Creating Change: Using the Arts to Help Stop the Stigma of Mental Illness and Foster Social Integration

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Aesthetics

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Stigma is a social justice problem that plagues persons with psychiatric disabilities, their families, and society. It fuels the fear underlying discrimination; undermines consumer self-efficacy; and blocks rehabilitation, recovery, and social integration. The author hopes to create a passion for change and suggest a way that everyone can help stop stigma. This approach is simple: to nurture the artistic talent many clients possess and connect them with public venues for their artworks. On display, too, will be the "ability" in "disability." This will reduce stigma while building self-efficacy and empowerment. Anecdotal evidence supports this hypothesis. However, research is needed; a design for a study to test this hypothesis is described. Significantly, an antistigmal arts intervention can be conducted by any aware practitioner; one does not need to be an art therapist or have any background in art, only a desire to make a difference and resources on which to draw.

Keywords: *empowerment; holistic nursing; mental health; nursing as an art; psychiatric nursing; schizophrenia; alternative therapies*

The Stigma of Mental Illness: A Social Ill

The stigma of mental illness is an illness of society. The origins of the term *stigma* are found in ancient Greece, where it referred to physical signs (e.g., branding) that were intended to expose something unusual and bad about the marked individual. Later, according to Goffman (1963), stigma became a more conceptual notion, "an undesired differentness (upon meeting someone) from what we had anticipated" (p. 5). "We" refers to "the normals (or those) who do not depart negatively from the particular expectations at issue" (Goffman, 1963, p. 5). The person with a stigma, Goffman writes, is not quite human.

As an illness, stigma is much like a syndrome, or a constellation of signs and symptoms: negative and false attitudes and behaviors toward persons with serious mental illness (SMI). Stigma "refers to problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination)" (Thornicroft, Rose, Kassam, & Sartorius, 2007, p. 192). Ignorance about mental illness is a void too often filled by prejudicial stereotypes of mental health consumers, for example, dangerous, lazy, dirty, stupid, or boring. As a result, discriminatory social behavior such as labeling (Link, 1987), persecution, harassment, and avoidance may occur. The result is a threat to the individual's personal and social identity (Major & O'Brien, 2005). Other negative sequelae include the undervaluing of worthy, intelligent, sensitive, and often talented individuals—and the loss to all of their participation in the daily discourse of the world community. In a sense, persons with SMI become invisible. This leads to a vicious cycle: You cannot know and value what you refuse to see. Thus, stigma remains an affliction. The vision of a richly integrated global society is dimmed. We are all the more impoverished because of stigma—literally, in terms of lost productivity, and soulfully, in missed human potential.

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Stigma exists at various levels. Corrigan (2005) distinguishes between public stigma (the outcome of the endorsement of the stereotypes of mental illness by a misinformed public) and self-stigma (the internalization of stigma by people with SMI). A third type, courtesy stigma, is defined as the stigma experienced by the friends and family members of people with psychiatric disabilities (Angermeyer, Schulze, & Dietrich, 2003). All forms of stigma are dehumanizing and debilitating.

Stigma is highly prevalent. A recent survey commissioned by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that (a) only one in four Americans agrees that the general public is caring and sympathetic toward individuals with a mental illness, and (b) just 25% of those surveyed believe that a person with a mental illness can recover. The result of such attitudes, especially among the vulnerable 18- to 25-year-old population, includes a high propensity for future disability due to the stigma attached to support seeking and services utilization (SAMHSA, 2006).

Chandra and Minkovitz (2006) support this contention, finding that 70% of adolescents who suffer from a mental health problem do not receive care. Top barriers to receiving services included the following: too embarrassed by what other kids would say (59.1%), don't want to talk about those kinds of problems with anyone (51.8%), and don't trust counselor (42.7%; Chandra & Minkovitz, 2006, p. 754-e4).

Statistics are similar for adults, whose disorders may be more advanced. According to the National Comorbidity Survey (Kessler et al., 2001), fewer than 40% of respondents with SMI such as schizophrenia had received medical treatment in the past.

Sadly, when it comes to seeking professional help, the avoidant instincts of persons with mental illness are adaptive (Corrigan, 2007). This is because by avoiding a clinical diagnosis, persons with SMI are also avoiding the label of "mental patient," its attendant stereotypes, and the shame that often comes from being seen entering a mental health clinic.

