

ART THERAPY FOR DIFFERING ABILITIES: SELF-ADVOCACY IN COMMUNITIES-OF-
CARE

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ABSTRACT

ART THERAPY FOR DIFFERING ABILITIES: SELF-ADVOCACY IN COMMUNITIES-OF-CARE

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This research seeks to answer the question: How can art therapists help people with differing abilities self-advocate within their communities-of-care? People with disabilities are often cast aside or ostracized by their communities because of their socially perceived deficits. There has been a strong social justice movement towards viewing disability as a diversity issue instead of a problem-oriented medical issue. A bibliographical qualitative research design was used to collect, analyze, and integrate critical disability theory and art therapy to answer the research question. This research provides a variety of suggestions, ethical concerns to consider, and recommendations for art therapists working with people with disabilities.

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Table of Contents

Chapter 1: Introduction	1
Chapter 2: METHODOLOGY	1
<i>Rational</i>	1
<i>Method</i>	2
<i>Procedure</i>	2
<i>Data Analysis</i>	3
<i>Ethical Considerations, Assumptions, and Biases</i>	3
<i>Validity and Reliability</i>	5
Chapter 3: LITERATURE REVIEW	5
<i>Disability Studies and Key Concepts</i>	5
The medical model	6
The social model	6
Self Advocacy	6
Communities-of-care	7
Biases and microaggressions	8
Bureaucracy	8
Social role valorization	8
Accessibility	9
Intersectionality	10
<i>Disability Diversity</i>	11
Invisible disability	12
<i>Negative Impacts</i>	13
<i>Art and Art Therapy</i>	19
Person-centered humanistic approaches to art therapy	19
Positive art therapy	20
Art as social practice	21
Outsider art and the grassroots movement	23
Social action art therapy	23
Disability pride and self-concept	24

Collaboration and sense of belonging	25
Positionality of art therapists	27
Supporting autonomy and resistance	30
Chapter 4: FINDINGS	33
Chapter 5: DISCUSSION	38
<i>Barriers and Limitations</i>	39
Chapter 6: CONCLUSION	43
References	44

Chapter 1. Introduction

In my art therapy master's program, I have been committed to breaking down social constructs and helping to lead the development of personal and social uses of art-related health. My art has been concerned with intersectionality, a term coined by Kimberley Crenshaw, that describes the interconnection of discrimination or disadvantage of one or more social groups such as sexuality, gender, disability, race, economic status, or other salient identities (Crenshaw, Gotanda, Peller & Thomas, 1995). I acknowledge my privilege in terms of being able to study art therapy and write this research project.

There has been an increasing demand by scholars and activists recently for self-narratives from people who identify as part of the disability community to lead the direction of disability studies. Doing this research was not an easy process. At times, I felt unqualified and was worried that I would further oppress an already marginalized group. However, there was something that drew me to conduct this research and I wanted to see it through. What helped me in this process was pivoting away from a medical model dependent on assessments, and movement towards a diversity model. Diversity and intersectionality are two things that informed my work. By doing this research, I hope to contribute to the education of other art therapists on ableism and the disability community. Disability is too often an afterthought in social justice movements. However, it should be the first thought as it can inform how we view other diversity issues. This paper starts with methodology used and is followed by a literary review of critical disabilities studies and art therapy. The findings and discussion chapters conclude the research paper.

Chapter 2. Methodology

This research project is the result of a theoretical investigation on how art therapy can assist people with differing abilities to self-advocate within their communities-of-care. In this section the rationale for the methodology, the analysis procedure, and data collection methods are presented. The section will also include pertinent ethical considerations, assumptions and biases regarding the topic of research. Lastly, the validity, and reliability of the methodology chosen will be explained.

Rational

My literature review highlights the historical ableist nature of psychology (Block, Kasnitz, Nishida, & Pollard, 2015a) as well as the growing need for “community-defined evidence” (Martínez, Callejas, & Hernandez, 2010). Based on the disparity between disability

studies and disability justice constructs (Block et al., 2015a), this research aims to examine the relationships between art therapy, people with differing abilities, and communities-of-care in North America in the last five to eight years. The intention of art therapy is to respond to the continuous social exclusion and its impact on well-being, to advocate for better inclusion, and to position social justice as essential to healing (Sajnani, Marxen, & Zarate, 2017, p. 28). The objective of the research is to determine what is currently being stated in the literature in response to these actions. The evidence will then be synthesized into recommended practices for art therapists working with adults with differing abilities.

Method

I answered my research question using a bibliographical methodology. This is a qualitative method that gathers information from published materials. This method creates an extensive and thorough idea of the findings across qualitative studies that are related to my general research topic (Knox & Lutz, 2014). The method allows me to review a range of texts in clinical psychology, art therapy, psychotherapy, and other related communities-of-care. It also allowed me to discover and document the essential elements of self-advocacy within these texts and informed my findings into an end product that may contribute to reshaping art therapy with this population (Knox & Lutz, 2014).

Texts used to conduct the research consisted primarily of peer-reviewed articles, however it also included thesis and research projects at graduate level, and published books to bridge the gaps between the different concepts related to this topic. Initial searches were conducted through PsychINFO and were retrieved primarily through Concordia's Library database and PsychINFO. Additional resources were found through Spectrum Research Repository, ProQuest, and Google Scholar. My search included the following keywords: "intellectual disabilities", "developmental disabilities", "disability" OR "neurodiversity" AND "art therapy", "creative art therapy", "community arts", AND/OR "advocacy" OR "social action."

Procedure

The data was collected through the following steps (1) read literature on decolonizing disabilities, the collective identity of people with disabilities, self-advocacy, and communities-of-care; (2) conducted an extensive search on disability studies in North America within the last five years; (3) used reference lists from the original collected texts to find additional sources

related to the topic; (4) repeated steps 2 and 3 until an exhausted list was compiled; (6) critically analyzed texts to see how art therapy can assist people with differing abilities to self-advocate. All of the texts were saved in the program Mendeley, which is a free reference manager system.

Data Analysis

The research content was analyzed through the use of a neutral method to create a quantitative description of the content by counting the number of times specific words and terms appear that are central to the topic (Marshall & Rossman, 2016). This method helped to systematically investigate and comprehend the ideas within the texts (Leavy, 2017, p. 146). This created “nonliving data,” which does not interact with other data and is separate from the research (Leavy, 2017, p. 146).

The first step in my data analysis included an extensive exposure to surroundings or conditions that are fundamental or pertinent to the object of study. This process relied on immersion strategies, wherein categories of ideas are created through exploratory and interpretive methods (Marshall & Rossman, 2016). Notes were taken on impressions that helped formulate decisions on analysis, coding, and interpretation. Codes were then applied to each source based on the research question to assist in creating units of analysis. These codes are used to find specific statements about relationships between the topics to connect different themes, and document grounded theory, which is when the theory is grounded in data (Corbin & Strauss, 1997). Based on these findings, new themes were developed and the content was analyzed until no new insights can be gained from the data (Leavy, 2017, p. 148). At this point, the data will be reduced to the most significant information needed to answer the research question.

