Windows to Discover: A socially engaged arts project addressing isolation

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Social isolation is an ongoing issue for those experiencing mental distress. This issue was the theme of the Windows to Discover project completed as part of an artist residency in Lille, France. This practice-based report reviews the social construction of social exclusion and the theory of socially engaged art and describes the project. A collaborative participation model was used for the process of the project. This meant that the artist facilitated the development of the work and shared with the participants the responsibility for developing its structure and contents. Mental health consumers and professionals participated in it over a period of three months. Focus groups and group readings were held, and then drawings, paintings and models were made. Construction and artwork making followed. The work was then shown at two separate community events. Five Art Psy newsletters enhanced engagement. Positive feedback was obtained, in particular improved self-esteem and group participation. However, some found the experience emotionally stressful. The project was a valuable learning experience for the artist and the participants. The positive aspect of social isolation was an unexpected observation. Drawing a larger audience into the project was difficult. Suggestions to improve this type of project are presented.

Keywords: socially engaged art; exclusion; social isolation

Introduction

Following deinstitutionalization and the emptying of the large psychiatric hospitals from the margins into many western cities, many psychiatric patients now face social isolation and stigmatization in the community. Despite increased awareness and information about mental disorders, the causes and the symptoms of severe mental disorders remain perplexing for most citizens. This need to understand also drives our urge to classify disorders in increasing number of categories (Pierre, 2012). This rigid classification may further fuel the stigmatization that leads to the exclusion of people with mental disorders by society and their subsequent loss of self-esteem.

Engaging in the arts has been found to improve self-esteem, self-understanding and interpersonal communication (Davies et al., 2012). This has led to an increase in the use of art in health care settings around the world (Fraser & al Sayah, 2012). In France in the early 1990s, the Ministry of Culture introduced the program “Culture à l’hôpital,” recently renamed “Culture/Santé.” An annual call for projects from public health care services is made. The objectives include having health care professionals, consumers and artists
create together projects that would take into account the community and establish partnerships with other cultural services, e.g., libraries and schools (Chopin, 2011).

In 2010, a submission for a project by the Etablissement Public de Santé Mentale de Lille Métropole (EPSM) for a three-month artist residency on the theme of social isolation was accepted by the Direction régionale des affaires culturelles (Drac). Its objectives were to further understanding of how isolation is experienced and to translate this artistically. Following a brief discussion of socially engaged art as it applies to this work, this paper describes the setting, the process and the work itself. It concludes with a discussion of what was successful and what could have been improved.

Socially Engaged Art

The definition of art engagement is being elucidated as more projects are being reported on (Davies et al., 2012; Helguera, 2011). The Canadian Council for the Arts (2012) recognizes it as a growing priority worldwide and defines it as: “Actively engaging more people in the artistic life of society notably through attendance, curation, active participation, co-creation, learning, cultural mediation, and creative self expression” (p. 3).

One may feel that this definition is too broad. Indeed, engaged art occurs on a continuum of audience and artist participation. Pablo Helguera organizes this multilayered participatory structure under the following taxonomy: nominal participation, directed participation, creative participation and collaborative participation (Helguera, 2011). They are summarized in Table 1.

Collaborative participation feels like it would be the form of engaged art that is likely to bring the most benefit to the audience and artists. The more active the audience is, the greater their level of engagement (Davies et al., 2012). In this project, a strongly positive component was that the funding program clearly stipulated that the process was more important than having a final product to show. The only a priori requirement was the theme that had been negotiated between the artist and the health care team. The development of the project, its strengths and constraints would emerge from the audience and the setting. The outcome could not be predicted.

The Setting

The health care team in which the project occurred is unique in France. The philosophy of the EPSM, rooted in community psychiatry and deinstitutionalization, is named psychiatrie citoyenne or citizen psychiatry. Jean Luc Roelandt (2004), then director of the service, worked hard over 30 years to implement it in its sector. It is now remarkable in the