Stigma Does Not Discriminate

Although most commonly associated with SMI such as schizophrenia in urban or suburban areas, stigma itself does not discriminate. It is uniformly virulent and contagious across the spectrum of disorders. Even the stigma of lesser illnesses such as hypomania and depression can ignite and spread "like wildfire" across members of a group (Jamison, 2006, p. 534).

Indeed, another group singed by stigma is rural women with depression (Hauenstein, 2003). The penalty for self-disclosure in small, isolated, poor communities is perceived to be high: "Mental health problems are stigmatized in all classes and regions of the United States but little is written about stigma and its effects on rural women" (Hauenstein, 2003, p. 6). In remote areas, fears of compromised confidentiality and the stigma perpetuated even by care providers is a powerful force for silence and inertia. The maladaptive avolition or vegetative state often characteristic of major depression—an impediment to help seeking—is thus inadvertently reinforced. The result is the invisibility of these women and their needs. One could also speculate on the lost opportunities for poverty-reducing employment, connectedness, and joy.

Stigma may be relative. Angermeyer and Matschinger (2003) compare the stigma of schizophrenia with that of major depressive disorder. The authors' study of a general population of German adults found that for both disorders, acute stress was the surmised etiology, a poor prognosis was expected, and pity and a desire to help were the most frequent reactions. Most significantly, though, the authors found that the diagnosis of schizophrenia evoked a negative reaction in respondents, whereas major depression produced a more positive response. The primary reason was that individuals with schizophrenia are more frequently considered to be dangerous and unpredictable, whereas people with major depression, who are perceived to be more benign, evoke more "pro-social reactions" (Angermeyer & Matschinger, 2003, p. 526) such as pity. It is interesting that women respondents in this study reacted more frequently than male counterparts with both pity and fear, and with less anger, to persons with both disorders.

Stereotypes

Corrigan (2005) states that the stereotypes of stigmatization, including dangerousness and character flaws, derive from the public's initial recognition of four "signals" of SMI: (a) symptoms, such as bizarre behavior; (b) social skills deficits, such as poor eye contact; (c) appearance, such as personal hygiene deficits; and (d) labels, such as "deviant." Thus formulated, stereotypes then lead to discrimination in

multiple arenas, including housing, employment, social relationships, and fundamental human rights such as justice. Stigma's negative stereotypes—often conveyed through dark media portrayals—and the discrimination it breeds powerfully affect individuals with psychiatric disabilities and exacerbate the burden of their illness for themselves, their families, and society.

A hospitalized man (Schulze & Angermeyer, 2003) who had been diagnosed with schizophrenia when he was 19 confirmed the power of media stereotypes. When the average person hears or sees something related to mental illness, he or she immediately think of the "looney bin" (Schulze & Angermeyer, 2003, p. 305), he said. Outdated images of barred windows or people tied to their beds are common. Such media-propagated stigma produces consequences that are daunting and painful for mental health consumers. Dinos, Stevens, Serfaty, Weich, and King (2004) interviewed an African Caribbean man, age 33, with schizophrenia:

> I've had moments when I was talking to someone quite happily, mentioned the sheer fact that I suffer from mental health problems and I turned to talk to someone else and their back turned, they're heading for the door literally. (p. 178)

Families also suffer from stigmatization of their loved ones, in a sort of "guilt by association" schema. To avoid their own discrimination, families often feel pressured to maintain the secrecy of their relative's illness, an orientation that may originate with care providers. Families also suffer from witnessing discriminatory structures and practices that affect their loved ones (Schulze & Angermeyer, 2003). In addition to such structural discrimination, Schulze and Angermeyer found three other dimensions of stigma: interpersonal interaction, public images of mental illness, and access to social roles. One remedy is for families to support mental health consumers in gaining both employment and its stereotype-breaking, favorable social status.

Ironically, however, families sometimes may be part of the problem. A survey of mental health consumers by Wahl (1999) showed that for more than one third of the interviewees, relatives were a top source of stigma—second only to the general community. Respondents reported instances of a sibling publicly denying the consumer was a relative and of an adult son who refused to speak to his mentally ill mother. The roots of such behavior need to be investigated.

Finally, stigma and its outcomes appear to be universal, both reflecting and impacting the global community. "Much of the stigma of mental illness is engrained in deep and ancient attitudes held by virtually every society on earth" (Jamison, 2006, p. 533). These attitudes control societies' decisions regarding their behavioral norms. Stigma is also reflected in policy decisions, access to care, employment discrimination, and research priorities and spending. Thus, stigma and its stereotypes represent a global illness that infects virtually every aspect of modern life in every way.