Ethical Considerations, Assumptions and Biases

The research has been described through the lenses provided by social justice, feminist, queer, and political theories. Feminist therapy theorists have adopted an intersectional approach to therapy to foster a therapeutic relationship and empower clients. Intersectionality is the belief that multiple forms of discrimination intersect and shape an individual’s experience of the world (Crenshaw et al., 1995). Feminist methodologies also highlight the importance of non-hierarchical interactions and bi-directional learning (Yassi et al., 2016, p. 202).

For the purpose of this research, the term ‘disability’ refers to a collective identity as opposed to a medical category, and acknowledges the various intersections of disability inequity and inequality (Block et al, 2015a, p. 3). Conlin (2017) points out the diagnostic definitions of

“healthy” and “unhealthy” are subjective (p. 78). Human development is an intricate assemblage of multiple factors and a medical diagnosis is only a portion of it. Although disability is defined as a collective identity, I recognize that other researchers and academics may define ‘disability’ in their own terms in relation to their study or theoretical position. This research project will primarily use the term “people with differing abilities” because it is in line with the social model and decolonization of ableism. This will be discussed further in the literature review when discussing language surrounding disabilities.

To do this study, I think it is important to recognize my own social locators and theoretical stance and how it may influence my work. Firstly, I acknowledge that I do not know the lived experience of someone with a visible disability. Since this population is considered vulnerable, I chose to focus my research on how art therapy can assist in self-advocacy before implementing any directives. This helps to safeguard people with differing abilities and may help deconstruct ableism present in communities-of-care.

I also want to recognize my position as a Western scholar and that the limited accessibility of formal higher education is compliant with ablest systems of oppression (Block et al., 2015a). Furthermore, the medical mental health field itself has been a source of oppression, trauma, and violence based on a history of institutionalizing adults with differing abilities (Bartlett, & Schulze, 2017; Pereda, 2012; Wexler & Derby, 2015). I believe in the ongoing activism and critical analysis that is needed to work against these systems of oppression within my own field.

As a queer art therapist student, I have an understanding of the personal, societal and political implications of ‘outing’ myself as part of a marginalized group. I believe that this understanding influences my research when it comes to safety and trust. I also want my research to help move the profession beyond simple binaries. It seems that both social and economic systems have contributed to an increase in power and exploitation of minorities by privileging the rich (Kuri, 2017, p. 118). I hold the assumption that this is made possible through society’s binary classifications, such as Black-White, male-female, and heterosexual-homosexual, and abled-disabled (Builes Correa, Anderson Gómez & Arango Arbeláez, 2017, p.19). These classifications contribute to the polarization, appointing people to be one or the other, ignoring individuals that do not fit within these agreed-upon norms. As an art therapist who incorporates

cultural humility and social justice in my practice, I am against oppressive power structures such as ableism, sexism, racism, homophobia, and transmisogyny.

My assumption is that these oppressive power structures are entrenched within academic literature. I also believe that there has been a shift in the last decade to adopt a more ground-up approach. This includes working with people with differing abilities to empower them to take control of their own lives, along with the care they receive. I think these approaches help to equalize hierarchies and give people autonomy to make their own decisions. I believe that art therapy can assist clients with differing abilities to self-advocate within their communities-of-care.

Validity and Reliability

In order to increase the validity and reliability of the research design, I used theoretical and investigative triangulation. My preliminary research included multiple sources, methods, theories, and investigators. In order to increase my credibility, my literature review also included research that counters my biases. Hence, I looked at literature that assists with self-advocacy as well as literature that either counters self-advocacy, and/or examines the risk factors of art therapy with this population. This allowed me to increase my understanding of the research question. I also discussed my data analysis with my advisor and peers, and with someone with a lived experience of a disability. Their perspectives helped increase the objectivity of the research being conducted.

Chapter 3. Literature Review

This section is a culmination of information from research and theories that will help inform guidelines for art therapists working with adults with differing abilities. This literature review begins by defining key concepts, which includes the medical and social conceptions of disability, self advocacy, communities-of-care, ableism, biases and microaggressions, bureaucracy, social role valorization, accessibility, and intersectionality. Next, this review discusses the diversity of the disability community, including diversity of language, different levels of ability, different perceptions of disability, and invisible disability. After, the review covers the negative impacts that have been experienced by people with disabilities. Then it will introduce the different art therapy practices as well as the grass-root movement. This section also explores how art therapists are currently working with individuals with differing abilities.

Disability Studies and Key Concepts

The medical model. The 2012 Canadian Survey on Disability (CSD) revealed that 160,500 people in Canada aged 15 years and older were recognized as having a developmental disability (Bizier, Fawcett & Gilbert, 2015, p. 3), and 40% of which also have a psychiatric disorder (Spassiani, Abou Chacra, & Lunsky, 2017, p. 74). According to the American Psychiatric Association (2013) developmental disabilities are classified as a psychological disorder. The diagnostic criteria include deficits in adaptive and intellectual functioning. Intellectual disability is understood to be an umbrella term for global developmental delay, unspecified intellectual disability, communication disorders, language disorders, speech sound disorder, child-onset fluency disorder, social communication disorder, unspecified communication disorder, autism spectrum disorder, attention-deficit/hyperactivity disorder and specific learning disorder.

The social model. There has been a recent shift in disability studies that views disability as a diversity issue and not a medical issue (Dirth & Branscombe, 2018, p. 1302). The social model of disability believes disability is a societal attitude that views differences as disabilities (Gallagher, Connor, & Ferri, 2014; Hutchinson, Roberts, & Daly, 2018). Social constructionism is a theory in which people collectively assign meanings and understandings of the world that are based shared assumptions, but may not represent reality. Critical disability studies suggest that people are viewed as having limitations because of the way society is built and the social attitudes and assumptions that have been formed around ability. In the social model, people with differing abilities suffering primarily comes from inequality, stereotypes, discrimination, microaggressions, and limited access, as opposed to suffering from medical issues (Taylor et al., 2015, p. 23).

Block, Kasnitz, Nishida, and Pollard (2015b) state “The medical/social model binary is oversimplified along with disabled/non-disabled, scholar/activist, and perhaps the most difficult illness/disability” (p. 360). Disability studies have moved from a treating disability as a physical disease or mental disorder to looking more broadly at disability and community, participation, and justice (Block et al., 2015b, p. 360). Scholars emphasize that the social model view-point does not treat the individual but is linked to changes that need to be made in society (Siebers, 2008, p. 73, Gallagher et al., 2014, p. 1123).

Self advocacy. ‘Nothing about us without us’ is the chief foundation on which disability studies and politics are constructed (Kuppers, 2016, p.94). The ‘All Means All’ movement of

people with disabilities incorporates all who advocate and normalize perceptions of dignity and opportunity (McLain & Walus, 2015, p. 239). This can include friends, care-workers, family, guardians, employers, and other community members. Self-advocacy is defined as respecting oneself and others and their rights, recognizing strength, self-determination, having the ability to get information, identify one's own needs, and assert one's own position (Friedman, Arnold, Owen, & Sandman, 2014; Pacheco & McConnell, 2017). Advocacy can encourage people with differing abilities to create a future that benefits them and their community (Dirth & Branscombe, 2018, p. 1310) and also challenges the public's biases about them (Corbett, 2016, p. 1236). Self-advocacy focuses on accessibility and strengths. In art therapy, self advocacy is also referred to as social action art therapy, which is discussed further in the section 'Art and Art Therapy.'