<table>
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<th>Table 1. Socially Engaged Art Participatory Structures.</th>
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<tr>
<td><strong>Artist(s)’ role</strong></td>
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<tr>
<td>Visitor(s)’/participant(s)’ roles</td>
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few hospital psychiatric beds that remain in their sector, the range of alternative residential resources available, the involvement of mayors and city hall in the development of services and the presence of a well-being and culture/arts multidisciplinary outpatient team called Frontières. It is from within this team that the project was implemented. Frontières’ weekly activities include a home improvement team that works to maintain and upgrade the apartments of consumers and a range of art workshops (drawing, printing, bookmaking, percussion, singing, theater, cultural outings) and adapted physical activities. A call for voluntary participation in the project was made to all consumers and staff in the service. Public organizations were also informed. The number of participants fluctuated ($n = 30–10$) according to the phases of the project and the degree of participation required. A core group of 10 persons were involved throughout the project. Most were consumers of the mental health services. All the consumers had participated in various art workshops offered by the team Frontières. A couple staff from the team actively contributed as well. It was emphasized that the primary goal of the project was the exploration of the meaning of social isolation as lived by the participants and that this project did not have the therapeutic objective of decreasing participants isolation, if present. The project was implemented in four phases. The process drew on the constructivist educational approach and the philosophy of knowledge of Wilthem Dilthey. For Dilthey, knowledge occurs on a continuum from the logical, deductive, objective and statistical (Erlaken) to the emotional, intuitive, subjective and holistic (Verstehen) (Ghaemi, 2010).

First Phase (Cognitive Knowledge)
This phase consisted of three group meetings with consumers and professionals. The first session was a presentation of the project, the artist’s previous work, an introduction of the participants and logistics planning for further meetings.

The next two sessions were focus groups, one on the meaning of art and another on the experience of isolation. The content of these discussions is summarized in Tables 2 and 3. Notes from the meetings and readings on the topic were distributed (Hannoun, 1991; Maisondieu, 2010). Maisondieu questions the motives of contemporary society in recognizing the marginalized. Possibly, human societies have always constructed groups to exclude to calm their fear of the unknown, the strange or the other (Maisondieu, 2010). Hannoun concludes that solitude will be the major problem of our times. He analyses the complexity of emotional solitude recognizing its ubiquitous nature (Hannoun, 1991). The discussion on the value of art identified the necessity of art for emotional well-being, its aesthetic value and its important role as a means of communication and self-expression. This could be interpreted as in keeping with the democratization of artistic creation, the removal of frontiers between arts, the artist and living beings advocated by the French

<table>
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<th>Table 2. The Signification of Art for the Participants.</th>
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<tr>
<td><strong>Spiritual health</strong></td>
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<tr>
<td>Human need</td>
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<tr>
<td>Feeling of freedom</td>
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<tr>
<td>Calm – pleasure – joy – passion</td>
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<td>Nourishes the soul</td>
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<td>Permission to make</td>
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artist and philosopher Robert Filliou. He said: “Art is what makes life more interesting than art” (Moulinier, 2010). For Filliou, artwork is truly collective. The public is invited to participate so that the distinction artist/public is negated at the same time as the distinction creation/action. Art is no longer defined as a simple representation of the real/imaginary or abstractly as an end in itself (art for art’s sake) but as participation in life, a piece of life. This goes further then just suggesting that our lives are enriched by the mean of art but that there is no separation, no definite frontier between art, the artist and the living (Moulinier, 2010).

Our next group explored the meaning of social isolation. Table 3 summarizes the comments made by the participants. The notable observation from this discussion was that social isolation had a positive value for some particularly when it was a choice. Spiritual growth and emotional protection were valued. It was made clear that the project would have to integrate that aspect as well as the more negative ones. Exclusion and the loss of self-esteem and relationships had harmful effects.

The objectives to explore the reason to make art on this theme and to better understand the multilayer of social isolation in the community had been met.

Second Phase (Embodied Knowledge)

The next two groups were spent drawing, painting, making models out of cardboard and clay, and discussing the form the project would take. Photographic exploration was made available with disposable cameras. Requirements emerged. It was to be a 3D object large enough that the public could enter it. Both the positive and the negative aspects of social isolation would have to be reflected. Each artist would invest the structure with their art in their medium of choice. A space for continued public engagement would be part of the structure. More specifically, the space had to be a place that was difficult to get into and to come out of, and a place from which one could look out and not be clearly seen. Positive images and words would also be part of it. These works shown in Figure 1 exemplify the above points.

Third Phase (Making the Work)

First, a shell was constructed. During the process, ideas for content emerged. Materials and objects for installation and collage were obtained. This time was emotionally challenging
for some, as personal issues seem to be triggered. Others found this phase stimulating. The limitations of space and time came to play on the project although it was agreed that it could continue to grow after the residency was terminated.