Self-Efficacy and Empowerment

Another way to define the social and economic costs of stigma and self-stigma is through the concepts of self-efficacy and empowerment. According to Vauth, Kleim, Wirtz, and Corrigan (2007), both variables represent the evaluating dimension of self-concept—with self-efficacy seen as a more generalized aspect of control expectation and empowerment as more related to the experience of SMI.

Schwarzer and Jerusalem (1995) measured perceived self-efficacy in respondents in three countries by means of the General Self-Efficacy Scale (GSES). General self-efficacy (GSE) is defined as the belief in one's competence to cope with a broad range of stressors or challenges. The GSES measured relationships between social-cognitive variables such as goal intention with GSE. GSE beliefs were consistently positively related to behavior-specific self-efficacy beliefs. For example, among patients with cardiovascular disease, a higher GSE was associated with a stronger intention to exercise.

Empowerment is discussed by Vauth et al. (2007) in the context of treatment; that is, "the individual in the treatment process feels accepted as a human being and as an individual, rather than as an object of medical intervention . . . and gains a reasonable hope for recovery from mental illness" (p. 73).

Clearly, the variables of self-efficacy and empowerment may be negatively affected by the illness itself as well as by medication side effects. Impaired social, cognitive, and coping skills, for example, may make employment in a competitive workplace problematic. Still, public stigma exacerbates the risk for diminished self-efficacy and empowerment. One factor, according to Schulze and Angermeyer (2003), is structural discrimination, including political decisions and legal constraints that deny access to

social roles, especially vocational and educational opportunities. Consumer "G." states:

> . . . the doctors said that I shouldn't bother studying, I mean, continuing with my studies and . . . I would really like to work as a programmer, but they tell me that isn't possible, because with that illness, I wouldn't be capable for that. That's what bothers me, you know! (pp. 303-304)

Self-stigma is similarly disempowering. It includes "buying into" a set of stereotypes that one is weak and unable to care for oneself (Corrigan, 2007, p. 32). Such self-stigma related to labeling with a psychiatric condition (Link, 1982) has been associated with a failure to pursue work or other opportunities that might be attainable. Such underachievement, in turn, breeds shame, expectations of rejection (Link, 1987), and continued risk-aversive behavior. Thus, a vicious cycle is established. The result is an impoverished individual, family system, and society.

Rehabilitation, Recovery, and Social Integration

Phelan, Link, Stueve, and Pescosolido (2000) report on continued stigma, especially toward persons with psychotic illness and their care professionals, as well. This social distance can only impede recovery efforts. If recovery is to occur, state Schulze and Angermeyer (2003), rehabilitation must take place. Vocational rehabilitation is especially important, the authors maintain, "in order to challenge the exclusion of people with schizophrenia from important life chances" (Schulze & Angermeyer, 2003, p. 310). Collaborative efforts between service providers and employers—including interview-skills coaching and the creation of appropriate-level jobs with flexible, part-time schedules—can offer solutions.

The final outcome, social integration, is a process (Ware, Hopper, Tugenberg, Dickey, & Fisher, 2007). It follows the reversal of social exclusion by making accessible "socially valued activity, adequate income, personal relationships, respect and recognition from others, and a political voice" (Ware et al., 2007, p. 469). A "capabilities approach" (Ware et al., 2007, p. 470), based on competencies and opportunities, can help make this happen. This requires that persons with SMI be regarded open-mindedly, as human beings with health deficits but also with innate talents, dreams, and the desire to create and be productive. They must be given a chance. Only then do we have hope of creating the change that will eradicate a tenacious social ill: stigma.

Assessing Competencies: Artistic Talent and Endeavor

In creating change that leads to social integration, as we have seen, competencies count. But first, the strengths of persons with SMI must be perceived and valued. Finally, opportunities must be created to apply and make visible these competencies in ways that will reach the general public. By becoming more familiar with service users, reducing fear, and correcting misperceptions, stigma can be reduced. "Contact counters the stigma by highlighting people as individuals with complex lives that exceed the narrow description of diagnosis" (Corrigan, 2007, p. 36).

Creativity and Mental Illness: A Link?