Communities-of-care. Community and collective care are important for helping to sustain an individual's physical and emotional wellbeing, and their rights and privileges (Nishida, 2015, p. 155). Communities-of-care are interlaced systems of individuals, families, community, national and international levels of organization who advocate for the health and support of people with differing abilities (Kudler & Porter, 2013, p. 164). These communities follow the principles and approaches that are rooted in disability culture (Kudler & Porter, 2013, p. 164). Communities-of-care extend from clinics to social communities who work towards developing an environment of respect and support people with differing abilities (Kudler & Porter, 2013, p. 167). Basting (2018) recognizes that there is a need to create a supportive system for families caring for loved ones at home, and where care partners can strengthen relationships within a growing community (p. 745). Within communities-of-care, responsibility can be restructured horizontally from individual to individual living with differing abilities (Francisco-Menchavez, 2018). Kudler and Porter (2013) add that public health practices may need to mobilize the power of the community that surrounds each individual (p. 163). Clinicians and public health professionals can work together to create accessible and supportive communities where everyone is able to participate (Basting, 2018; Kudler & Porter, 2013).

Ableism. More recent research has recognized the 'ableist' nature of psychological foundations (Block, Kasnitz, Nishida, A., & Pollard, 2015a). Ableism is the belief in superiority of ablebodiedness and ability that often leads to discrimination, prejudice, and exclusionary treatment towards people with disabilities or people who are perceived to have a lack of ability.

Dirth and Branscombe (2018) add that is ableism is separate from a medical view that highlights a social reality of the human experience (p. 1310). Ableism impacts systems, policies and practices (Beneke, Newton, Vinh, Blanchard, & Kemp, 2019, p. 28). It privileges those that walk, speak, and read, without the use of a wheelchair, sign language, or Braille. It manifests through society's physical, intellectual, and emotional standards of what is normal (Beneke et al., 2019, p. 28). When people do not match these standards they are treated as disadvantaged (Beneke et al., 2019, p. 28). Authors point out that ableism seems to be more frequent and socially admissible than any other type of prejudice (Ford, 2009, p. 16; Kattari, Olzman, & Hanna, 2018, p. 477).

Biases and microaggressions. Biases are irrational feelings or opinions that people form about a social group. Microaggressions are actions that include statements, treatments, or circumstances that can be either indirect, slight, or inadvertent, that can cause someone to feel shame or a loss of dignity. Both biases and microaggressions towards people with differing abilities stem from ableist notions and can be a reflection of the society one lives in. Nishida (2015) explains that it is our social conditions that make engagement inaccessible for those living with a disability (p. 151).

Bureaucracy. Bureaucracy may be a key determinate of whether or not a person receives the services they need. Education, work and other jurisdictions require people with differing abilities to self-identify in order to access accommodations and legal safeguards (Dirth & Branscombe, 2018, p. 1312). Most services and organizations require a diagnosis in order for individuals to benefit from their programming. They may also operate on exclusionary criteria that dictate who is ineligible and some programming can only accommodate certain people (Block et al. 2015b, p. 363). Additionally, Mooney and Lashewicz (2014) reflect that support services and funding often change and can be conflicting to those who are trying to access services in moments of crisis (p. 181). There are many instances of accommodations available for people with differing abilities, however the structure requires that they make their disability known to others in order to receive the accommodation.

Social role valorization. Social Role Valorization (SRV) is defined as the use of culturally valued means to enable, establish, enhance, maintain, and/or defend valued social roles for people at risk (Wolfensberger, 1983, 1999, 2000). It is a theory that society's negative perceptions cause suffering for people with differing abilities because it often causes

mistreatment of these individuals in their communities (Vick, 2015, p. 832). This concept was developed by Wolfensberger (1983) who believed that quality of life could be enhanced if these negative perceptions were changed. SRV calls for systematic and strategic changes in perceptions towards socially valued qualities of people with disabilities (Vick, 2016, p. 832). Art therapist, Randy Vick (2016) supports capabilities and dignity and opposes incapacity, infirmity, and pity (p. 836).

Accessibility. Accessibility is about being able to participate fully in communities or being able to access services without any barriers. Williamson (2018) notes that initiatives to address these barriers began as a response to veterans with physical limitations returning from World War II (p. 8). Accessibility is usually defined by how usable a construction of buildings and products are by people with differing abilities, which favours mobility rather than social welfare (Williamson, 2018, p. 15). However, accessibility extends beyond physical environmental factors to include economic, institutional and educational systems that enforce restrictions on people with disabilities (Gallagher et al., 2014, p. 1123). Feminist, queer, crip scholar Alison Kafer adds that it's not only about ramps, parking, or places to sit but allowing people to stay in their bodies, take care, and be part of a community as much as possible (Kafer, 2016, p. 3). The scholar recognizes that individuals may need additional emotional and mental support in order to engage in their environment and feel safe (p. 2).

Physical, psychological, and social barriers can cause marginalization, discrimination, and can further impair peoples' abilities (Hutchinson et al., 2018, p. 176). Barriers and regulations that restrict accessibility can maintain statuses of unemployment, isolation, dependency, and poverty (Gallagher et al., 2014, p. 1123). Simplican and Leader (2015) believe that communities people belong to are socially constructed and defined through shared values (p. 723). This perspective seems to exclude or marginalize those that do not share all the same values or characteristics of their social community. For example, when people in disability advocacy groups must share the same political view in order to belong, people that hold different opinions can feel marginalized or oppressed (Simplican and Leader, 2015, p. 723).

Although some communities-of-care are accessible to some, they are not accessible to all. When issues of accessibility are raised in neighbourhoods, hospitals, schools or other public spaces, they tend to justify their exclusion of people with differing abilities based on outdated and inequitable policies (Beneke et al., 2019, p. 28). This means that it is more common for these

public resources to enforce their policy instead of making appropriate changes. This is known as social exclusion, which is when individuals are prevented from accessing their rights to these public resources. Therefore, people with differing abilities are frequently marginalized to specific spaces such as inner cities, shelters, nursing homes, or special education programs (Mirza, Magasi, & Hummel, 2015, p. 166). Terzi (2014) argues that as a matter of justice, people who may have limited abilities should be able to obtain applicable resources that will allow them equal and effective opportunities to achieve the well-being and reach their fullest potential (p. 486).

