believe that feminism creates a space to talk about more than just gender; it is a lens through which many differences can be examined including sexuality, race or ability.

Feminism acknowledges that there are many intersecting identities of a person that can affect the way they are viewed and treated by society. The International Women's Development Agency explains that intersectionality "encompasses more than just the intersections of race and gender. It's now widely used to illustrate the interplay between *any* kinds of discrimination, whether it's based on gender, race, age, class, socioeconomic status, physical or mental ability, gender or sexual identity, religion, or ethnicity" (IWDA). For example, I myself am a white, heterosexual, middle class woman with mental illness. Because I am white, I never have to worry about being prejudged based on my skin color. Yet as a woman, I may be paid less than a man for the same job. As a member of the middle class, I rarely worry about where my next meal comes from. But as someone with mental illness I worry about being stereotyped negatively. Every person has different identities that interact with social systems in different ways which can lead to more or less discrimination. The theory of intersectionality is an important theory that grew from feminism.

Feminism is important because inequality affects all parts of life including disability. The intersection of gender and disability is important to acknowledge as it can affect women with disabilities in many ways. As stated in the definition, feminism provides a lens through which to see the world and perceive the differences of equality that exist is our society. For example, feminism is important for women with visible disabilities because our society is often influenced by patriarchal ideas which views these women as non-sexual beings compared to visibly able-bodied women who are often seen as sexual objects. Ferri and Gregg state, "in describing the construction of gender and sexuality as influenced by the presence of a disability…the eternal poster child image categorizes women with disabilities as absent of sexuality" (432). This quotation is a good example of how disability and gender can intersect. Garland-Thomson states, "Feminist theory can offer profound insights, methods, and perspectives that would deepen disability studies" ("Integrating Disability, Transforming Feminist Theory" 2).

One such insight that feminism provides is the analysis of power relations. There are diverse types of power relations that exist in our society; rich and poor, men and woman, able-bodied and disabled. In terms of mental illness, one of the most important power relations that I have encountered is that of doctor and patient. This is a perfect example of how feminist theory insights into power relationships can help disability theory by offering another way to look at the issue of disability. In terms of mental illness, the doctor is in the position of authority and knowledge while the patient had less social and political power. As someone who has been admitted to a psych ward in a Winnipeg hospital, I have encountered the power relationship between patient and doctor. At times the relationship is balanced, and I am included in my diagnosis and treatment; other times it is not balanced. Examining why power relations exist and how they function in society has allowed me to better understand my rights when I am in hospital.

In 1969, Carol Hanisch was the first to state that "The personal is political." Hanisch states "Personal problems are political problems. There are no personal solutions at this time. There is only collective action for a collective solution" (114). This slogan was widely used in the second wave of feminism to explain why women's issues were important. Schuster states that, "Second wave feminism [is] a feminist ideology that developed in the west since the late 1960s and is mainly concerned with structural disadvantages of women living in a patriarchy" (648). While this slogan was originally used to better understand patriarchy, it is an idea that can be and has been used in disability theory.  Because the political is personal, personal stories of experiences of disability become politically charged when published. This relates to the experiences of those with disabilities being heard in mainstream society. For example, by writing my thesis about my own history with mental illness, I am using my personal experiences to make a political statement about disability. That statement is that the disability movement is important as well as the feminist movement and any other movement that pushes the rights of the marginalized forward. Feminism offers different perspectives to look at power relations. Feminism also created a space for personal stories in a politically charged world.

In conclusion, there are three main theories or ideas from feminism that I will utilize in this thesis: the theory of intersectionality, the theory of power relations, and the political is personal. These three ideas will help me to better analyze my different experiences with mental illness in our society.

## Crip Theory

Crip theory is important for research into the lives of people with disabilities. The term Crip is "considered to be an inclusive term, representing all disabilities: people with vastly divergent physical and psychological differences. Crip represents the contemporary disability rights wave and is an "insider" term for disability culture…the term Crip within the disability community reflects the political reclaiming of the historically derogatory term "cripple,"" (Williams).

Crip theory does what feminist theory and queer theory has done before in that it further complicates the idea of identity. Crip theory emphasizes "the importance of studying or bearing witness to the myriad resistant ways in which individuals and groups have 'claimed disability'" (McRuer 164)  Moreover, Crip theory works against "compulsory able-bodiedness" (McRuer, *Crip Theory: Cultural Signs of Queerness and Disability,* 9).

Adrienne Rich explains that it is through compulsory heterosexuality that "Lesbian experience is perceived on a scale ranging from deviant to abhorrent or simply rendered invisible" (632). Just as compulsory heterosexuality indicates that heterosexual views and experiences are more valued than homosexual views and experiences, compulsory able-bodiedness indicates that the views and experiences of the able-bodied are more valued than less-able-bodied. Crip theory dismisses the equation of disability with deformity, ugliness, dependence; instead Crip theorists embrace the word "Crip" to develop new meaning.

Crip theory is a tool with which to combat negative representations by reclaiming "Crip" and "disability" as areas of pride, similar to the way that "queer" has been reclaimed by some LGBTQ2+ communities. Brontsema explains, "the first instance of queer's public reclamation came from Queer Nation…this new coalition chose 'Queer Nation' as its name because of its confrontational nature…for a coalition committed to fighting homophobia and "queerbashing" through confrontation, queer…was certainly an appropriate—perhaps perfect—choice" (4). In a comparable way, Crip theory helps the disability movement to reclaim the terms "Crip" and "disability". Löfgren-Mårtenson speaks about Crip theory stating, "by claiming the power of the terms themselves and appropriating them, the perspective is reversed and the stigma embraced" (414).

Crip theory works to show the ways in which those with impairments can become proud of who they are and view themselves (and have others view them) as full and useful members of society. One of the first steps in doing so is to question able-bodiedness and its mental health equivalent as the ultimate goals of personhood. I would never give up my mental illness as it makes me who I am and has opened doors to me that otherwise may have been closed. My research and growth as a scholar has made me prouder than ever to self-identify as a disabled artist.

## Conclusion

The three theories discussed above (disability theory, feminist theory, and Crip theory) will form the theoretical background for my thesis. Each offers diverse definitions, methods, and perspectives that augment my work.

Disability theory is vital firstly to give a definition of disability, that disability is both a physical and/or mental condition, as well as a socially constructed condition that causes individuals to become disabled and marginalized within a given society. This definition includes both the physical/mental realities of disability as well as acknowledging that most of what makes a condition "disabling" is a result of socially constructed ideas of what disability is and means.

Feminist theory is vital as I am a woman, and patriarchal conditions still exist in our society. Feminist theory gives methods to view power relations and speak about them. It also provides the theory of intersectionality which allows for a discussion on how different "isms" (ableism, racism etc.) interact with each other. Finally, feminist theory is important as it expresses that the personal is political and provides a platform for those who have been silenced in the past to speak up and express their personal experiences politically.

Crip theory is important because it complicates identity, so that it can be acknowledged that there are many factors that make up a person's identity, not just one defining factors or characteristic. Furthermore, Crip theory examines the concept of compulsory able-bodiedness which places higher value on those who are able-bodied. Finally, Crip theory gives a space for those with disabilities to express their pride in their community. This is very important for me as I am writing from a disability perspective and wish to acknowledge the ways in which disability can be empowering.

# Methodology Review

## Introduction

When I was deciding the type of methodology to use for my thesis, I stumbled upon a book by Carolyn Ellis called *The Ethnographic I: a methodological novel about autoethnography.* I was so blown away by this book that I read it cover to cover within days. In this book, Ellis defines and explains autoethnography through a story. The idea of creating a story to present research intrigued me. The more I read about autoethnography, the more certain I was that this was the methodology for me. I have always been creative, and this methodology allowed for that. In fact, it encourages it. This section will further explain the process of autoethnography and its place within the academic world.

### <u>Autoethnography:</u>

Autoethnography is a contemporary methodology by which the researcher examines their own life and experiences to gain insider information into culture being researched. The term "autoethnography" can be divided into two parts; "auto" which refers to the self and "ethnography" which refers to the study of a culture. Farrell et al. states that autoethnography combines “autobiographical narrative detail with a cultural analysis and interpretation” (975). I will examine the details of my personal history to show how it relates to others in similar situations and how these experiences help shape what we think about disability. Autoethnography is especially important for disability studies as the stories that we hear about disability usually come from doctors or other figures of authority (Russo and Beresford 153). The voice of those who live with disabilities is rarely heard and it is important to give voice to those who are silenced. Richards explains “People living with disability or illness are seen as objects of study and not agents of study” (1719). Therefore, by using autoethnography I will be an active agent in examining my own experiences with disability and art. This methodology will allow me to convey my experiences in my own voice.

The value of autoethnography is that it allows for self-examination, enabling voices that are sometimes silenced to be heard and it can provide insight for others in similar situations (Russo and Beresford 153). In terms of self-examination, autoethnography is important because it allows you to look at your own experiences more critically and objectively, which can allow for new insight. Anderson states “Autoethnography provides an opportunity to explore some aspects of our social lives in a deeper and more sustained manner” (390). By analyzing and generalizing to the larger culture your own experiences, you can fully understand why certain things occurred and why you reacted to them in the ways that you did. Jones explains “It (autoethnography) takes the therapeutic use of self one step further by integrating the professional’s feelings, biases, beliefs, and concerns into narrative form” (578). The therapeutic use of self is “a term used to encapsulate the therapist’s role in working consciously with the interpersonal side of the therapeutic relationship to facilitate an optimal experience and outcome for the client” (Solman and Clouston

514). Therefore, as I explore my experiences with mental illness, I will be able to have a better understanding of these experiences. This is exactly what did occur for me as I wrote about myself. I was better able to see how my experiences with mental illness helped to shape who I am. As a result, I was left with an understanding of how my experiences could help others by opening a discussion of mental illness.

Allowing disabled voices to be heard is very important within disability studies. For this reason, autoethnography provides an ideal method for those who are disabled academics. Denzin states "autoethnographic work must always be interventionist, seeking to give notice to those who may otherwise not be allowed to tell their story or who are denied a voice to speak" (6). Historically those with disabilities have not been able to tell their stories. It has always been the doctors or nurses who have told the stories. Of course, as I mentioned earlier on in this thesis, we can not know whether these nurses and doctors were disabled themselves. The importance of autoethnography in disability studies is that it encourages the author to fully disclose their personal details to create a more nuanced and complicated picture of disability.

Crepaz-Keay and Kalathil explain that it is important for those with mental illness to tell their stories to help balance: "The overwhelming majority of material written about those who are labelled mad by those who do the labelling and those who study them" (pars 9). It is important that those with disabilities speak out so that we are represented the way that we wish to be. As an individual who is proud to be disabled, I feel it is especially important for me to tell my story as it can provide a positive image of what it really is like to live with mental illness. Denshire states, "Embodied auto-ethnographic accounts of professional practice in health and disability studies…can reconfigure power relations, opening out disembodied renderings of experience and remaking practice interactions" (840). As someone who has admitted themselves to a psychiatric facility, I have firsthand experience dealing with the unbalanced power relations that exist between patient and practitioner. As a patient, you have less power than the doctor. It is the doctor who prescribes the medication. The doctor decides if you can go outside unsupervised for cigarette breaks or walks. And many times, it is the doctor who decides when you can be discharged. These power relations can be frustrating to deal with. While doctors may have much experience observing others in similar situations and reading medical texts, I believe it is important for doctors to listen to their patients and give value to their input.