Like all people, persons with SMI vary widely in their gifts. However, one competency that many mental health service users demonstrate is creative talent and/or artistic activity. Whether due in part to the biology of their illness, an instinctive coping style, or a simple coincidence, the artistic talents and pursuits of persons with SMI have been discussed and debated throughout history. Lavis (2005) writes disparagingly of the "artist-genius" and his or her role in the "madness/genius myth" (p. 153). Jamison (1989), on the other hand—a professor of psychiatry who has publicly disclosed her bipolar disorder—maintains that a link exists between psychosis, especially hypomania, and creativity. But there may be a downside to such giftedness: Numerous famous artists, such as the poet Sylvia Plath and the novelist Virginia Woolf, suffered from mood disorders and committed suicide.

Aspects of the Creativity Connection

What is creativity? Folley and Park (2005) define the process and products of creativity by citing Guilford's (1959) concept of divergent thinking and Mednick's (1962) criterion of the artist's generation of novel associations. Bogousslavsky (2005) also defines creativity in terms of certain psychological traits, including "openness, lack of conventionalism, and playful thinking with risk taking" (pp. 103-104).

Looking at thought disorders, including the schizophrenia-spectrum illnesses, Folley and Park (2005) find "overwhelming support" (p. 272) for a positive relationship between creativity and schizotypy, or traits found in the less-impaired relatives of persons with schizophrenia. The major psychosis of schizophrenia and its attentional deficits, though, may mask the increased creativity of these individuals, the authors speculate. Bogousslavsky (2005) concurs, stating, "a certain coherence in mental activity is necessary for creativity" (p.103). He lists four phases of creativity: preparation, incubation, inspiration, and production. As a result of a broken chain among those phases, he writes, "the most severe psychiatric patients are not creative at all" (Bogousslavsky, 2005, p. 104). That, though, is debatable: Witness, for example, the prolific output of painter Vincent van Gogh, who by all accounts suffered from psychosis.

Delving deeper, the neurobiology of artistic activity bears further study, Bogousslavsky (2005) states, noting that neurological insults such as head injuries, dementia, and cerebrovascular accident may change artistic style for the better or for the worse, thereby impacting the public's assessment of creativity and normality.

Given that persons with a psychiatric or neurological illness often may be artistically talented, the question arises: Can the artistic efforts of persons with SMI—a competency—be matched with the other piece—opportunity—necessary for social change and integration?

Toward Social Integration: Using the Arts to Create Visibility

Like rural, poor women with depression, whom Hauenstein (2003) deemed "invisible," the creative activities of persons with SMI have remained largely hidden. Many artist-consumers work quietly on their own. In rare cases, talent historically was made visible by accidental discovery or the favors of a patron.

More recently, the arts-based therapies—using visual art, music, drama, poetry, and even horticulture—have emerged as vehicles for mental health service users to express their thoughts, emotions, and ideas symbolically. Still, it is process, rather than product and publication thereof, that is the focus. Thus, the work may remain hidden from view and from its role as a potential weapon against stigma.

Nevertheless, the process itself remains important. For many, the nonverbal communication route of visual art facilitates an otherwise challenging activity. Persons with schizophrenia, for example, may have difficulty articulating their ideas due to a formal thought disorder with distortions of thinking and perception. Per Ruddy and Milnes (2007), individuals with a diagnosis of schizophrenia may especially benefit from art therapy as an adjunct treatment to medication. "Through an image an individual can communicate 'both the rational and the irrational and find an acceptance interpersonally that need not threaten the integrity of the maker' " (Sarra, 1998, as cited in Ruddy & Milnes, 2007, p. 2). Such artistic externalizing of problems (Keeling, 2006) can further help to define a sense of self, which in schizophrenia may be vague, especially in an institutional setting.

McNiff (2007) also endorses the therapeutic value of engaging and transforming difficulties such as war-induced posttraumatic stress disorder through art. McNiff was a workshop leader at the Imagine Conference, held in 2006 in Tel Aviv, Israel, to explore arts-based solutions to geopolitical strife such as that in the Middle East today. "Vulnerabilities and rejected aspects of our personal lives are empathetically embraced as sources of creative energy that suggest approaches to the larger sociopolitical conflicts of the world" (McNiff, 2007, p. 392). Another team of presenters at the Imagine Conference, Estrella and Forinash (2007), discusses the process of narrative and arts-based inquiry as approaches to conflict resolution and reconciliation.

Thus, it becomes apparent that art by persons with psychiatric disabilities holds great potential for many: the artist, the community, and society. What is needed is a vehicle to make such art visible in mainstream public venues. This might be a step toward reducing the stigma of mental illness and facilitating social integration.