Disability is an issue of societal access and acceptance (Gallagher et al., 2014, p. 1136). Disability activism recognizes the inherent value of people with differing abilities, which allows them to be set apart from non-disabled and questions what is 'normal' (Dirth & Branscombe, 2018, p. 1310). People should have equal access to quality education, therapies and arts, technology and scientific advancements in research, and not have to carry the weight of stigma associated with mental illness (Gayle-Geddes, 2015, p. 124). McLain and Walus (2015) believe "Change could be realized if culture embraced diversity where community no longer questioned the 'who can' and 'what is' work and focused on the 'how'" (p. 239). This requires ongoing dialogue in order to gain a deeper understanding of 'how' and a commitment of communities-of-care to shift towards diversity and inclusion (McLain and Walus, 2015, p. 239). Nishida (2015) asserts that "shifting blame to society by articulating systematic ableism allows disability to emerge and coalesce as an identity around which people can come together to fight ableism" (p. 151).

Intersectionality. Although ableism is the most accepted and far-reaching 'ism,' it is not the only 'ism' facing people with differing abilities (Kafer, 2016; Kattari et al., 2018). Block et al. (2015b) argue "the real context of disability, cannot expect to meet the needs of people who are more likely to be marginalized because of their multiple issues" (p. 364). Kattari et al. (2018) brings up the need for intersectional approaches to disability and diversity (p. 478).

Intersectionality is the belief that multiple forms of discrimination intersect and shape an individual's experience of the world (Crenshaw et al., 1995). An intersectional approach looks at how social structures determine a person's position in society, oppressing some and privileging others because of intersecting social locations (Kuri, 2017, p. 119). Privileges and disadvantages can affect an individual's level of access. Intersectionality is "crucial to a deeper understanding

of the multiple forms of oppression they may face in conjunction with ableism” (Kattari et al., 2018, p. 488). Gallagher et al. (2014) argues that “we must always account for ways that race, gender, social class, and sexuality intersect with disability and engage in collaborations with other critical theories/scholars to help flesh out these effects” (p. 1138). Crenshaw (1991) identified the goal of analyzing intersections of identity is social empowerment (p. 1242).

Disability Diversity

Language around disability is diverse and often self-defined. Ugalde (2017) believes that labels can demonstrate how people feel about themselves, others, and their environment (p. 62). This suggests that context is particularly important. Block et al. (2015a) points out that choice of language around disability is due to culture, region, professional vocations and activist communities (p. 8). These can result in different classifications of disability (Dirth & Branscombe, 2018, 1301). Ugalde (2017) explains that labels can impact how an individual is received and valued by society (p. 62). A more recent term that has been adopted by North Americans is ‘People with Disabilities’ because it acknowledges the individual before the disability (Ugalde, 2017, p. 61). Research has shown that due to stigmatization and negative perceptions, people with differing abilities are less likely to identify themselves (Dirth and Branscombe, 2018). Dirth and Branscombe (2018) found that individuals who do not want to be associated with their disability will often refrain from being accommodated (p. 1309). This can put them at unfair physical or mental disadvantages. Koppers (2016) argues that unlike the queer community, there is not enough cultural visibility that allows people with differing abilities to form alliances or their ‘chosen families’ (p. 93). The cultural attitude of disability is continuing to evolve and labels, such as ‘differently abled,’ ‘savant,’ and ‘specially gifted,’ suggest disability does not have to be defined as someone who is inferior (Koppers, 2016, p. 93). These definitions are less definitive and view disability as a spectrum.

There are also different conceptual levels of disability. Scholars point out that disability is an umbrella term of a wide range of conditions and illnesses, which range in degree and length of time, that create impairments and include intellectual, learning or emotional difficulties (Ferguson, 2017; Gallagher et al., 2014; Grandin, 2008). Block et al (2015a) explains that disability is group membership that is connected to a person's sense of self and their experiences, which are shaped by their impairments, diagnoses, and embodied differences, either visible or invisible, and that are connected to societal values, assumptions, and barriers (p. 4-5). Block et

al. (2015b) point out that group membership, whether formal or informal, can be determined by the consensus amongst community members (p.363). Although narrow definitions allow people to preserve their distinctive identities, develop awareness, knowledge and skills, it can also create injustices when these distinctions are related to occupation and continuance of physical barriers (Block et al., 2015b, p. 363).

Dirth and Branscombe (2018) find that the structural and symbolic components of disability shape cultural knowledge and personal experience of disability (p. 1302). How people relate to their disability can also change depending on context. Disability can transform because of personal, political, institutional, and global contexts (Dirth & Branscombe, 2018, p. 1301). Members may have different changes they want to see enacted by their communities-of-care, whether it be more accessibility or change in beliefs and attitudes (Kattari et al., 2018, p. 487). This can be indicative of the tensions that exist within the disability community as each individual can have different thoughts and feelings towards ableism (Kattari et al., 2018, p. 486).

People can move in and out of group status of having a disability. Continuous group membership can be impacted by consolidating physical or mental limitations (Dirth & Branscombe, 2018, p. 1304). Additionally, people can be identified as disabled either from birth or later on in life (Dirth & Branscombe, 2018, 1305). Sometimes their disability may be temporary or conditions can change that alter their identity status. An individual's disability status may change because of changes in their environment or community because it can influence their social engagement. Friedman and McNamara (2018) find this is especially true for individuals with difficulties with expression, social participation, and comprehension (p. 111). It can be helpful to have a term that is both inclusive and flexible so that people can access services, supports, and stability (Ferguson, 2017, p. 2).

Invisible disability. Kattari et al. (2018) reflect that 'passing' as non-disabled can be both a privilege and a challenge for individuals whose impairments or disabilities are less apparent (p. 477). The authors explain that they can still experience rejection, ableism, and discrimination, while also needing to prove their disability (p. 477). They may have to 'out' themselves and can be challenged to prove they are disabled (Kattari et al., 2018, p. 477). In a study by Kattari et al. (2018) participants with invisible disabilities reported being policed by others, feeling like they are not 'disabled enough,' struggling with their desire of disability

justice, and experiencing internalized ableism (p. 485). Policing bodies was found to cause feelings of shame, frustration, and stigmatization (Kattari et al., 2018, p. 485).

The structure of ableism allows for a hierarchy of ability to be created and privileges those that are at the top of it. Kattari et al. (2018) found that those with invisible disabilities report that they are 'lucky' their disability is not as serious (p. 487). However, ableism impacts each individual who is part of the disability community, whether their disability is apparent or not (Kattari et al., 2018, p. 487).

Negative Impacts

In 2014, around 40 million people in the United States identified themselves as having a disability because they experience difficulties with everyday activities (Hinton, Kraus, Richards, Fox & Campbell, 2017, p. 899). People with differing abilities are more likely to die early, experience more health issues, are victims to intimate partner violence, live in poverty, and have less educational attainment than their non-disabled equivalents (Dirth & Branscombe, 2018; Hinton et al., 2017). Hinton et al. (2017) found that this group is not getting the recommended amount of exercise and have higher levels of tobacco use, which may be causing them to be overweight (p. 899). People with differing abilities also have a high risk for victimization and its aftereffect. This may be due to power differentials within the way society is structured. Past injustices have included being institutionalized against their will, economic exclusion, and denial of the right to vote (Bartlett and Schulze, 2017).