Another benefit of autoethnography is that it allows the researcher to tell their stories in more detail than would be possible in an interview. Vryan states “If anyone else sought to study my life as an impostor, no amount of interviewing or observation of me by a researcher would have been capable of producing the depth, richness, and fullness of data I was able to assemble via fully-immersive (and documented) self-observation, self-interviewing, and self-analysis” (407). When the researcher is the one who experienced what is being analyzed, they can fully immerse themselves in the process and critically examine the experiences they are researching. Who knows better what questions should be asked than those who have lived through the experiences? As a budding scholar and a member of the disability community, I am in a unique position to make use of my skills and experiences from both worlds.

Kidd and Finlayson explain that there is a criterion for evaluating autoethnographic research; “substantive contribution, aesthetic merit, reflexivity and impact” (22). This means that as I write about my experiences, I must be thoughtful in how I write. The story must be engaging so that it will draw the reader in. I will also need to examine how these experiences have shaped my bias and beliefs surrounding disability and art. I will need to ensure that what I write makes a difference. I am not just writing my story to tell it, but to analyze how my life and outlook have been shaped by the disability art movement and how it can benefit others in a comparable situation to my own.

Autoethnography goes beyond just telling a story. Ettore explains, “As narratives of the self, autoethnography extract meaning from experiences rather than depict experiences as it was lived” (484). This is an important feature of autoethnography in terms of academia. While I believe it is important that all voices be heard, for the purposes of my thesis I need to go beyond the telling of my story. I need to be able to analyze my experiences and autoethnography will allow me to do that. I will need to look at theories of othering and stigmatization and how these phenomena influenced how I felt about my diagnosis. Palfreyman defines othering of a group (in this case those with disabilities) as “maintaining social distance and making value judgments (often negative) based on stereotyped opinions about the group as a whole” (214). Therefore, theories of othering will help to explain how I felt at the time of my diagnosis. While I was relieved to have a name to put to how I was feeling and what I was experiencing, I was reluctant to take on the label of disability as I felt it would label me an “Outsider”. Stigmatization also works like othering in that those who are the “others” are stereotyped and looked upon as less than. Stigmatization however, goes beyond othering. Along with being stigmatized by the society in which one lives, it is also common for those with mental illness to experience self-stigmatization (Corrigan and Watson 35), as I did. In this situation, the individual stigmatizes themselves which can impact their self-esteem. These theories will allow me to analyze my experiences fully as I have experienced both during my life.

Ellis and Bochner explain that because autoethnography is so personal, “it (autoethnography) needs the researcher to be vulnerable and intimate” (431). In this way autoethnography can be both painful as well as therapeutic. Ellis further states “the selfquestioning autoethnography demands is extremely difficult. Often, you confront things about yourself that are less than flattering" (xviii). While autoethnography may be difficult to accomplish, it can also be very rewarding to reveal and understand new aspects of your experiences and share those experiences with others to further advance the knowledge of a certain subject matter or cultural group. In my case, I hope to reveal all the minute details that are pivotal about having a mental illness. Kidd and Finlayson explain that "The overt inclusion of emotional and emotionality is a unique feature of the approach, rendering it particularly relevant for the use in mental health" (22). It was important for me to find a methodology that would not inhibit my emotionality while telling my story. Autoethnography does that by encouraging one to give in to the emotions and embrace them. Ettore states, "when autoethnography is done well, the intention, shape and rapport of the artistic piece should emulate the emotional and scientific commitment of the author, story and reader" (480). I believe that I was able to do just that, by providing literature data along side my personal experiences.

I have chosen to focus on two types of autoethnography: analytic autoethnography and evocative autoethnography. While both use personal experiences to examine larger cultural issues and realities, analytic autoethnography is more concerned with the analysis of the experiences while evocative autoethnography is more concerned with creating compelling and evocative stories (Ellis and Bochner 433-4).

Leon Anderson, a key advocate of analytic autoethnography (A.A.) believes in the importance of analyzing one's experiences to broader cultural generalizations. Anderson outlines five key features of A.A. "(1) complete member researcher (CMR) status, (2) analytic reflexivity, (3) narrative visibility of the researcher's self, (4) dialogue with informants beyond the self, and (5) commitment to theoretical analysis" (378). Anderson's version of autoethnography is based on more traditional ethnography, with the addition of the examination of individual experiences. This means that the analysis is what is ultimately important when doing A.A. Furthermore, interviews with others are highly recommended by Anderson. He states, “one of the defining features of analytic ethnography is that it requires dialogic encounter with other social actors beyond the self” (“On Apples, Oranges, and Autopsies: A Response to Commentators.” 456). This is important as the emphasis on analysis and generalization requires that there is more than one perspective being researched, this to better generalize to the culture under study. As I am only including my own experiences in this thesis and no one else’s I am technically not doing A.A. Still there are useful aspects of A.A. such as the commitment to theoretical analysis which I am implementing in my thesis.

Carolyn Ellis is a pioneer in evocative autoethnography and writes in this style. Her work often reads as a story as well as an informed text. She attests that “Autoethnography wants the reader to care, to feel, to empathize, and to do something, to act” (Ellis and Bochner 433). In Ellis’s version of autoethnography, importance is put on emotional resonance. While the details are important, there is less emphasis on analysis and interpretation of the experiences being researched. The emphasis is on the value of the story itself. While this makes for very rich texts to read, the lack of analysis makes this version more difficult to use in an academic setting. While it is possible to create scholarly texts in this manner (which Ellis has accomplished) doing so requires the reader to think more critically about the story. The part of evocative autoethnography that I most appreciated is its ability to get the reader to empathize with the author as well as encourage them to act.

Both versions of autoethnography have essential elements. Burnier cautions against creating distinct categories of autoethnography stating “Autoethnographic writing is both personal and scholarly, both evocative and analytical, and it is both descriptive and theoretical when it is done right" (410). Burnier hits the nail on the head with this statement. I want my own research to be both rich in personal detail and experiences as well as contain analytical components. For this reason, I combine the two types of autoethnography to create my own version in which I can fully detail and relate my experiences while analyzing the culture which I will be examining (artists with disabilities). I have chosen to combine the two types of autoethnography because I believe both evocative and analytical autoethnography have valuable characteristics. Analytical autoethnography is important because I am writing in a scholarly setting and therefore must put an emphasis on examining my experiences with disability analytically. Evocative autoethnography is important for me as well as I wish to write a compelling story that will engage the reader and draw them in. It is important to go beyond auto-biography or memoir and use the tools of autoethnography to fully integrate my experiences into theories and practices that affect our social lives.

On a personal note, I have found that reading first-person accounts from those who have been in similar situations as me empowering and enlightening. Reading others accounts by those who have experiences with mental illness, has helped me to better understand and cope with my own difficulties. These accounts have also guided me in how to write autoethnography. Three articles that I read impacted me and illustrate the diverse ways that autoethnography can be used.

Alexandra Nowakowski has detailed her struggle with trying a new medication. Nowakowski attests that "I…treat my own experiences as an ongoing empirical observation from which social researchers may gain insight" (899). Nowakowski intertwines theories of gender, class and privilege with her firsthand experiences. She states that she is visibly white, female and that she grew up in a middle-class family to help situate her experiences with disability (902). She uses the technique of looking in, then out, then in. There is no clear line between her story and the analysis she presents. Nowakowski states, “I build directly on the foundation of previous literature by using myself as an example of how social structures, interactional contexts, and individual agency often collide in the course of illness management” (902). Her use of analysis of her social, gendered, and disability background create a clear picture of her experiences of managing a new medication.

Kidd and Finlayson ask nurses to write their own stories about dealing with mental illness in the workplace and then analyze and generalize their stories. For example, they state “The aim of the study was to explore the stories of nurses who have experienced a mental illness while they were in clinical practice” (22). Kidd and Finlayson differ from Nowakowski. They use many stories instead of just one perspective to examine diverse ways that mental illness can affect nurses. They state, “published autoethnographies to date tend to remain focused on the original story and using that single story to extrapolate wider social and political meanings…However this research departed from that tradition by inviting other autoethnographic stories from nurses who had also experienced mental illness, which were then collated into a ‘collective autoethnography’” (22). Kidd and Finlayson allow the stories to be told completely before they use their analytical skills to further delve into topic and provide insight and suggestions on how to better support nurses.

Barbara Jago uses personal narrative, which is a style of evocative autoethnography. Using a journal style, her entries chronicle her battle with depression while struggling to become a professor. She inserts direct quotes from her journals that she kept during the time she is examining to clearly illustrate how she felt in that moment. The journal entries also serve to create a description of the events with clear and precise details. Her style is full of evocative details and is emotionally reflective. For example, Jago writes in one of the journal sections, “‘Hi,’ I respond, my words chasing him down the stairs. He probably has to get to a class, an appointment, something important. Don't take it personally. Simple moments in the hallway are now ripe with meaning" (731). While there is very little analysis in her article it accurately depicts the feeling of living with depression. I could see myself in many of her journal entries. Her struggles with academia and depression resonate with me.

These articles use autoethnography in diverse ways, yet they have much in common. They tell a personal narrative and relate that to the larger culture. What sticks most with me with these articles is the bravery of the authors to relate their stories as honestly and openly as possible. They inspire me to try to do the same. For this reason, I believe it is important for me to add to the voices that are already out there so that others can look to my story to help them cope with any difficulties they may face. Autoethnography allows this in an even more in-depth manner than traditional scholarship because of the analysis which accompanies the lived experiences, enriching the story being told and providing insights that may not be possible by just telling your story.

Autoethnography is an important methodology. Whether one is doing analytic autoethnography, evocative autoethnography or a combination of the two, it can provide a rich and entertaining scholarly text. As my research is very personal, it makes sense that I choose this method. Furthermore, I have kept personal journals throughout my life and therefore have a large amount of primary source material that I can access. By using this method, I will be able to situate myself in the research to provide an insider's perspective into disability art in Winnipeg.