Going Public to Stop Stigma: Creating Opportunities for Artist-Consumers With SMI

Several organizations are already raising the visibility of artist-consumers. There is anecdotal evidence to support the hypothesis that the reduction of the stigma of mental illness is occurring as a result. A study is needed to determine whether this is the case. A proposed design is discussed later.

Case 1: VSA Arts of Washington (VSAW)

VSAW is a branch of VSA arts, an international organization whose mission is to provide opportunities for regional artists with both physical and psychiatric disabilities. Seattle-based VSAW offers professional development opportunities for emerging artists with disabilities and helps forge links among such artists, and between them, arts communities, and the general public. To facilitate its mission, VSAW operates the Vision Gallery, located in the downtown arts district of Pioneer Square. Exhibits change monthly and represent all media. Artists may choose to disclose their disabilities or not. However, the gallery is clear about its exclusive focus on artists with disabilities.

One recent exhibitor at the Vision Gallery was Alaska artist Erik Behnke, whose colorful drawings and paintings of animals were displayed during a "First Thursday" art walk in September of 2006. Behnke's Web site (Brown Bear Products, 2007), listed on his business card available at the show, states that he experiences Down syndrome and autism. Behnke sat quietly, smiling, as gallery visitors viewed and appeared to appreciate his work.

According to Behnke's Web site, a show such as that at the Vision Gallery represents an accomplishment that once seemed out of reach. "For years, mom had dreamed that Erik would someday work as an artist but it seemed impossible due to the level of his disability" (Brown Bear Products, 2007, para. 3). In fact, Erik's portfolio includes a coloring book, greeting cards, and the poster for the 2001 Special Olympics World Winter Games. In the summer of 2007, *Erik's Story: Finding a Gift Against All Odds in Rural Alaska,* was published (Thompson, 2007). Behnke hopes his work will inspire other mentally or physically challenged young people and their parents to dream of career success like his.

A study to measure any reduction in the stigma of mental illness attributable to a show like Behnke's could be done in the future, states VSAW Executive Director Patti Lee (personal communication, July 11, 2007). One approach would be to leave a one-page, five-question survey near the exhibit for voluntary completion by gallery visitors. Questions might include the following:

1. Did you know that the mission of the Vision Gallery is to support artists with physical or mental disabilities? (y) (n)
2. Before visiting the gallery, did you think persons with disabilities could be artists? (y) (n)
3. Now, after visiting the gallery, are you impressed with the quality of our artists' work? (y) (n)
4. Has your impression or opinion about people with disabilities changed? (y) (n)
5. Please tell us your thoughts or feelings about people with disabilities, including their abilities, talents, and rights to equal opportunities. (open field)

Thus, the value of consumer art as a stigma reducer could be assessed in more than anecdotal terms. Interventions might be changed or modified based on survey input.

Case 2: Idaho State Traveling Art Show

In January of 2006, an art show of works by children with and without serious emotional disturbances (SED) made its debut at the state capitol in Boise. Cosponsored by the Idaho Department of Health and Welfare and the Idaho Federation of Families for Children's Mental Health, "The World Through Our Eyes" traveled throughout Idaho during the year. The 42-by-18-foot multipanel display contained colorful paintings and poetry and showcased the talents of some of the state's estimated 17,000 children with SED (Aleccia, 2006). A voluntary short survey of visitors' attitudes and opinions lay on a nearby table; results have not yet been analyzed. Educational materials were also available. A list of resources, including toll-free mental health hotlines, rounded out the take-home materials.

The exhibit, states co-organizer Chandra R. Story (personal communication, June 29, 2007), was part of a statewide program aimed at decreasing the stigma of SED. It was effective, Story says: "I saw a lot of attitude change. It was very helpful. The kids are so stigmatized and marginalized. This boosted their self-esteem. It was also an opportunity for them to interact." The fact that the show included the work of children with and without disabilities was important, as it helped to integrate the experiences of everyone, Story says. This is a form of social integration.

Case 3: Spokane, Washington, Poet With Bipolar Disorder Publishes Book

Poet Teresa White of Spokane, Washington, published *Gardenias for a Beast*, her second book, in early 2007. White and her book were featured in an article in *The Spokesman-Review* (Webster, 2007). White, age 60, is open about her bipolar disorder, which was diagnosed when she was an 18-year-old freshman at the University of Washington. She discusses her illness and numerous hospitalizations in frank terms: "When we go into that schizoid state we might as well be schizophrenic because we're in psychosis. We can't tell what's real from what's not" (Webster, 2007, p. D5).