Block et al (2015a) notes that there are numerous employment opportunities for people working with this population yet people with disabilities experience difficulties finding employment for themselves (p. 5). Stapleton and Burkhauser (2003) remark that the employment gap of people with differing abilities has not changed since 1990's Americans Disabilities Act (as paraphrased in Ameri et al., 2018, p. 330). People with disabilities tend to receive lower pay, do not receive adequate job training, have lower work benefits, and less security (Ameri et al., 2018, p. 330). Ameri et al. (2018) discovered that employers tend to have a bias in hiring people with different abilities, even when their impairment would have no impact on job performance (p. 359).

Women are negatively impacted by multiple forms of discrimination. Women with differing abilities have difficulty finding sexual, romantic, or intimate partners due to poverty, isolation, and depression (Drummond & Brotman, 2014, p. 534). In a disability study by Pacheco

and McConnell (2017) the women reported experiencing combination of physical, sexual, and financial abuse, as well as rape and batter, silencing, and disability shaming (p. 504). Mothers with differing abilities experience discrimination amongst child welfare workers. Pacheco and McConnell (2017) noticed that they tend to search for deficits and often ignore their strengths or the context of their disability (p. 501). Queer women with differing abilities have increased health risks, substance abuse, addictions, and mental health problems (Drummond & Brotman, 2014, p. 534). Lesbians and bisexuals with differing abilities report that they do not feel welcome in either disability or queer communities (Drummond & Brotman, 2014, p. 535).

A study by Beail and Warden (1995) revealed that sexual abuse of people with differing abilities is a severely under-reported and important issue. Benedet and Grant (2014) acknowledge the history of eugenics and how this population was sterilized to prevent them from procreating because of the assumption that they would pass on their deficits (p. 137). The compounding factors of eugenics and ableism are what make this population particularly vulnerable to sexual abuse. Experiencing intimate violence can cause emotional and behavioural difficulties. Benedet and Grant (2014) believe that sexual assault of people with differing abilities is gendered because of the intersection of ableism and misogyny (p. 133-134). The authors theorize that women with differing abilities may feel powerless and are often coerced into sexual acts (p. 131). The authors also believe that women experience minimization of their complaints, are blamed, or are assumed to be unable to tolerate a criminal investigation (p. 134-135).

Keller (2016) also explains there is a high percentage of sexual offences reported by adults with disabilities. Risk factors can include sexual abuse in childhood, past violence, poor attachment, low self-esteem, anti-social attitude, age, culture, and community environments (Keller, 2016). Another study by Mishna (2003) showed that children with disabilities have a higher risk for peer victimization and experiencing psychosocial difficulties (p. 3376). Peer victimization may cause anxiety, insecurity, and internalization of distress. Bull and O'Farrell (2012) conclude that the increased victimization and lack of reporting leads to the invisibility of this population within their communities (p. 14). All these factors seem to contribute to poorer health outcomes.

People with differing abilities may have difficulty developing a sense of identity because of lack of opportunities that are available to them. Beneke et al. (2019) believe "The implicit and

explicit messages early childhood practitioners send about disability have important consequences for young children's developing identities and sense of belonging" (p. 26). Most people with differing abilities have been stigmatized, stereotyped, and pigeonholed (Bull and O'Farrell, 2012); and isolated and excluded from society (Fennell and Jones, 1998). Ableist beliefs and ideals can be internalized by people with differing abilities. Bull and O'Farrell (2012) remark that there has been a collective persona that has been ascribed to people with differing abilities (p. 160). This collective persona does not take into account their individualism and tends to view people with differing abilities as unsafe. This is part of the discursive framework that perpetuates stereotypes and allows people to create assumptions. Autistic academic, Melanie Yergeau points out that this experience can lead people who have a disability to feel they are no longer their body's author (2015, p. 84). Their mannerisms and behaviours too often get attributed to their disability. Black Feminist Activist, Pauli Murray noticed that discrimination is strengthened by compliance and sense of helplessness of people who are experiencing oppression (as cited in Pacheco and McConnell, 2017, p. 507). Not only does this negative attitude contribute to poor psychological well-being, but can lead to higher uses of community based services and increased contact with the police (Spassiani et al., 2017, p. 81).

Yergeau (2015) observes that not having a choice in having a disability has also been pathologized. The authors explain that when disability is described as involuntary it suggests that these individuals have no agency, rhetoric, or narrative purpose, and that they are trapped inside their own bodies (p. 86). However, this description is conflating choice with agency, willfulness, and consciousness, and negates that fact that compulsions exist for everyone (Yergeau, 2015, p. 93). Yergeau (2015) clarifies by stating that blinking is not always willful, scratching an itch is not always voluntary, and emotions are not always conscious, yet these automatic reactions tend to be forgotten in the discussion of disability (p. 93). When autism is framed as "dis-empathy", it positions it as rhetorical violence, and when it is thought of as involuntary, there is a rhetorical distance created that is othering (Yergeau 2015, p. 90). When people are 'not us' it can make it easier to diagnose and judge them. In other words, pathologizing people can have a de-habilitating and dehumanizing effect.

Even with disability legislation, such as the American with Disabilities Act (ADA) of 1990, the Canadian Charters of Rights and Freedoms of 1982, the Canadian Human Rights Act of 1985, the Americans with Disabilities Amendment Act of 2008, and Section 4302 in the

Patient Affordability and Care Act, accessibility is still insufficient in healthcare facilities and services across North America (Hinton et al., 2017, p. 899). Exclusion of people with disabilities from participating in community wellness programs is often not directly intended, it may be the result of inaccessible environments; lack of alternative transportation options; non-representative recruitment materials; or any number of other physical, social, or economic obstacles and failures to provide environmental accommodations (Hinton et al., 2017, p. 902). Corbett (2016) reports that community-based events are not accessible for children with autism spectrum disorder (ASD) because of affordability, social and physical barriers, and less supports (p. 1233). Corbett (2016) states that all children should have the right to participate in their communities in accessible ways (p. 1234).

Friedman and McNamara (2018) point out that people with differing abilities have more health problems yet experience disparity in the health care system (p. 111). Spassiani et al. (2017) found that there is a lack of support leading up to and during a psychiatric crisis for people with differing abilities (p. 79). Hospital staff are unable to care for people with differing abilities because of their lack of knowledge of disability experiences, psychosocial needs, capabilities, and other nonclinical challenges (Mitra et al., 2017, p. 1357). Biases amongst hospital staff has led to people with differing abilities feeling stigmatized, disrespected, patronized and unsupported. Martin, Ouellette-Kuntz, and McKenzie (2017) found that people with differing abilities fear health care providers reinstating a medical model (p. 272).