# Part 1: The Early Years

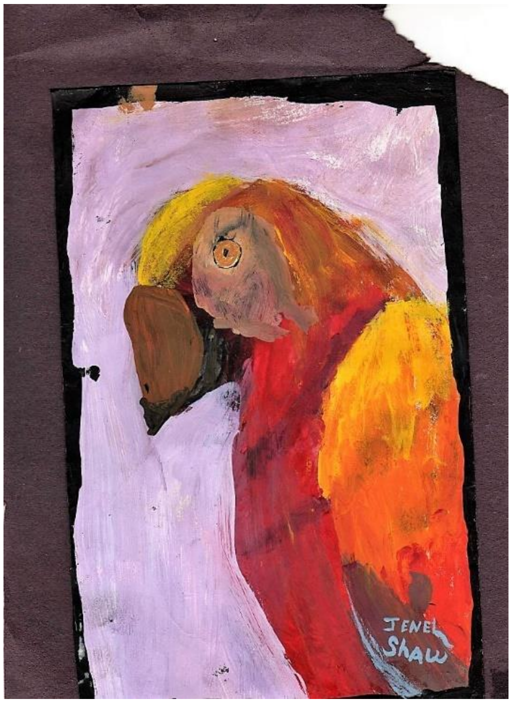

Fig. 3. (Shaw, *Parrot*)

## 1.A: Early influences

As a child I had a wild imagination. When I wasn't day dreaming, I was very creative. I would create art constantly out of anything I could find. I re-call as a child turning a candy bar wrapper into a boat with a man fishing. While I loved to craft and re-use old material, I also had access to more traditional art tools such as paint and paper. Figure 3, *Parrot*, is an artwork that I created when I was eight years old. I painted it while watching *The Joy of Painting* with Bob Ross and was extremely proud of the results, which is why I have kept it all these years. The image is an acrylic painting of a red and orange parrot with a lilac background. I chose this picture to depict my earlier work because it is a piece that I was very proud of. On the back side of Image 1.1 *Parrot*, I found a handwritten sticker for 25¢. When I was young I, used to hold "art sales" in my living room for my family. This was a way for me to share my artwork and make money for candy.

Artmaking has had a huge influence in my early years and continues to even now. Art was my first love and one that has never totally gone away.

Nature also was an influence in my younger life. My backyard faced a forest and as a child I would often explore it with my siblings. We would walk for hours through the woods picking up leaves or branches that I would use later in my artwork. I recall when the city began to bulldoze the forest to make room for another community suburb; it broke my heart to see all those trees torn down. In the summer, I would often visit my grandmother on her farm and help with the care of the animals. She had pigs, goats, cows, chickens, horses…even a peacock! I vividly remember having to wake up before the sun to feed the pigs with everyone during the summer. I also recall long happy days exploring the farm land and visiting with other family members. After the flood of 1997 (Flood of the Century. Manitoba, Canada) much of this changed. My family's farm land was seriously flooded, and all the animals had to be sold or transported elsewhere. The farm never really bounced back afterwards though they continue to farm the land and raise pigs.

In many ways, I was a typical child. I was loving, energetic and I enjoyed gymnastics and soccer. I looked up to my big sister and loved to play with my younger brother. My dad worked for the federal government and my mother was a psychiatric nurse in a youth ward. We even had a dog. On the outside everything seemed perfect, yet inside, even as a child, I felt different. I remember thinking as a young child that I was "bad", that I wasn't good enough to deserve the love of my family and would often feel depressed. I was extremely sensitive and emotional as a child which became an issue for me as I entered the school system.

Learning was something that always interested me. I remember watching my older sister going off to school and wishing I could go with her. Though I loved learning and wanted to have lots of friends, school was difficult for me. Right from the beginning, I was bullied because of the way I spoke. I have a speech impediment which was much more pronounced when I was a child. I had difficulty pronouncing the letter “R” and I had a lisp. The children at school often teased me about the way I spoke. The teasing increased when I went to speech therapy as the therapy took place at school and I would be taken out of class to attend. My classmates often called me “retarded” because of my need for these special classes or they would say that I spoke like a “retard”. Satcher and Dennis state “name calling may substantially impact victims’ self-esteem” (77). This was true for me. My self-esteem suffered because of the name calling. It also made me afraid to speak in public and I developed an anxiety surrounding public speaking. This parallels Satcher and Dennis’ results in their study as they note, “name calling among elementary school children…may have substantial developmental implications” (78). The impact of bullying has lasted a life time. To this day, I continue to experience anxiety when speaking publicly.

### 1.B: Bullying and Me

From kindergarten through to grade nine, I went to school with the same group of children. While I did have friends, I was often made fun of for the way I spoke. It was not only the bullies who teased me but my friends as well. Nicknames such as “loser” and “retard” were used most often. While I was never physically bullied, I was excluded at times by the other children, including those who I considered my friends. This exclusion and teasing were extremely difficult for me to handle as I was such a sensitive child and already suffered from poor self-esteem.

The verbal bullying weighed heavy on my mind. Wolke et al. conducted a study on peer victimization and Borderline Personality Disorder (BPD), to see if there was a connection between bullying occurrences of an individual being diagnosed with BPD. They found that “children who were exposed to combined (overt and relational) or chronic victimisation (at 8 and 10 years) were at highly increased risk of developing BPD symptoms" (851). Another study by Winsper et al. came to a similar conclusion stating, "this study reveals a prospective link between bully victimisation and BPD specifically, adding to an emerging evidence base highlighting the importance of peer relationships in the development of BPD" (6). As someone who later in life was diagnosed with BPD, these studies are of interest to me as I examine my personal history. I wanted friends so badly that I often put up with bullying and would say nothing to my parents or any adult about the bullying that I experienced.

This bullying did end for me in grade nine when I switched schools. I transferred from a French immersion school to an English school where all the students were new to me. Instead of making fun of me for the way I spoke, my new classmates were intrigued by my speech or "accent" as they called it. It was a whole new world for me. Instead of being a "loser," I was popular. Girls talked to me and wanted to be my friend. Boys liked me and asked me to go on dates with them. My self-esteem slowly began to grow. It was at this time that I met a new friend, Jessica (not her real name).

Jessica and I were inseparable. We used to joke that we were attached at the hip. While we were very close and had many fun times, there as a darker side to the friendship. She would often manipulate me to get what she wanted. If I was wearing something that she wanted to wear, she would demand that I take it off, so she could wear it. If I refused, she would often say that I owed her since she paid for me often when we went out. She would frequently have mood swings and would become angry. At these times Jessica would often put me down calling me a *loser* and a *reject*. The following excerpt from my diary in 2001 illustrates the dangerous and violent power imbalance in our relationship.

> April 22, 2001
>
> Well it’s been a while. Lots has happened. I’m not friends with Jessica anymore and looking back and reading back I’m glad. She wasn’t too nice to me. She even punched me in the head once. You want to know why?!? Because I wouldn’t get mad at her! WTF!
>
> (Shaw, *The Diary of Jenel Shaw*)

For many years I put up with the abuse because I was scared to lose a best friend. Mishna and Van Wert reflect on bullying among friends by stating, “despite the victimization, the child might still feel a sense of closeness to the aggressor, may not even identify the behavior as bullying, and might attribute any difficulties to him or herself” (57). This statement was true for me. I often thought that it was my fault when Jessica became angry and aggressive. Self-esteem and self-worth have been an issue for me throughout my whole life and this was doubly the case during my teenage years. I often felt unworthy of love and let the abuse happen, thinking it was my fault when it occurred.

The effects of bullying still impact me today. Even writing about these experiences is difficult for me. As I write about me friend Jessica, I can almost feel the panic and terror I experienced during her mood swings. Mishna and Van Wert explain “those individuals who were bully-victims in early adolescence had the highest levels of suicidality, depressive disorder, generalized anxiety disorder, and panic disorder in young adults” (16). This statement fits with what I experienced as a young adult. I was bullied in my early life and later was diagnosed with a depressive disorder. Whether my mental illness was brought on by genetics or experiences or a combination of both, being bullied very much affected my mental health.

### 1.C: My supportive family

During my younger years, I had a challenging time speaking about the feelings I experienced. This is something that has stayed with me, and I continue to struggle with. To address this issue my parents decided to start a communication journal with me in 1995 when I was eleven years old. This allowed me to express what was bothering me and gave my parents a space to respond, as is evident in the following excerpt from the journal.

> May 16, 1995
>
> Dear Perants, (sic)
>
> How come Bud [my brother] can do all sorts of things and I can't? How come you can swear and it's no problem. You can get mad no problem! I get mad big problem!!! I just don't get it? Well the principle (sic) didn't talk to me today. My plant is doing very well. Good-bye. (sic)
>
> Love, Jenel
>
> May 16 (eve) 1995
>
> Dear Jenel,
>
> You have a point, your point is well taken. It's not o.k. for Justin [my brother] to do all sorts of things. It certainly is not o.k. for me to get mad or swear. And most certainly not o.k. for you to get mad…

Love, Mom

(Shaw, et al. *Communication Diary*)

The journal created a safe space for me to talk about my feelings, the good and the bad, and allowed for my parents to address the issues that I was facing. Journaling (writing thoughts in a journal) is a practice that I have maintained through the years. When I am unable to speak about an issue, it is another method I've used to address my feelings. Along with writing journals from an early age, I have also kept art journals. Hiemstra states journaling provides "an enhanced ability at self-discovery. Learning to trust that inner voice and interpret new thoughts or even dreams can increase self-confidence… in many… settings (24). For me this was very true, while I often did not speak to others about my feelings, writing was a way for me to deal with those feelings. By writing down what I was feeling and experiencing, I was able to better analyze those feelings and experiences. Krpan et al. also speak of the benefits of journaling. They concluded that "These data suggest that expressive writing may be a useful supplement to existing interventions for depression" (1148). By journaling I was able to look back at how I was feeling at a certain time and notice if my mood was improving or not. For example, the following is an excerpt from my journal (Figure 4.) during June of 2007; "What am I looking for? I keep searching but I can't stop. I have no idea what my end destination is, but I keep going. Why can't I stop? Why can't I just enjoy the now for more than a week?" (Shaw, *The Diary of Jenel Shaw*). Along with the writing, this journal page also has the face of a woman looking up within a black circle. In this passage it is notable that I am depressed. I am so involved in fears of the future that I am unable to enjoy the present. Six months later I wrote the

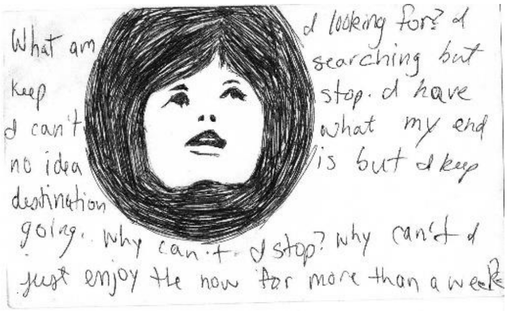

Fig. 4. (Shaw, *The Diary of Jenel Shaw*.)

following, “I’m always claiming to be sick so I don’t have to go out. I still feel pretty miserable and empty. Hopefully tomorrow is better” (Shaw, *The Diary of Jenel Shaw)*. These two entries illustrate that my depression lasted quite a while. Whenever I was writing in my journal I would look back at past entries and through this process I am able to notice when my symptoms where becoming more pronounced which allowed me to take proper action to manage my symptoms better. Beyond that, writing and journaling has allowed me to get to the point I am at now. Today I can talk openly about my experiences and my mental illness. These tools have served me well over the years, allowing me to express myself when verbal communication was not an option.