Aside from her poetry, White is proud of her work ethic that pushed her to be productive, maintaining employment at office jobs when her illness was stable. She learned her skills through the Washington State Department of Vocational Rehabilitation, thus defying a stereotype that persons with SMI are lazy.

White's psychiatric prescriber, advanced registered nurse practitioner Illa Hilliard, affirms the link between mental illness and talent. "On the whole, we know that people who are bipolar are exceptionally, unusually bright and creative. Not all, but many" (Webster, 2007, p. D5).

The article also had an educational component, a sidebar with plain-language information on bipolar disorder from the National Institute of Mental Health. Included were etiology, epidemiology, signs/symptoms, and treatments. A listing of local helplines was also included.

Other Examples of Stigma-Reduction Activities

Numerous U.S. and international corporations and nonprofit groups support projects that raise the visibility of artists with psychiatric disabilities and thereby help to combat the stigma of mental illness. Examples include the following:

- *Aspirations: Creating New Possibilities Through Artistic Expression*, a 23-page promotional booklet published in 2005 by Janssen Pharmaceutical Products. It features the paintings of persons with schizophrenia who also wrote captions expressing their feelings about their art and their lives. The last page contains advertising material about Risperdal Consta, an injectable antipsychotic medication.
- The National Veterans' Creative Arts Festival in Rapid City, South Dakota, an October 2006 presentation by the U.S. Department of Veterans' Affairs (VA). Open to the public, it featured the visual art, performance art, drama, dance, or writing of 130 veterans. The purpose, according to a VA fact sheet, was as follows: "This annual competition recognizes the progress and recovery made through that [creative arts] therapy, and raises the visibility of the creative achievements of our nation's veterans after disease, disability or life crisis" (U.S. Department of Veterans Affairs, 2006, para. 5)
- The 2006 corporate holiday card of Subaru of America, Inc. It featured a snowflake image accompanied by the heading "Friends are like snowflakes—all different." A caption identified the artist as Shabre, a 13-year-old with Asperger's syndrome and a student at Kingsway Learning Center in Moorestown, New Jersey. The special education school has a 7-year association with Subaru for producing the cover art for its corporate holiday card.
- "Art works! Using the arts to counter stigma and discrimination," a November 14, 2006, teleconference training held by SAMHSA. Similar trainings on stigma-combating strategies are hosted periodically by SAMHSA; these and other resources are listed on its Web site (http://www.stopstigma.samhsa.gov). One such resource, *Reaching Across With the Arts*, a self-help manual for mental health consumers, is cited on the SAMHSA Web site and is available free online at http://www.bluebirdconsultants.com.

Stigma Reduction: Benefits to Artists and Society—The Vision

Before proposing a formula to reduce the stigma of mental illness, a diagrammatic recap of the problem is useful:

SMI → Stigma → Negative impact to individuals → Negative impact to society

As we have seen, efforts to utilize the arts in service of stigma reduction appear to reduce negative outcomes for artists and for society. Benefits to artists include increased self-efficacy, increased empowerment, a voice for concerns, enhanced productivity, possible rehabilitation, and possible recovery. Benefits to society include lowered stigma, more treatment of disorders, greater compassion, greater social justice, and a more beautiful world. A study to confirm or

refute the available anecdotal information is needed. This hypothesis would be diagrammed as such:

SMI → Arts intervention → Benefits to individuals → Benefits to society

The Vision

As discussed by Ware et al. (2007), the social exclusion of individuals with psychiatric disabilities remains a persistent injustice. Capacities for connectedness and citizenship must be exercised. Connectedness entails "the construction and successful maintenance of reciprocal interpersonal relationships" (Ware et al., 2007, p. 469). Citizenship denotes the "full rights and responsibilities of citizenship" (Ware et al., 2007, p. 469). According to the capabilities model espoused by the authors, entailing competencies and opportunities, consumer art can help to create change.

The competencies of persons with SMI, especially artistic talents and works, are by all accounts highly prevalent but need to be made more visible. Opportunities created by the general community would provide a platform for that visibility and transparency so needed by mental health service users. Next, with their connectedness with others not defined by mental illness, their full participation as citizens would be facilitated. The outcome would be improved social integration of persons with SMI. This, in turn, would paint a picture of progress and a more just world for all.

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