Research by Spassiani et al. (2017) found that health care providers tend to treat people with differing abilities as dangerous or imply that they are taking advantage of emergency services (p. 81). This results in turning them away or resorting to unethical methods. Friedman and Crabb (2018) uncovered that staff in emergency and crisis situations are still using restraint, seclusion and restrictions and interventions, which are infringing on the rights of people with differing abilities and can lead to trauma, injuries, death, or other negative outcomes (p. 171). Furthermore, the authors found that people with differing abilities disagreed with staff that these methods were used as a last resort and that a high percentage of Medicaid Home and Community-Service waivers were permitting these interventions (p. 182). Spassiani et al. (2017) report that people have been hand-cuffed by police and were not able to access the appropriate services when they were experiencing a psychiatric crisis (p. 76). Sometimes people with differing abilities, in particular those with difficulty communicating, use challenging behaviours,

such as aggression, destruction, noncompliance, self-injury, in the absence of alternative approaches (Friedman & McNamara, 2018, p. 113). Friedman and McNamara (2018) found that these behaviours can be received and managed poorly, often resulting in restrictions, separation, or isolation, which can have a negative impact on their quality of life and restrict their participation (p. 113). The authors believe communication skills between community partners and people with differing abilities need to be expanded so these behaviours can be better managed while ensuring the safety of everyone involved (p. 113).

Research shows that there is a lack of empathy, information, and communication provided to people with differing abilities or caregivers (Friedman & McNamara, 2018; Spassiani et al., 2017). Spassiani et al. (2017) reflect that staff seem disinclined to accommodate people with differing abilities in healthcare institutions and that their policies and practices are founded on ableist principles that indirectly and directly obstruct people with differing abilities access to appropriate care and community services (p. 80). In a study by Kattari et al. (2018) a research participant reported that no one asks how it works, what works best, or how they personally would like things to be (p. 482). This demonstrates there is a gap between people with differing abilities and care workers. Spassani et al. (2017) advise that community-based services can provide support and increase their accessibility to reduce the reliance on emergency services (p. 80).

The negative actions and attitudes of helping professions, such as healthcare and social care providers, can be harmful and cause more disablement, vulnerability, helplessness, discouragement, and lower self-esteem (Hutchinson et al., 2018, p. 192). Baumbusch, Moody, Hole, Jokinen, and Stainton (2019) recognize a shift in community living of people with differing abilities and the issues with healthcare providers and services, both structurally and personally (p. 11). The research shows that healthcare systems are not prepared for people with differing abilities to age prematurely (Baumbusch et al., 2019; Martin et al., 2017). The shift in community living means health care delivery needs to shift towards meeting clients' needs through community based supports and respite (Durbin, Sirotich, Lunskey and Durbin, 2017; Spassiani et al., 2017). Durbin et al. (2017) found that people with differing abilities and psychiatric disorders use a high number of community mental health services than other individuals (p. 19). The authors also identified that people with differing abilities have a higher

risk for physical health problems and that care for these problems is frequently compromised (p. 21).

Art and Art Therapy

Art is an inherent human ability that dates back as far as 28,000 BCE. Art provides opportunities for healing, catharsis, meaning-making and communication. Art is an expression of human creativity and imagination, which can be manifested through a wide variety of materials, including modelling clay, watercolours, pens, inks, pencils, oil pastels, photography, and digital medias. Kris (1952) believes that art is a reflection of inner experiences and that there is an intrinsic therapeutic potential within the process of making art. Kramer (1971/1993) is known for her approach 'art as therapy,' which focused on the defense mechanisms transpiring through creative expressions. Kramer (1971/1993) believed that the art-making and the product were processes of sublimation, where emotional energies could sublimate into constructive behaviours. This theory focuses on the transformational qualities that art has on the individual. McNiff (2004) adds that art is adaptable, insightful, and has heightening powers to those experiencing difficulty (p. 5). Art can be experienced as something personal as well as something shared. McNiff (2004) suggests discovering methods to liberate creativity and then maintain it through a disciplined practice (p. 5). Wherever and whenever art-making is possible the individual is able to access its inherent transformative and healing qualities. Art therapists can position themselves as leaders in caring for the phenomenon of art as therapy, and promote knowledge and understanding through communities that are already using it for healing (McNiff, 2004, p. 7).

Art is a universal language, which can enhance people's understanding and perception of the subject of mental health. The creative process holds the potential to offer new perspectives beyond dominant discourses and demonstrate unique abilities (Sajnani et al., 2017, p. 56). It has the potential to become bigger than the participant and the art therapist. The participant's visual imagery can represent their creative perspective of mental health. It may allow them to communicate something that cannot be expressed in words. Collins (2014) describes art as a method for creating a new way of being as someone accepts their reality, while creating and transforming something new (p. 6). Overall, the properties of the materials and processes can have a healing effect.

Person-centered humanistic approaches to art therapy. Humanistic psychology was developed in the 1960's and 1970's and is related to Carl Roger's (1951) 'Client-Centred Therapy' (Moon, 2016, p. 204). Moon (2016) explains that humanism is a way of being and is more than an art therapy approach (p. 203). At the core of this theory is that, "people are essentially trustworthy, ultimately responsible for the quality of their lives, and capable of self-directed and meaningful change" (Moon, 2016, p. 204). Personal experience and internal realities are valued, and objective knowledge is seen as a fragment of a broader view (Moon, 2016, p. 204). Moon (2016) explains that "part of the therapy process is understood as helping the individual to embrace their basic goodness and to assume responsibility for the quality of [their] life" (p. 204). Some authors advise authentically meeting participants where they are, on a neutral level, as opposed to diagnosing or prescribing interventions (Brodley, 1997, p. 19; Moon, 2016, p. 204). Rogers (2016) reports that art therapy helps people conceive the constructive changes that they want to make in the world (p. 231). The art therapist is there to facilitate a space and follows a person's lead so that they can reach their fullest potential (Rogers, 2016, p. 231).

Moon (2016) states three key elements are needed for a humanistic art therapy approach: "(1) being present, accessible, and open to clients; (2) honouring clients' thoughts and feelings in the immediate experience; and for some (3) engaging in artistic self-expressive activity along with clients" (p. 205). These elements may help to create a space of authentic caring, respect, and acceptance and can lead to healthy and creative self-directed expression (Moon, 2016; Rogers, 2016). Rogers (2016) added that art therapists communicate their empathic understanding of what the participant is bringing back to them. She recognizes that it can be uncommon for people to feel accepted and understood, especially for those who have been marginalized, which can be inherently healing (p. 232). Rogers (2016) points out that "by genuinely hearing the depth of emotional pain and respecting the individual's ability to find [their] own answer, we are giving clients the opportunity to empower themselves and discover their unique potential" (p. 232).

Rogers (2016) also emphasizes the healing properties inherent in the artistic process, which includes art therapies, journal writing, imagery, poetry, mediation and body improvisation. She adds that art produces discovery and insight that comes from an emotional reach (p. 230). Art can be used as a universal language to communicate our inner world (Rogers, 2016, p. 230). Rogers (2016) appreciative that engaging the body, mind, and emotions can foster spontaneous

and creative abilities, and perceptive and organized thoughts (p. 231). Art therapy not only offers a non-verbal form of communication, but also a different form of self-exploration (Rogers, 2016, p. 231).