When I became a teenager, many of my mental illness symptoms became more pronounced. I was often depressed and withdrawn at home and would rarely speak to my parents about my issues and experiences. As a young adult, I began to use drugs and alcohol to deal with my anxiety and depression. At the beginning, the drugs and alcohol did help me, but soon began to take over my life. When I speak to my parents about this period of my life, I can see how it has affected them. While they were always happy to have me home the many times I had to move back because of my mental illness, the uncertainty of my safety during this period often concerned them. When I spoke to my mother about this time in my life, she told me she was often afraid for me. She recalled the times that I would call them in the morning not knowing where I was, with no I.D. and no money. I often drank to the point of blacking out during this period and would end up in unknown places. They would always pick me up and support me anyway they could. While my mother has had more insight into mental illness because of her career as a psychiatric nurse, my father was just as supportive. Even though he did not understand what I was going through he continued to support me in any way he could whether that meant I needed someone to talk to, twenty dollars for groceries or a home to come back to. They have supported me both emotionally and mentally over the years and continue to support me as I write my story.

My parents were not the only ones in my family who have supported me over the years. From a young age, my brother and I have been extremely close. We were born 18 months apart and were best friends from the start. From childhood through our teenage years and even into our adult lives, we have continued to stay close. When my mental illness symptoms first began to manifest themselves, I felt very lost. I was living on my own, working and going to school. Within two years I was in and out of the hospital, was falling behind in my schooling, and had quit my job to focus on school and my mental health. During those years of struggle, my brother stood by me and supported me as I tried to get a handle on my life. When he purchased his first home, he invited me to move in. The amount of rent he asked for was nominal, which allowed me to move out of my parents' home and become more independent again. Beyond offering me a home, he was always there for me, no matter how extreme my moods were. When I was very ill and had overdosed, he would sit with me and just be there. He would also re-arrange his life if I needed help. When I moved out, I was always welcomed back if things didn't work out, which happened a few times. No matter what happens, I have always been able to count on my brother.

My sister was supportive during these years, though in different ways. While we were close as children, we did drift apart during our teenage years. She also moved away for work during the worst of my mental illness episodes, which meant she did not have the same insight my brother and my parents did. Therefore, her understanding of my mental illness was different than theirs. My mental illness was a topic that we rarely discussed. Nevertheless, she has always encouraged me to do that the best I can in life and always looks out for my best interests.

I have been extremely lucky to end up with the family I did. While they might not all have understood what I was going through they have been supportive in every way I could ask. They allowed me to be who I was and have encouraged me to express the feelings and experiences that have shaped me as I write this thesis.

## Part 2: The Learning Years

Fig. 5 (Shaw, *I'm Fine*)

### 2.A: The Stigma of Mental Illness

Before I delve into my experiences with mental illness and art, it is important to understand the far-reaching impact of the stigma of mental illness. From being bullied as a child with disability slurs (retard) to the self-stigma that I continue to experience to this day, the impact of the stigmatization of mental illness has played a significant role in my life, especially when I was first hospitalized. Figure 5, *I'm Fine*, is an artwork that I created while in hospital. This piece is a pencil drawing of a woman with long hair with nails in her forehead and head. I chose this image because I felt that it illustrated very well how I felt at the time. I was feeling very overwhelmed, I had just found out that one of the doctors on the psych ward was an ex of mine who was unaware of my mental health history. The blank look on the woman's face represents how I was attempting to be ok with the situation, to be "fine". The nails represent how depression in always present and painful regardless of outward appearances. This image expresses how mental illness and the stigma of mental illness affects me. I had not seen my ex for over five years and was feeling very self conscious of how he would view me in this situation. While I may be feeling terrible on the inside, I will often say "I'm fine" when others ask me how I am because I feel as though I need to hide my mental illness symptoms. To understand how the stigma of mental illness affects those with mental illness, it is important to review the history of the term and the use of the term "stigmatization".

## The History of Stigmatization

Historically in Ancient Greece, stigma referred to a mark on the body of slaves or criminals which denoted their station (Falk 17). While we no longer physically mark those who are stigmatized, the "mark" is still there in an invisible sense. In modern times, "stigma" or "stigmatization" refers to an invisible negative attribute that a person possesses which marks them as an Outsider or other, which can limit their inclusion in many aspects of everyday life (Falk 17). Thornicroft et al. explain that the term stigma "contains three elements: problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination)" (192). This means that, to address issues of stigmatization it is important to examine the knowledge, attitudes and behaviours that the public experience to fully understand how stigma works. To do this, we will examine the language of mental illness (ignorance), the portrayals of mental illness (prejudice), as well as how this plays out in the day-to-day life of those with disabilities (discrimination).

## Language and Stereotypes of Mental Illness

In terms of language, the jargon used to describe those with mental illness, such as psycho, retard, crazy, basket case, etc. illustrates the negative connotations of mental illness that our society holds. These words have lasting effects. I have had personal experience with this as mentioned in part 1. As a child, I was often called “retard” by my classmates, and the use of this term still to this day makes me cringe.

Words are powerful and define how we, as a society, view mental illness. Stuart et al. explains, “while a person can *contract* pneumonia, *suffer* from cirrhosis of the liver, or *have* a broken leg; one *IS* mentally ill” (5, emphasis in the original). This means that mental illness is often the defining characteristic of a person. For me, this was problematic. While my mental illness is a part of who I am, I do not believe it is my “master status” or defining status. Master status is defined as, “the master status of an individual is one which, in most or all social situations, will overpower or dominate all other statuses” (“Master Status”). For those with mental illness, our disability often becomes our master status. When mental illness becomes your master status all aspects of your life can be affected. For example, one way that this can be problematic is in terms of mental illness and sexuality. Davidson and Huntington state “Sexuality is a complex and fundamental aspect of a person’s health and mental well-being, yet mental health professionals generally seem reluctant to discuss sexuality related issues… [for] women with enduring mental illness" (240). Because there is a reluctance to speak about sexual health, these women are not seen as full adults. This example relates to the misconceptions that are held in our society about people with mental illness.

Corrigan and Watson state that there are three common misconceptions of those with mental illness; "people with mental illness are homicidal maniacs who need to be feared; they have childlike perceptions of the world that should be marveled at; or they are rebellious, free spirits" (36). These misconceptions or stereotypes affect those with mental illness by either patronizing them or labelling them as dangerous. In the example above, surrounding the issue of sexuality of women with mental illness, the mental health professionals could possibly view the women in a patronizing manner, viewing them as childlike.

When these negative words are the only ways that mental illnesses are described it can be difficult to picture your life with mental illness in a positive manner. When I was first diagnosed with mental illness in my late teens/early 20s, I had a challenging time accepting my diagnosis. To avoid the stigma that I felt, I would often stop taking my medications or avoid going to the hospital for fear of what others would think of me. Because I had no positive role models with mental illness, it was difficult to see the positive in my diagnosis.

## Mental Illness and Media

Many studies have been done which examine the types of stories that are told about the mentally ill in the media. Corrigan et al. state that "studies have shown that as many as 86 percent of stories dealing with mental illness focus on violence" (483). This statistic refers to articles written about people with mental illness in newspapers. This is disheartening when information disseminated by the media, especially news, is seen to be factual. Thornicroft states "newspaper coverage of mental illness tends to be short of accurate and detailed content, emphasizes violence over all other aspects of mental illness, and reinforces prejudices against people with mental illness" (113). This quote struck a nerve for me. It is discouraging that there are few facts shared about mental illness when a story surrounding a person with mental illness is published. The representations of the mentally ill in news tends to lean towards a sensationalism versus factual portrayal. Because those with mental illnesses are a part of the general population and because we are exposed to the same stories and prejudice ideas of mental illness, those with mental illness can take these stereotypes to heart and internalize them, as I did.

Thornicroft notes that "a content analysis of prime-time television in the USA concluded that mentally ill characters were nearly 10 times more violent than the general population of television characters" (113). Once again, this study illustrates the focus on the violence of those with mental illness. When the media continually refers to people with mental illness as dangerous, the wider population comes to believe this, regardless of the actual diagnosis. Furthermore, it is not just adult programming that portrays this, but children's shows as well. Thornicroft also noted that a "Canadian study looked at Disney animated films for children and found that…85 per cent contained verbal references to mental illness and were mainly used to 'set apart and denigrate' the characters" (116). These studies illustrate just how pervasive the stereotypes of mental illness are. Markowitz also noted this trend stating, "stereotyped conceptions of mental illness are learned in early childhood and continually reaffirmed in ordinary social interactions and mass media" (131). From an early age we are told (through media) that those with mental illnesses are unstable, unpredictable and/or violent.

The portrayal of the mentally ill in newspapers, new shows, television and movies have a real impact on everyday people. Thornicroft explains “television pictures of what mental illnesses are, and what they mean, are important. Because this medium is the main source of information about mental illness for most people” (114). It is therefore important to change the way in which those with mental illnesses are portrayed. It is important to get factual information to the public, whether through campaigns or personal narratives such as this study, to help remove the stigma that is created through mass media.

## Stigma and Treatment

When I entered the hospital for treatment, the stigma of mental illness followed me, and was at times augmented through power relationships. Nordt et al. states “the general public has as many negative stereotypes about people with mental illness as mental health professionals do” (711). This means that often those who treat people with mental illness view them through the lens of negative stereotypes. For me, I have experienced instances of patronization augmented by the power imbalance between mental health professionals and mental health patients. I recall one incident where I had gone to the emergency room to be admitted into the hospital. I was feeling depressed, suicidal, and generally terrible. Once I was admitted to the hospital, a nurse came to take me to the psychiatric wing. He had a wheelchair with him which confused me since I had no problems walking at the time. When he asked me to sit in the wheelchair to be taken to my floor I refused, explaining that I did not need a wheelchair and would prefer to walk on my own. He then told me that I had to sit in the chair and that it was hospital policy. I again refused and explained that I had never had to use a wheelchair before and did not want to now. For me is was an issue of dignity and choice. I was on edge and wanted to claim some choice in the manner. He then explained that I should sit down voluntarily because otherwise he would have to force me and that I would make things very difficult for myself. Defeated, I sat in the wheelchair. This incident left me feeling as though I had no rights. I felt patronized, and even worse than I did coming into the hospital. This is just one example of how those with mental illnesses are sometimes handled when they go into treatment. Thornicroft explains “a series of recent studies in North America and Europe have shown that even while inpatients are technically admitted on a ‘voluntary’ basis, most understand that they are not fully free to stay or leave as they wish” (153).

Beyond being afforded freedom of movement, there is also the issue of medication. One of the occasions that I was in the hospital, the doctor had prescribed me new medication without first consulting me. When I asked the nurse about the new medication, she told me that I had to take it for now and could talk to the doctor about it in the morning. When I explained that I did not feel comfortable taking any medication without knowing why it was prescribed or having any information about the medication itself, she indicated that if I refused to take the medication orally, she would be forced to give it to me intravenously. I felt I had no choice, so I decided to take the medication voluntarily. Both events illustrate the lack of power one can experience as a patient. While there are, of course, many positive aspects of inpatient treatment, it is the negative events that remain in the mind. This has often caused me to hesitate to get the help I need. I believe that it is important that the patient being treated should have a say in how they are treated. This can not always happen, where a patient is in crisis and refusing treatment and is a danger to themselves and others. It is however, important to include the patient whenever possible. By simply explaining to the patient why certain medications are prescribed and any viable options, the patient can feel that they are included in the discussion. There have been times when doctors have done just that with me, such as the last time I was hospitalized, and the doctor described the attributes of a newer drug and asked if I wanted to try it. In this instance, the doctors included me in their discussions and as a result I have felt more empowered and more capable of recovery which has led me to gain my mental stability more swiftly, reducing the time I am in hospital.