Fourth Phase (Showing the Work)

The first exposition of the work was as part of a community art festival called Open Windows in a park in the community of Faches Thumesnil. The work was titled Window to Discover. It was a success as the audience quickly got actively engaged by coming in and out of the space, peering through the holes in the faces, and drawing and writing on the space provided. The children were the most eager participants.

It was next shown in the community center of Mons en Baroeul. More images were added as well as photographs. The plan was to install it in a library next. Figure 2 shows images of these events.

The ArtsPsy Newsletters

To broaden the audience that could be reached, in particular the professionals in the health care system, five newsletters were circulated. The first one introduced the project and described what an interdisciplinary practice is. Working across traditional boundaries is an area for innovation where the challenge is to find the balance between too much rigor and not enough heart or too much heart and not enough rigor (Larameé, 2000). The second newsletter reported on the findings of the focus groups on the meaning of art and social isolation.

The third newsletter focused on an exhibition of altered books critiquing the prevailing psychiatric diagnosis system – “DSM Re-revised and other related texts” (Leichner, 2012) – of altered books critiquing the prevailing psychiatric diagnostic system that was showing at the University of Lille cultural center and several libraries in town. The fourth described the emergent process of the project as presented in this article. The final newsletter reviewed the experience and discussed socially engaged art. We concluded by encouraging the readers to do the right thing in their practice, share their knowledge, look

Figure 1. Drawings and Models.
and think more in-between and around issues rather than directly on them, and to integrate art into their personal lives for well-being.

Conclusion

Art always functions to help humans better understand their reality. This socially engaged art project required collaboration from mental health care consumers, artists, health care professionals, community organizations and the public to explore the theme of isolation in the community. A dozen artists were involved to varying degrees in making the work and

Figure 2. The Work Exhibited at a Community Festival and a Community Center.
many more in viewing it. The layered nature of isolation was elucidated and expressed in both its positive and negative aspects. It thus led to both new knowledge production for the participants and to knowledge translation through the art (Fraser & al Sayah, 2012).

There were a few limitations and some were unexpected while others could have been anticipated and prevented.

The artists and the health care team set the theme as part of the funding application. The community was not consulted. For ethical considerations and to further engagement in this type of project, a consultation with the community prior to setting the theme might have been beneficial.

Although three months is a reasonable period of time for a residency, more planning ahead of the arrival of the artist could make the making-art phase start earlier. Specifically, information about the project could have been circulated and time and place for the focus groups arranged to start immediately on arrival. This could have also increased the number of participants. Despite the newsletter and repeated invitations, no professionals outside those from the Frontières team participated. One can speculate that as elsewhere professionals are time-constrained in their work and also that participating in a nonhierarchical art project with consumers may not be valued adequately.

Another aspect that could have been expanded on relates to ethical considerations of such work (Ponic & Jategaonkar, 2012). As part of the introduction to the project giving attention to the costs and benefits of engaging in such a project – in particular the potentially emotionally upsetting nature of working on this issue – should have been discussed. One participant found that confrontation with the issue made her realize her degree of isolation and this might have triggered a relapse in her addictive behavior.

The nature of collaborative participation project is such that one cannot predict exactly the practical needs that will arise. However, it could be expected that materials would have to be bought as a budget was allotted for this. Finding a way to have rapid access to these funds would have prevented some delays and frustrations. Similar bureaucratic frustrations had been reported in previous projects (Chopin, 2011).

Most artists strive to be heard and seen. Although the process for the work is invaluable, the artists who participate gain pleasure and self-esteem from having the public see their work. A venue to show the work could have been planned for at the onset as was recommended by Chopin in her evaluation of previous projects (Chopin, 2011).

Finally, an evaluative component for the residency was not implemented from the onset. A debriefing group was held with the artists in the project and the staff. All mentioned frustration with the space and time constraints. Overall, the feedback was positive. Pride was expressed about what was accomplished within the time and resource constraints. The consumers mentioned increased self-confidence and self-esteem. A structured evaluative process was not implemented.

With the improvements suggested, I have no doubt that such residencies can make positive contributions to our understanding of illness, the health care system and the well-being of all those engaged.

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