Moon (2016) observes that people come to art therapy because of some form of crisis, painful event, and personal circumstances (p. 210). The author reflects that existential art therapy recognizes there are shared concerns of the human existence, including isolation, suffering, and a need for meaning-making (p. 205). Art therapy focuses on inviting the participant to explore these concerns through their artwork. This may cause the participant to be more mindful. Moon (2016) states “Mindfulness leads to creative anxiety, create anxiety leads to action, action facilitates change and fosters expression, and expression deepens mindfulness” (p. 205). Moon (2016) also emphasizes the shared concern of isolation and how it fosters the need for meaningful connections and community (p. 205). Loneliness is then combated through making art in the presence of each other (Moon, 2016, p. 205).

Positive art therapy. Chilton and Wilkinson (2016) state that “positive psychology builds upon the foundations and practices of mental health practitioners and art therapists with a new perspective that enables us to be more effective in our attempts to help others not only to survive, but to *thrive* in the face of adversity” (p. 249). The mission of this approach is to increase the well-being of individuals and their communities by developing what is good and useful in their lives (Chilton & Wilkinson, 2016, p. 249). This technique is related to humanistic principles and can be easily combined with other therapeutic approaches in variety of settings. Chilton and Wilkinson (2016) observe that this approach calls attention to what is not working in someone’s environment and nurtures resources towards making those changes (p. 250). Positive psychology supports personal strengths and social connections in order to increase a person’s health and well-being (Chilton & Wilkinson, 2016, p. 251).

The framework of positive psychology includes positive emotions, engagement, relationships, meaning, and achievement (PERMA) (Chilton & Wilkinson, 2016, p. 251). Chilton and Wilkinson (2016) propose that art making can highlight strengths, create a sense of mastery, induce a state of flow, facilitate making meaning out of one’s experiences, and increase positive emotions (p. 261). Chilton and Wilkinson (2016) point out that art-making process has inherent strengths such as investment, imagination, concentration, creativity perspective, balance, and many more (p. 256). Additionally weaknesses can be reinterpreted as overuse of

strengths that have not been modified to meet the demands of a particular situation (Chilton & Wilkinson, 2016, p. 255). The state of flow is an effortless concentration, attention, and focus, that usually occurs in art-making when there is a balance between skill, effort, and stimulation, which can increase positive emotions (Csikszentmihalyi, 2014, p. 181). Meaning-making is created through symbols, metaphors, stories, that are illustrated through participants artwork, which can offer alternative perspectives (Chilton & Wilkinson, 2016, p. 258). Creating artwork together is a different way of relating that can encourage the development of positive relationships (Bailey, 2016; Callus, 2017; Herzog-Rodriguez, 2015; Kapitan, 2015; Morris & Willis-Rauch, 2014).

Art as social practice In the late 1970s, people started to realize that people with differing abilities have emotional needs and that their emotional experiences are still present even with learning difficulties (Bicknell, 1983; Hackett, Ashby, Parker, Goody, and Power, 2017; Sinason and Stokes, 1992). Bull and O'Farrell (2012) believe that postmodernist distrust of authority, human rights policies, and person centred approaches may have increased understanding and awareness of social inclusion for this population (p. 5). Vick (2016) notes that deinstitutionalization, civil rights, suffrage movements, and other mid-century changes is when the first disability studios appeared (p. 831). Decottignies (2016) observes that disabled artists seem to be impacted by biased perceptions and not limited art opportunities. She adds that this population seems to depend on non-disabled people for access to arts (p. 43). People with differing abilities' needs, such as, forming meaningful relationships, building agency, and positive decision making, are not being met within their communities (Martinovich, 2006; Wexler & Derby, 2015). Bull and O'Farrell (2012) argue that person-centred approaches are beginning to emerge through partnership boards, consumer evaluation groups, person-centred planning and social action researchers (p. 6).

Community art programming can provide individuals with a sense of belonging and acceptance (Macoretta, 2017). Through these programs participants can find their place and begin to advocate for themselves and educate others (D'Amico, Lister, Snow and Tanguay, 2009, p.36). Becoming an artist can create a sense of identity through the exploration of art. It can provide participants with safe environment that may offer new perspectives and greater coping skills (Bull & O'Farrell, 2012, p. 11). Wilson (2003) writes that the art room is a place that facilitates the opportunities for mastering materials and outcomes (p. 265). Vick (2016)

comments that he was witness to momentous personal and social transformations happening through the art in community studios (p. 829).

Vick (2016) states that “Studios are the birthplaces of art therapy” (p. 830). These studios do not generally have a definite therapeutic orientation yet they are helping to generate positive change in the lives of individuals and their communities (Timm-Bottos, 1995; Vick, 2016). The ability to access programs that support self-directed art making can provide a sense of empowerment and increase autonomy. Open studio art can thwart possible stigma associated with conventional therapy groups (Williams & Tripp, 2016, p. 420). Rubins (2016a) notes that the studio has made a comeback for those that practice art therapy (p. 17). Vick (2016) believes, “The world of the disability studio lies just beyond the current edges of the profession of art therapy” (Vick, 2016, p. 837).

Outsider art and the grassroots movement. Wexler and Derby (2015) researched what community arts were able to offer people with differing abilities. The authors discuss how ‘Outsider Art’ challenges traditional clinical discourses and institutional art programs began to reinvent how artists create and the ways in which they are defined (p. 128-130). The term ‘Outsider Art’ came from the term ‘art brut,’ which was coined by a French painter Jean Dubuffet who admired untrained artists that were outside of mainstream culture (Vick, 2016, p. 830-31). This seemed to change what art was and who could do it, which were opposite to the standards set by the academy (Vick, 2016, p. 831). Artists were becoming inspired by alternative sources, including institutionalized patients (Vick, 2016, p. 831). Decottignies (2016) believes that this redefinition of art can help reshape reality and provide a more accurate representation of society (p. 46).

Edelson (2011) believed that this art movement in the 1970s, along with other concurrent factors, lead to the United States ‘Studio Art Movement’ (as paraphrased in Vick, 2016, p. 830). The Creative Growth Art Centre (CGAC), House of Artists in Austria, and the Grass Roots Art and Community Effort (Grace), Creativity Explored, Gateway Arts, Very Special Arts, and the National Institute on Art and Disability are the pioneers of art centres working with adults with disabilities, which allowed artists to develop their own style using nontraditional teaching methods (Vick 2016; Wexler & Derby, 2015). The authors describe that these centres gave new identities of an artists and the ability to create something sustainable and culturally monumental

(p.133). These centres offered a new way for its participants to engage and communicate with their community.

More modern examples of the grass roots movement in Canada include The Deaf, Disability and Mad Arts Alliance of Canada (DDMAAC), Disabled Young People's Project, SPiLL/PROpagation, Tangled Arts Disability, and others (Decottignies, 2016). These organizations bring together disability-identified artists in order to respond to the inequities they face in society and the art world by promoting social justice perspectives and diversity to challenge artistic, cultural and sociopolitical hegemony through integrating values, visions, and skills of people who live on the 'outside' of social norms (Decottignies, 2016, p. 43- 45). In Kuppers' (2016) view, "Labels in turn fuel some of the markets for outsider art, one of the first places of disability culture work in modernity" (p. 93). Decottignies (2016) concludes that this movement has resulted in higher degrees of equity (p. 45).