## Self-Stigmatization

Self-stigma is defined by Stuart et al. as occurring when "an individual internalizes negative cultural stereotypes and comes to feel that they are of no value to anyone" (8). This is something that I have experienced on an ongoing basis since even before my diagnosis. In fact, self-stigma has been the trickiest thing for me to overcome. I don't believe I have completely eliminated my self-stigma to this day. My self-esteem suffers the most, and some days I feel as though I have nothing to offer anyone in the world because of my mental illness. Luckily my work with disability and arts organizations have greatly helped me to overcome my self-stigma. Thornicroft states "people who are starting to have symptoms of mental illness are also members of the general population and share the same pool of information about psychiatric disorders" (90). This means that the stigmatizing ways in which mental illness is viewed affects those who are diagnosed as mental ill. This, of course, can lead to treatment avoidance to distance oneself from the label of mentally ill. Personally, when I was first diagnosed with mental illness, I was not ready to take on the mantle of being disabled and what it entailed. I was afraid of how others would view me, which resulted in me avoiding treatment. This reaction has been noted by other authors as well (Stuart et al 8), (Hinshaw, x) and (Corrigan 23). Hinshaw explains "given the negative perceptions of mental illness and given the ignorance that is still rampant, it is not surprising that a great many people with mental disorders delay seeking help for years, even decades" (x). One of the reasons for this may be because we view those with mental illness as responsible for their illness. Corrigan and Kleinlein explain “people believe they are able to cope because of some personal strength and that mental illness is moral weakness” (24). I cannot count the times that others have said to me to “toughen up” or “just get over it”. Mental illness is not a mood that can be changed with the force of your mind. It is a serious condition which requires at times medication and hospitalization.

Beyond others viewing you in a stigmatizing manner, you yourself can begin to view yourself in this negative manner as well. Thornicroft explains, “there is now strong evidence that people with a diagnosis of mental illness expect to be discriminated against…and that these expectations can themselves be profoundly disabling” (155). When I came out of treatment the first time and returned to work as an inclusion worker at a daycare, I was terrified that someone would find out and that I would be fired. The only person at my work who knew that I was in-hospital for mental illness treatment was my immediate supervisor who had dealt with her own mental illness struggles and was very understanding. She suggested that I not inform anyone else the real reasons for my absence as it was a personal matter, and one that would likely bring discrimination against me. I worked hard to never show my feelings so that no one would suspect. The façade that I created was difficult to maintain and meant that I lost out on any workplace accommodations. Stuart et al. noted this as well, explaining that “employees who have a mental illness will go to great lengths to ensure that their supervisors and work colleagues never find out that they were ill, thus making them ineligible for any workplace accommodations” (23). As I was working with children, I was especially careful who I told of my experiences as I was worried that if the parents found out they would not want their children to be cared for by someone who has been in hospital for mental illness. As I researched stigma in the workplace, I found a study that echoed my concerns. In 2008, the Canadian Medical Association’s annual national survey found that only 14% of those surveyed, “thought that they would have someone with a mental illness take care of their children" (Stuart et al. 72). In this case, the felt-stigma that I experienced which led me to hide my diagnosis was accurate. I was right to feel this stigma as I may have lost my job had I disclosed my condition.

### 2.B: In hospital

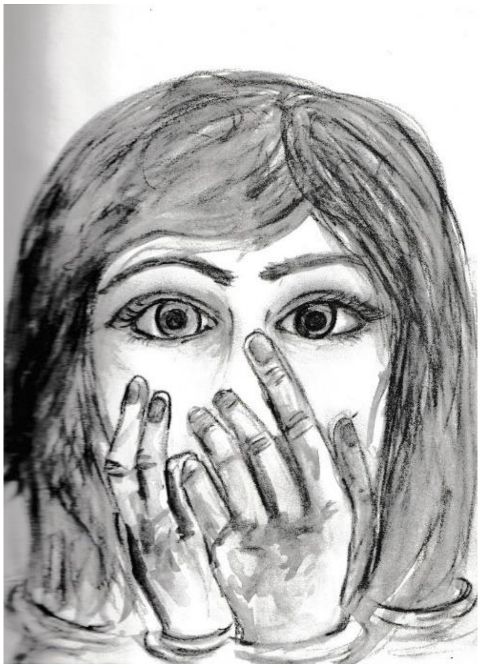

Fig. 6 (Shaw, *Don't Speak*)

My becoming an artist is intertwined with my journey to accepting my disability and embracing it. During my first day in the hospital the self-stigma I felt was so strong. I felt as though I was losing my identity as a person. I was now mentally ill. I almost felt as though after I left the hospital that people would be able to just look at me and see that I was mentally ill. The "invisible" mark of stigma felt incredibly visible. Figure 6, *Don't Speak*, reflects these feelings. This image is a charcoal drawing of a woman in water with her head sticking out and her hand covering up the bottom half of her face, while her eyes are large and expressive. I was afraid to tell others how I felt and my experiences. I felt it would be better if I did not speak. Though, the beginning of my journey may have been dark, there was a light at the end of the tunnel though, and that light was art.

My first day in the psychiatric ward in 2008 was a bit of a blur. Some parts are vivid in my mind with colours and feelings while other parts seem to blur and fade at the edges. I remember calling my supervisor at the daycare I was working at to tell her that I had decided to admit myself to the hospital and that I would not be at work for at least a few weeks. She knew the struggles I had in the past year and was supportive. I was nervous that other people at work would find out that I was in the hospital and wouldn’t be as understanding. I recall the nurse in the emergency room asking to see my cuts while my mom sat next to me. I did not want my mother to know that things were so bad that I had begun to cut myself to deal with the pain of depression. Cutting was an outward manifestation of my internal pain and one that I worked hard to hide. I wore long sleeves, even in the summer, and was angry that the nurse had exposed my depression to my mother. I remember another nurse on the ward going through my bags to make sure I had nothing I could hurt myself with. Her voice was gentle and calming and felt like a balm on my nerves as she explained how the ward worked. I remember feeling scared as my mom left. I was in my early 20s and had left home a few years before, but I still felt as though I needed my mom. As a psychiatric nurse, she has been very supportive and understanding through all my struggles. The last thing I remember of that day is walking around the ward after my family had left and coming across some paper and pencil crayons. It had been a while since I even picked up a pencil to draw. When you are depressed, doing anything is a challenge and that includes making art. Seeing those few meager art supplies felt like a light at the end of the tunnel. I knew that there would be long days ahead of me but seeing something familiar felt so comforting. While the art supplies gave me hope, the feelings of despair and shame were still overwhelming.

Over the years, I have been in hospital five times and each time it is a difficult decision. The following is an excerpt from my diary one of the times I was waiting to get checked in (Fig. 7).

> Date unknown:
>
> Out of place. Alone. Dim remembrance of the days. I take a shower, a victory. I tried so hard to be O.K. on my own. To keep the feelings in check; to be safe. I've finally given up and gone to ask for help. To ask for help is the hardest thing. You give up everything, your power, your ideas, everything. To then wait 23 hours, waiting to see, yes or no, are you sick enough? Is there room for you? You are in the crucible, at their mercy. It almost makes me wish that I had overdosed instead of just thinking about it. Then I would get the help I desperately need, or it would be over. I'd never have to feel like this again. It's exhausting, mentally, physically, emotionally. My body aches, my mind is stuck, and my spirit is gone. Flown away to a better place with no stress, tears, pain and forgetfulness. What do you do when the wave is about to crash on you and the people say they don't have anymore life vests…to just hold on…?

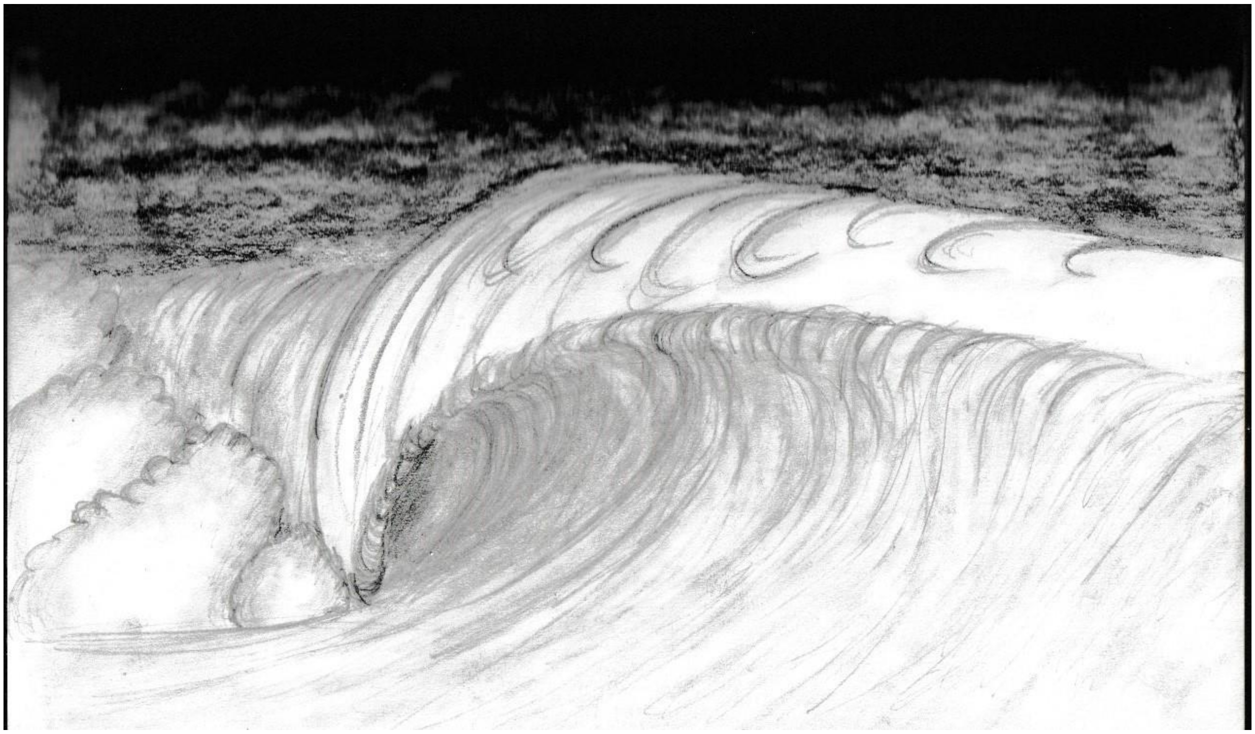

Fig. 7 (Shaw, *The Diary of Jenel Shaw*)

This excerpt illustrates the stress involved in making the decision to enter the hospital. This image that accompanies this passage is a charcoal drawing of a big wave that is about to crash with a dark sky. There is always the worry that you will be turned away because of the lack of beds or the doctors will decide that you are o.k. to go home. There are many other factors that affect your decision to enter the hospital. For me I was always worried about what was going on at the time: exams coming up, or Christmas, or a birthday. I always tried to hold off until I felt I had the time to take care of myself. Because mental illness is just that, mental, it can be difficult for others to understand the distress you are in. I found though, that art helped me to express how I was feeling. I have never been good at talking about my feelings and my experiences with mental illness to doctors and nurses, or anyone else for that matter. The fact that I am writing this thesis on my experiences with mental health illustrates the growth that I have gained over the years. While I still have difficulty speaking about my experiences, writing this thesis has been a stepping stone for me to talk to others about my mental illness. By laying out my experiences on paper I have found that I have been able to feel more comfortable with being open.

Once the doctors have decided that a stay in the hospital would be beneficial, I found that there were many hours to fill. Some hospitals have daily group meetings that last about an hour, though most do not. You also meet with your doctor every day or two to see how you are progressing which also lasts for an hour at most. Sometimes there are weekly activates such as cooking, games and sometimes art. Overall though, your days are open. The only regulated activities were meal times and bed times. I found that art was a wonderful way to fill the time. It also allowed for me to express what I was feeling. Other times I drew and painted for the pure joy of creation, or to meditate and relax.

I found the biggest obstacle to creating artwork in hospital is the supplies. Most psychiatric wards will have limited art supplies such as pencils, pens, pencil crayons and paper. There is very little beyond that. Some hospitals have paint and brushes, but they tend to be of poor quality and limited in color options. In terms of programming there are very few art programs available. The last time that I stayed in the psychiatric ward, two artists would come with supplies to run an art class once a week. I found that I really looked forward to these classes. The chance to use different materials (which they brought) and try different techniques was like a breath of fresh air through the ward. Figure 8 *Printed Flowers* on the previous page is an example of work from one of those classes. The image is a red paint print of flowers on a blue paper. The two artists brought Styrofoam sheets that we indented and carved an


Fig. 8 (Shaw, *Printed Flowers*)

image into. We then painted the Styrofoam and pressed it to a piece of paper to transfer the image. This was a technique that I had never tried before, and I found that learning this artform provided me another avenue to express myself in new ways.

Many of the patients who were able would join the art classes. I found that not only did the creating of art helped to pass the time, it also promoted interaction between the patients. As I personally tend to withdraw from society the more depressed I become, it was a crucial step to my recovery to begin to interact with people once again. The idea of interaction and personal empowerment through group art creating was also noted by Morris and Willis-Rauch. They set up a voluntary art group in a psychiatric hospital called Art Club. They state “We… observed increased group socialization over time. Joint problem solving… demonstrated the members’ ability to socially interact effectively” (36). I found that creating art with my fellow patients was beneficial for me as well as them. Due to of the lack of art supplies and art programs in the psychiatric wards, I would often ask my parents to bring me my supplies from home. When I would sit in the communal areas with my supplies, other patients would often ask to join in and create art with me. I learned over the years to always bring extra supplies for the others. Sometimes we would create our own art groups and spend the afternoons together interacting and creating. I found that it would lift the whole mood of the ward. The day that I brought actual canvases for everyone plus good supplies, such as new brushes of assorted sizes, as well as a decent quality paints was one of the best afternoons I experienced in hospital. Everyone was talking and laughing. The nurses were happy to see us busy and being productive. My impression was that we had accomplished something that day. And we had. We had re-connected with others and created work that we could all be proud of. Figure 9, *Red Haired Woman,* is one of the artworks I created during one of these

Fig. 9 (Shaw, *Red Haired Woman*)

sessions. The image is a woman with long red hair done with black pen and water colours. This painting was important for me, because of the feeling of the artwork. The woman in the image has a slight smile, which differs from much of the artwork I created in hospital in that it was a positive image. Often the artwork I created in hospital reflects my mindset at the time. The images are often dark and illustrate the pain that accompanies depression. This image is different as it reflected the positive mind frame that I experienced while creating art in a group setting in the hospital. It was a great experience to interact with others in a creative way.

There are so many benefits to creating artwork, especially for those with mental illness. For myself, creating artwork allowed me to work through my self-stigma. It was becoming an artist that led me to be proud and accepting of my disabilities. The following sections delves more into the ability of art to help with symptom management and empowerment.

## 2.C: Benefits of Artmaking for People with Mental Illness

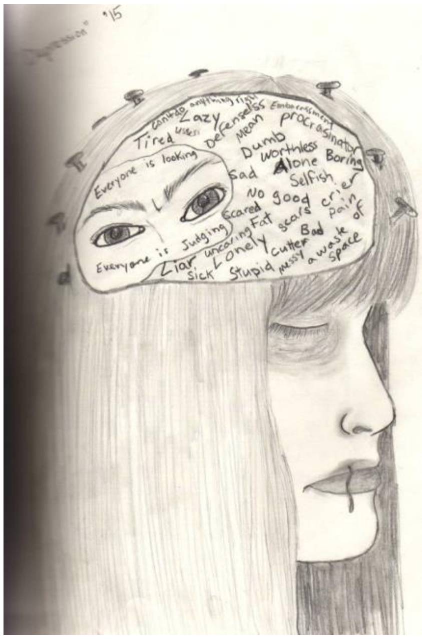

Fig. 10 (Shaw, *Depression*)

While I have participated in diverse types of therapy, art therapy has not been one of them. I do however believe in the healing powers of art. I have experienced the many benefits of artmaking in my own recovery from mental illness. I have seen how art can bring patients together in an in-patient scenario many times. This section will explore my own experiences with art and how those experiences compare to the literature surrounding art as therapy. I will mainly focus on artmaking as a tool for managing symptoms, reducing stigma and gaining empowerment.

There are many ways in which art can help with the management of symptoms of mental illness. I have personally used art to relax or to take a break from the world. When I am creating artwork, I tend to a shut the world out and almost go into meditative state. I sometimes get so enthralled in my work that I don't notice the passing of time. I always leave these sessions feeling calmer.

There has been much research into artmaking to reduce mental illness symptoms. Boekhoven et al. speaks of art therapy stating, "positive results included mitigating the frequency and severity of clinical symptoms" (166). This sentiment is echoed by Gussak who states, "art can diminish pathological symptoms without verbal interpretation" (446). These two statements reflect the experiences that I have had with artmaking. When I was first diagnosed in hospital with mental illness, I had turned away from art. It was in the hospital that I first rediscovered my love of art creation. I found that when I was agitated in hospital, I was able to use artmaking to refocus my mind and to calm myself. In this manner the process of creating the artwork reduced my symptoms. Instead of using medication to control my anxiety I was able at times to focus my art to reduce my anxiety. There are, of course, periods when my anxiety is so high medication is a must, but it is empowering to be able to reduce the frequency of these incidents by using art.

There is also the benefit of being able to express yourself non-verbally. By creating an art piece that expresses my feelings, I can communicate how I am feeling without speaking. For example, in the artwork at the beginning of this section figure 10, *Depression*, it is easy to see how I was feeling at that time. This image is a paper drawing of a woman with long hair in profile with a black eye, bloody lip and nails in her head. There is also a black spot where her brain would be which is full of thoughts that I had at the time. The space is divided by a pair of eyes with the words "everyone is looking" above and "everyone is judging" below the eyes and a bunch of words on the other side. The words are: "can't do anything right, lazy, useless, tired, defenceless, embarrassment, procrastinator, numb, worthless, sad, alone, boring, selfish, no good, scared, fat, scars, crier, liar, uncaring, sick, lonely, stupid, cutter, bad, messy, bad, a waste of space". In the image the thoughts of my mind are visible. I find that it is easier for me to write the many thoughts that run through my head on paper versus saying them out loud. The black eye, bloody lip, and the nails in my head illustrate how I feel physically when I am in a depressive state. I often feel beaten up, sore, physically drained. In this drawing I was able to express these feelings and thoughts without saying verbally how I was feeling. Heenan agrees with this stating, "there is a range of ways that art can make a contribution to promoting positive mental health… it can be a self-initiated activity providing a form of self-expression" (182). Beyond being a form of self-expression, artmaking can also be used to explore one's self.

Art allows me a space to explore myself and my feelings. It also allows me to gain confidence and the ability to fight stigma. Blomdahl et al. state "art therapy can help clients by promoting personal change, development of identity and self-awareness" (322). The development of identity was important for me when I first began treatment. I was unsure of how to incorporate my diagnosis with who I was. Through the process of artmaking I regained confidence. Gussak states “The ability to create ‘good art’ is a status builder and can earn respect and friendship for the artist from his or her peers” (445). This statement rings true to me. During the times at the psych ward when I brought extra supplies and created artwork with other patients, we built a friendship and mutual respect for each other and our work. By being the one who set up these sessions, I also gained more self-confidence. I felt as though I was helping others by showing to them what had worked for me. As someone who has always tried to help others, it was a boost to my self-esteem to know that even though I may have mental illness, it did not mean I couldn’t be a productive member of society. Artmaking really helped to solidify who I was and to incorporate my diagnosis into who I wanted to be. I believe that others could benefit from the same experiences that I have had by incorporating more artmaking into programs at psychiatric facilities. Art is powerful and should be accessible to everyone, especially those who are battling with self-identity and self-stigma.

## Part 3: The Empowering Years

Fig. 11 (Shaw, *Dusty*)

Art and empowerment have been linked forever for me through my work with two Winnipeg organizations that use art and politics to empower women artists and artists with disabilities. Mentoring Artists in Women's Art (MAWA) first exposed me to strong women artists and activists that were invested in supporting art in the community and mentoring women artists through their careers. This mandate spoke to me as a woman artist and a feminist. Because of my experiences with mental illness my sense of empowerment was very low. I did however know the healing power of art and the ability of it to bring people together. My work with MAWA solidified this and helped me to see how art can change lives.

The Arts AccessAbility Network Manitoba (AANM) is the second organization that I worked with. It was through this organization that I really became empowered as a disability artist. As a member of the board for many years, I had the opportunity to meet many artists with disabilities. It was through these meetings, as well as through organizing events that celebrated artists with disabilities, that I changed my outlook on my mental illness. I found that I was no longer ashamed to say that I had mental illness. I witnessed many artists with disabilities who were empowered through their art, which showed me that I could do the same.

These two organizations really shaped who I am and how I view myself. Both MAWA and AANM showed me how empowering art can be by creating a platform for artists who are often excluded (women and those with disabilities) to showcase their art and experiences, as well as mentor others to do the same. Figure 11 at the beginning of this section is an example of the type of artwork I do today. This piece called "Dusty", was an artwork that I created for the Royal Aviation Museum for a fundraiser. The piece is a two book ends that are attached. On one side is a silicon mold of a woman's face with no mouth which is lite up with blue el-wire and the other side is a resin caste of the mold. Attaching the two book ends is a piece of a table that belonged to my friend Dusty whom the piece is named after. My friend Dusty passed away as a result of mental illness. He was struggling with his moods and was newly on medication and had just taken a leave of work to deal with his new mental illness issues when he passed away. This piece speaks about the silence surrounding mental illness and the battle that those with mental illness face coming to terms with their new diagnosis. The books that are in between the two bookends are mainly mental illness literature. It was through my work with these two organizations (MAWA and AANM) that I felt strong and confident enough to put an artwork on display that speaks of mental illness.

### 3.A: Work with MAWA, meeting strong female artists

Fig. 12 (Dempsey, *Photo of Jenel Shaw and Erna Anderson*)

I first was introduced to MAWA during my undergraduate program in 2012. I was completing a major in Women and Gender studies when one of my professors announced an intern position available at MAWA for a student in the program. I decided to try my luck and apply. Happily, I got the position and became an intern in the Crafternoon program at MAWA. Figure 12 is a photograph of my co-worker Erna Anderson and I during one of our events. We have our arms around each other and are both wearing “I ♥ MAWA” pink t-shirts. Before I began work, I researched the history of MAWA to understand better the place I would be joining.

MAWA began in 1984 as an initiative of the Plug In Institute of Contemporary Art in Winnipeg, to help women artists in achieving their career hopes (“History of MAWA”). In 1990, MAWA became an independent organization and began to focus more on encouraging women’s art in the community through mentorship. They have since then grown into an organization that funds many projects from mentorship to art classes to art auctions.

My job at MAWA was to help organize and run an event called the “Crafternoons”. This event runs once a month at MAWA (except during the summer). Every month we feature either a newcomer woman or an aboriginal woman who is a master crafter in their own type of artwork. They are hired to teach their unique crafting skill to those in the community through an afternoon workshop. The classes vary from creating medicine pouches to making beads by hand.

The workshops are free and include childminding as well as snacks which reflect the facilitator’s heritage. Those who come to the classes come from diverse backgrounds with different ethnicity, sexuality, class, gender, age…etc. We help encourage this diversity by advertising the events in different areas of the city such as at universities, in resource centers for newcomers, in art galleries, etc.

The Crafternoons are empowering in many ways. First, the women that we hire to facilitate our workshops are paid a fair wage which reflects their expertise. If they choose to handle the catering for the event they are also compensated for their time and the cost of the food. In this way the women who lead our workshops are empowered, advancing their careers by gaining meaningful employment. This is important because, Fields states, “female artists faced discrimination in pursuing professional careers and because art depicting women’s subjective experiences was discouraged and disparaged by the art world establishment” (2). This program is important to women artists as it provides a safe space to create and teach their artwork.

Secondly, because these classes are free, women of all different social levels can access this program. This is important to make art accessible for all. Often, art tools and materials can be costly; this is a chance to try a new technique without having to buy all the materials needed. As someone who is always looking for new techniques in artmaking I found it empowering to be able to try such a variety of crafts and artmaking.

Thirdly, because we offer free childminding, mothers are also able to access this program. The mothers are free to participate in the workshop while their children are cared for. This is an important accommodation that does not exist in many workshops. Because women tend to be the primary caregivers for children, this was a way to allow more women to be included in these workshops. Because I have a background in childcare, I often ran the childminding station. I created a child’s box for these workshops that included toys for a variety of ages that continues to be used to this day. While this may be a minor contribution, I found that it was a wonderful resource for the caregivers. We also provided artmaking tools for the children, which included typical childhood art tool such as paper, markers, crayons, etc. Beyond creating a space for mothers to participate in the workshops, I found that these workshops also created a space for children to participate. If the children were older, they often participated in the workshops with their parents. If they were younger there was a space for them to create their own artwork. It was important for me to create an art space that was empowering for the children as well as the adults.

Fig. 13 (“Newsletter Winter 2011-2012)

Lastly, what I believe to be most empowering about these events are the connections that are made. There is such a mix of women (though men are also welcome) from all different backgrounds that women who may not meet in the normal course of their lives get a chance to mingle and talk. I have been able to meet and converse with amazing women artists and crafters who have expanded my artistic horizon. While I usually paint or draw as my go-to art medium, over the years I have begun to use other techniques I have learned from the women facilitators. One workshop which has stuck with me, was the workshop on Alebrijes by Alejandra Noemi Diaz Roman (See Figure 13 on this page). In the photograph is Roman holding one of her colourful Alebrijes creations. Alebrijes are “figures in cardboard, sometimes with a wire reinforcement…and represent the strangest of monsters, quite extraordinary, fantastic, multi-coloured beings. All sorts of paper are used in their creation…they are painted with acrylic” (Bartra 68). In this workshop, I learned how to create these colourful creatures by using different materials to make a base, then covering them in paper and finally painting them to bring them to life. Not long after this workshop I was in hospital again with some mental health issues. I explained this workshop to some of the other patients and they loved the idea. We spent the next day building our creations out of whatever we could find, empty yogurt containers, toilet paper rolls, etc. We then papered them and left them to dry over night. We painted them the next day. It felt really empowering for me to be able to pass on what I had learned during the workshop. The other patients were excited to try something new, and we socialized more together as a result. For me, this was very important as I sometimes distance myself from others. I felt that the others benefited from our work as well.

Beyond the empowerment that MAWA offers for women artists, MAWA was the first organization that I worked for that had a political goal. MAWA's political goal of creating a space for women's art was one I had not considered before. I had not noticed the bias that exists in art institutions. Vigneault explains the bias in art by citing the "male artist/female model" explaining that "this gendered binary [is] so prevalent in the discourse of art history and still deeply embedded in art institutions" (891). Therefore, the work that MAWA does, by putting the women artist in a position of power, by encouraging mentorship between women artists and by showing women's art helps to break down barriers for women artists. Beyond the collective goal to empower women artists, I found that the women who worked at MAWA were all smart, passionate and strong women. I felt honored to be a part of such an amazing group of women. I also began to become more confident in my own artwork as I worked at MAWA. I was presented with wonderful examples of strong women artists and that strength seeped into me. I began to feel that my artwork might have an impact on others, and that it was worthy of being shown. I began to submit my art to MAWA when they held their art auctions. I tried to sell some of my artwork with some success. I began to look at my artwork as more than just a pastime or a hobby. I really began to feel like a true artist with something to say.

To this day, I continue to work at MAWA volunteering at events and helping with the Crafternoons, even though I am no longer an intern. I work primarily as a childminder for these events, though if no children are present I help the other facilitators during their workshops. Beyond expanding my artistic horizons, it was through MAWA that I first encountered the Art AccessAbility Network of Manitoba. I had never heard of this organization until I was asked to host AANM's annual general meeting at MAWA. I decided to check out the AANM website to better understand the organization that I would be hosting. I discovered that they were an organization that supported artists with disabilities. As an artist and a person with mental illness, I was very intrigued. I was still coming to terms with my mental illness diagnosis at the time, and this organization was working to empower artists with disabilities. This organization seemed to go beyond empowering artists with disabilities by celebrating them and their work. I decided to sit in on the annual general meeting with the board of directors' permission. As I listened to the events that they had hosted throughout the previous year I realized what an amazing organization this really was. I was so enthralled that I became not only a member of the AANM, but I joined the board of directors. While I continued to work at MAWA, I began to become involved in the AANM which has encouraged me and empowered me in my own artwork.

### 3.B: Work with AANM, meeting strong artists with disabilities

After I became I board member, I decided to research the Arts AccessAbility Network Manitoba. I began by looking at their website to find the information about their formation and their mission statement. The Arts AccessAbility Network Manitoba (AANM) began in 2008 as an art piece called "the SPARK Initiative" by Susan P. Gibson ("History of AANM") . The art piece consisted of two community gatherings. Out of this the participants saw a need for an organization which connects artists with disabilities from all arts disciplines to support each other and work to create a space for disability art in the public canon of art.

Creating a space for disability art in the public sphere is important because it allows a space for those with disabilities to represent themselves. Representation is also important for those with disabilities, and representing our own realities is a step to reclaim past mis-representations of disability. Garland-Thomson states, “public pictures of people with disabilities that tell positive stories, that show disabled people as valued citizens with meaningful and satisfying lives, work against damaging received master visual about disability” (“Picturing People with Disabilities: Classical Portraiture as Reconstructive Narrative.” 24. The damaging master visual about disability that Garland-Thomson speaks about is the historical images of disability which mainly include images of freak shows, medical documents and charity campaigns (“Picturing People with Disabilities: Classical Portraiture as Reconstructive Narrative.” 23). By creating a space for artists with disabilities to show their art and their own realities the hope is that the public imagining of disability may change. While this is, of course, important, the AANM goes beyond this by working to support individual artists with disabilities.

The AANM’s mandate is “to facilitate a network of artists and stakeholders from both the arts and disability communities that supports artists with disabilities in achieving individual artistic excellence, promotes higher visibility of these artists within all disciplines and promotes policies and practices intended to make the arts more accessible to all Manitobans” (“History of AANM”). This mandate is important because it links artists with disabilities to stakeholders in the arts communities. The AANM is a resource not only for artists with disabilities but also for stakeholders such as art curators, museum directors, art supporters, and many more. For those without disabilities that want to support artists with disabilities, the AANM can help by providing an avenue to do so.

With this mandate, the AANM has helped organize many amazing events that celebrate, showcase and support artists with disabilities. The AANM hosted a variety of events to increase the awareness of artists with disabilities. The events have ranged from political events such as the "Wayfinding" event to more traditional events such as their disability art fairs. The "Wayfinding" event was held at an art gallery in the Exchange District which is known for its inaccessible buildings. The AANM blocked the main entrance of the building (with the permission of the art gallery) and directed traffic to the accessible entrance at the back of the building that those with wheelchairs or other mobility issue must use. The point of the event was to illustrate how those with mobility issues are often made to use different entrances, often in back alleys, to access buildings. One of my favorite events with the AANM was the disability art fair.

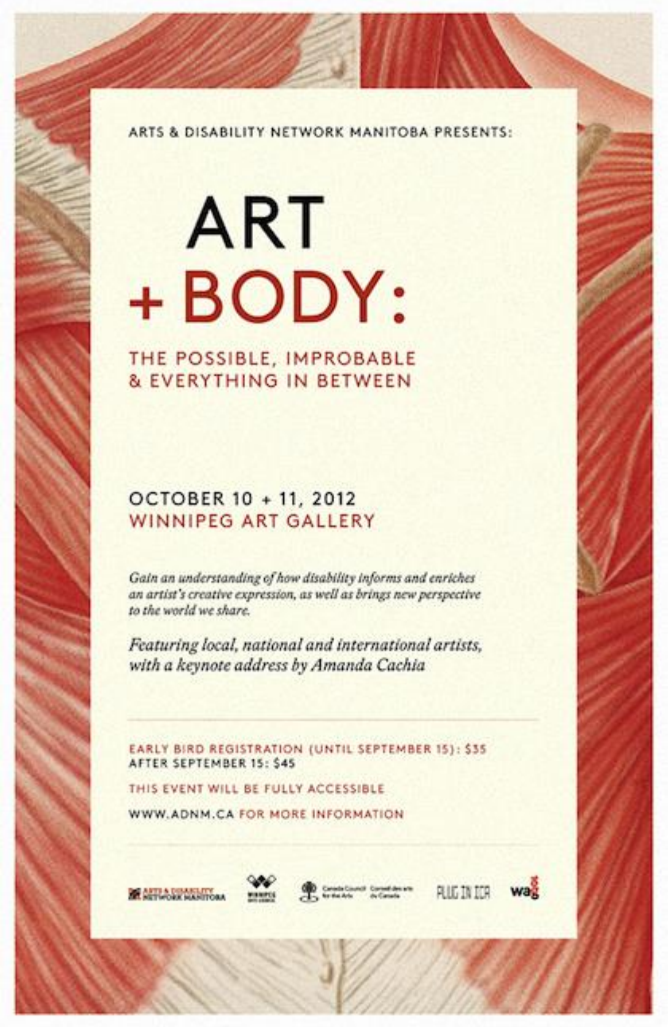

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Fig. 14 ("ADNM-ART_BODIES-POSTER-WEB420.")

One event that I was privileged to help organize was the "Art + Body: The Possible, Improbable and Everything in Between" event in the fall of 2012 (See Figure 14). Image 14 is a poster from this event. It is an image of the muscular system of a back with a large box container the

Fig. 15 (Shaw, *Thin*)

information for the event. This event featured speakers from across Canada as well as internationally who were artists with disabilities as well as curators and stake holders in the art world. They told their stories about how it was for them to be in the art world with disabilities. The event featured music and theatre, as well as an art exhibit by artists with disabilities. It was through this event that I first had my art on display in an art gallery (See Figure 15). I entered a piece called "Thin" for the art exhibit. The painting that I had made was a self-portrait that I had made after the death of my niece Lily. The image is an acrylic self portrait of myself drinking a glass of wine. There is a magnifying glass over one of my eyes with a large version on an eye with rain, lightening, skulls and a ghost in the iris. I had named the piece *Thin* because I felt that after her passing, I was walking a thin line between my depression and mourning for her. I was trying to be outwardly strong for my family, but inside I felt like I was falling apart. Showing my work in a public setting was a wonderful experience for me. I was able to speak directly with the public and explain why I had made this art piece. This allowed for discussion between me and the audience about grieving and managing depression. This event, as well as the turn out (which was impressive), illustrated to me the importance of fighting for the equality for artists with disabilities. It also showed me that this is a critical issue for many people, not just myself.

Working with the AANM has had a massive impact on my life. When I first became a board member I was still dealing with the stigma I felt as a person with a mental illness. Meeting others with disabilities who were pursuing their artistic dreams was empowering for me. Beyond that, it was the first time that I had interacted with a group of people with disabilities outside of the psych ward of a hospital or in group therapy. Corrigan et al state, “group identification, defined as feelings of strong ties to a socially defined collection of people has been shown to diminish the effects of stigma on people with mental illness” (796). I experienced this myself. I felt no shame of my illness when I was at the events the AANM put on, as well as in the board meetings. Interacting with other with disabilities who were trying to change things politically and make a space for those with disabilities in the art world opened my eyes to the possibility of feeling a sense of pride in identifying as a person with a disability.

The years that I worked with AANM helped me to gain pride in myself. It allowed me a way to be open with my mental illness. Because I had learned over the years to mask my symptoms of mental illness, very few members of my family (excluding my immediate family) or friends knew that I had been diagnosed with a mental illness or that I had been hospitalized as a result. Working with the AANM provided me a platform to speak about my mental illness and my art, which has allowed me to feel more comfortable speaking about these issues. After hiding my mental illness for so long it was difficult to speak about my personal experiences with mental illness, but I found the more I spoke, the more comfortable I felt. I was asked to represent the AANM in November 2016 at a round table discussion for a book launch. The event was called “Disability, d/Deaf and MAD Arts Round Table and Mobilizing Metaphor Book Launch”. I was very nervous because all my colleagues on the panel were the directors of their organizations. The questions that were to be discussed was sent out ahead of time to all the panel members, so I had a chance to prepare ahead of time. This was one of the first times that I represented the AANM by myself and I was nervous, not only to openly discuss my mental illness, but also to represent the AANM. As I mentioned previously public speaking is very difficult for me. The event allowed me to face my fear of public speaking as well to gain confidence in myself. I felt afterwards that I had represented my organization properly and I felt a little more comfortable speaking about my issues. Later that year, I was asked again to speak at an event, though this time I was not representing the organization.

In March 2016, I was asked to speak on a panel about disability and curating Martha Street Studios. I was very nervous leading up to this event. Public speaking is an issue that I continue to struggle with to this day because of my speech impediment. I was also nervous because I was asked to be a part of this event through my work with the AANM, yet I wasn’t representing them. It was the first time that I had been asked to join a panel on my own merits. At this event, I spoke about my own experiences with art and mental illness and the reaction of the audience helped to bolster my confidence. Afterwards, more than one person from the audience spoke to me about similar experiences that they had. I found that the more I spoke about my experiences to others the more comfortable they felt speaking about their own. While I still feel nervous about public speaking these events allowed me to gain confidence in myself. I began to see that it was important to share my experiences with others.

Working with the AANM has allowed me to grow as a person and to speak up about political issues that I believe are important. Through this organization I was able to meet other artists with disabilities who were working professionally as artists. This shows me that it is possible to pursue my artistic dreams. Finally, the AANM provided me a platform to speak about my own experiences with mental illness and art, which has allowed me to be more comfortable speaking about my experiences.

## Conclusion/Reflections

### Introduction

When I first began this thesis, I did not know where it would lead. I began with the idea of using my own experiences to illustrate how art can be empowering for people with mental illness and I found that I learned not only much about art, empowerment and mental illness but also about myself. For me, this thesis has been a way for me to examine a very emotional and difficult time of my life. I had pushed many of the memories and experiences I had during this time away. This was the first time that I have organized and really dealt with the memories and experiences that I have had. While it has been difficult to re-live this part of my life I feel as though I have gained so much. I am more comfortable than ever to speak with others of my experiences and to disclose to others that I live with mental illness.

My goal with this thesis was to illustrate the ways that art and artmaking can be empowering for those with mental illness and can help to disperse the stigma surrounding mental illness. My literature review highlighted the previous research, which emphasized the stigma that those with mental illness face. From negative stereotypes (e.g. Those with mental illness are violent and unpredictable), to self-stigmatization, there are many obstacles that people diagnosed with mental illness must face.  The literature review also highlighted the disability art movement, describing terminology such as artist with a disability versus disability artist, as well as highlighting the work that has been done by artists with disabilities.

The literature review helped to illustrate the body of work that has been done in the field of art and mental illness as well as the gaps that exist. While there are more articles that are being written by those with disabilities themselves, there is still a major lack of articles written by those with disabilities. This thesis addresses that gap as it has been written from my own perspective as an individual who has been diagnosed with mental illness.

With this base of research, I utilized autoethnography to analyze my data. My data consisted of journals, artwork and my memories from an age five to present day. An autoethnographic methodology allowed me to closely examine my own experiences as an *insider*. This methodology allowed for a personal narrative to be heard while also providing an academic framework within which to work.

## Research Objectives (summary of findings and conclusions)

My hypothesis that art is a tool for empowerment was proven through examining my journey from first been diagnosed and feeling very ashamed and stigmatized as a result, to becoming a confident and proud artist with a disability. Part one, the early years, illustrated the difficulties that I faced as a child such as bullying and a speech impediment. I was blessed with a strong and supportive family who helped me through this period. Part two, the learning years, examined my experiences with diagnosis and inpatient care. I found that while I was in a deep depression I had difficulty focusing on artwork. As a tool for recovery though, I found it invaluable. I have had difficulty from an early age expressing my experiences and feelings yet through art I have been able to express myself in an alternative manner. I also noted that creating art in a group setting can be very beneficial for all the participants. My final section, part three, the empowering years, examined my experiences working with MAWA and the AANM. In this section I found that working with others in similar situations was empowering. I met others who live with disabilities and are successful which offered me many role models that I have never had. It was also empowering to work at organizations that are actively working to challenge the stereotypes of disability, as well as the political status of those with disabilities to achieve real inclusion.

## Recommendations and limitations

My thesis focused on a very specific data source, mainly my own life and experiences. While this has led to a very detailed and in-depth analysis, it lacks generalization as only one subject was involved. This is a limitation that often accompanies autoethnography as it’s main focus is on only one subject, i.e. the author.

From the research that I have done, I have developed some recommendations. Firstly, it is important that more research be done by those with disabilities themselves. There is no better expert than those who live with disabilities. Secondly, I found that many psych wards within the city lack art supplies. As art is such a wonderful tool for those with mental illness to express themselves and a tool for bringing people together, I believe there should be a more varied supply of art tools available in hospital, besides the basic paper and pencil. Finally, I believe there needs to be more research done on art and art making as empowerment to fully explore how this can be utilized to combat the stigma of mental illness.

## Reflections

When I first decided to speak about my own experiences with mental illness and art within my thesis I was reluctant. I have long suffered from poor self-esteem and did not see how I would be able to add anything of importance by examining my life through autoethnography. However, through this thesis I have grown both as a person and an activist. By writing my stories, I was able to see how art has helped me and how it could potentially help others. I have also been able to speak more openly about my experiences as a result of writing this thesis. By organizing and analyzing my experiences I have been able to really see what worked for me to combat the stigma I felt.

While I am excited to add to the literature of mental illness, it has not been as easy or smooth journey. As I have mentioned previously, speaking about my experiences with mental illness is not an easy process for me. It was difficult to re-read my old journals and art books. When I read what I had written in the past it was almost like I was transported back to that time and re-lived what I experienced. At times, I needed to take a break from my work to distance myself from my past feelings. While reading my old journals was difficult, writing about these experiences was even more challenging. I found though that the more that I wrote about my experiences, the more I was able to talk to others about these experiences. Before I began my thesis, only my immediate family knew how severe my mental illness is. Now that I have completed my thesis I have been able to speak more openly to others about my experiences. I began by testing the waters by posting an abstract of my thesis on Facebook. The response was overwhelmingly positive. Many people praised me for my courage, as well as sharing their own experiences with mental illness. After this, I began to speak to people directly about my experiences and I found that the more open I was, the more open others were about their own experiences.

In our society, there is a feeling of shame that accompanies mental illness, one that I have felt most of my life. This thesis was an opportunity for me to disperse that shame. As someone with mental illness, I am often able to “pass” as non-disabled. This thesis is my way to open up about these important things and declare proudly that I am a person with disabilities.

Beyond that, this thesis has given me a platform to express what has worked for me in reconciling my mental illness. Art has been such an important part of my life and it was through art that I became empowered as a person with a disability. I believe that it is possible for others in similar situations to achieve the same.

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