Social action art therapy. Kuri (2017) observes that "In the last two decades, the profession of art therapy has been slow to engage with issues of diversity and social justice, despite the fact that many art therapists work with marginalized groups" (p. 118). Social action art therapy is defined by Golub (2005) as "a participatory, collaborative process that emphasizes art making as a vehicle by which communities name and understand their realities, identify their needs and strengths, and transform their lives in ways that contribute to individual and collective well-being and justice" (p. 17). Temple Grandin (2008), a scholar living with autism, upholds that it's about nurturing great talent and unique abilities (p. 27). Art therapy can provide a platform for people with differing abilities to learn to self-advocate. Art therapy can help people with differing abilities regain the power or stop others from taking it (Dorozenko, Bishop, & Roberts, 2016, p. 202). It is not about giving power to another person, but helping to prioritize marginalized perspectives.

The work requires solidarity with disenfranchised populations to facilitate the opportunity to positively impact their community (Yeh, Walsh, Spensley, & Wallhagen, 2016, p. 1947). de Castro and Levesque (2018) state that "advocacy efforts that effectively call attention to population health threats and promote the well-being of communities rely on strategies that deliver influential messaging" (p. 157). Art can be used to increase awareness about injustices regarding social and cultural aspects of health and wellness (Cox, Brett-MacLean, & Courneya,

2016, p. 74). It can offer a pedagogical space for learning (Cox et al., 2016, p. 75), where participants can explore their self in relation to their experiences.

Reflexivity can be encouraged through a series of mindful or provoking questions (Sitter, 2015, p. 915). For example, in the article by Sitter (2015) they asked participants how supports in sexual health could be strengthened, then later discussed eugenics and agency in regards to love and relationships and policies and support services that are systemically discriminatory (p. 919). Healthy and creative arts can help stimulate people and society towards affective, interpersonal, and embodied change against discriminatory experiences (Sajjani et al., 2017, p. 54). Art therapy helps provoke reactions that can sustainably affect change.

Visual images have the potential to create impressions on others, which can encourage change and challenge stigma of people with differing abilities (Simplican & Leader, 2015, p. 724). Leavy (2015) explains how images can elicit an emotional and inherent response that is different from reading text. He argues that processed images get stored in the subconscious and transform the conscious (p. 225-230). Visual art can activate the viewers into contemplation of themselves and society.

Disability pride and self-concept. Disability-identified artists can positively assert impairment as a base for diversity and pride (Decottignies, 2016, p. 44). Decottignies (2016) states that “disability-identified art inverts impairment into a source of aesthetic appreciation by affirming disability aesthetics: impairment-specific words, gestures, symbols, meanings, history, and collective responses to dis-ableism that cannot be authentically represented by the non-disabled” (Decottignies, 2016, p. 46). ‘Disability Pride’ is about empowerment, shared resistance, and a positive affirmation of disability culture (Decottignies, 2016, p. 46). Dirth and Branscombe (2018) report that there is valid evidence to support that disability pride can be a protective factor against stigma and psychological distress (p. 1316). However, disability pride is not mutually exclusive to internalized stigma. Individuals can feel validated in their experiences while also not wanting to carry the label of disability, and they can feel that what they do is substantial, given their limitations while also feeling inadequate because of them (Kattari et al., 2018, p. 483-484).

Cox et al. (2016) advocate that the creative process allows one to express and nourish self-identity, both as an artist and as an individual (p. 72). Creating art can help address social injustices, increase awareness about social and cultural aspects of health and wellness, and

modernize medical education (Cox et al., 2016, p. 74). The art created can provide a necessary perspective and make the invisible visible. Cox et al. (2016) explains that the creation of art can be a way to tell a story, and make sense of their experiences and the emotions that people with differing abilities face. The authors add that this can increase their awareness of self in relation to the others and may help them be more present in social situations (p. 76). Furthermore, art can be an externalized expression of thoughts, emotions, and perceptions, which can foster awareness of values and generate introspection and dialogue with self and others (Cox et al., 2016, p. 79). Art has a visceral quality that can promote new insights, reach different levels of communication, and stimulate an emotional response (Cox et al., 2016, p. 79).

Art therapy can support a person's self-concept through an affirmative orientation to their different abilities (Dirth & Branscombe, 2018, p. 1312). This involves facilitating a space that is accepting, supportive, and understanding without imposing a treatment or an outcome. It also can facilitate discussions that shift the focus to a more positive view of life (Hutchinson et al., 2018, p. 192). Art expression can help participants liberate themselves from the burden of stereotypes and diagnosis's that have been placed on them by society (Kuppers, 2016, p. 94). People with differing abilities can create narratives that deconstruct personal tragedies and reconstruct them into valuable social identities (Dirth & Branscombe, 2018, p. 1313).

Collaboration and sense of belonging. Art therapists' recognition of deficit-based thinking can help them take action to support and increase people with differing abilities sense of belonging in community programs (Beneke et al., 2019, p. 28). Physical, instructional, social, and representational exclusion can lower self-esteem, increase loneliness, and alter sense of justice (Beneke et al., 2019, p. 27). Bogart, Lund, and Rottenstein (2018) theorize that the negative impact of stigma can become better when members identify with each other as opposed to the majority (p. 155). A shared sense of disability is comprised of a shared history of oppression and celebration as well as a multitude of other intersecting factors including class, race, gender and nationality (Kuppers, 2016, p. 96). It is the culture of disability that bring them together towards a united action for social justice.

Rogers (2016) proposes that connecting with one other person, in a supportive and accepting environment can offer participants ways to relate to the community (p. 242). Once people are free to be authentic and empowered within a small community, they can be encouraged to continue their path within the community at large (Rogers, 2016, p. 242). Group

art therapy has the ability to facilitate mutual understanding, where perspectives are validated and respected.

Simplican and Leader (2015) believe that a sense of self is belonging to a community has positive impact (p. 719). Dirth and Branscombe (2018) observe that social integration and belongingness are correlated with positive health outcomes (p. 1316). Macoretta (2017) has witnessed participant's transformation towards personal growth healing, increased self-confidence, and sense of belonging through collaborative art-making (p. 1). Hinton et al. (2017) found that their focus groups believed they would benefit from collaborating in smaller groups of similar disabilities and age groups (p. 902). Chilton and Wilkinson (2016) explain that "fostering connection and sense of belonging similarly help change perception in a positive way" (p. 257).

People can enrich their reality through social interactions, which can alter how they think about their world and reality (Sitter, 2015, p. 918). Group art therapy can create a space where all members are able to express themselves simultaneously (Williams & Tripp, 2016, p. 424). In a study by Sitter (2015) participants were able to co-create a safe space where they could explore their experiences. One participant described feeling comfortable to ask questions, give opinions and disagree with others, while another participant expressed the power of hearing other's experiences (p. 922). Sitter (2015) describes their participants as 'co-filmmakers' where they collaboratively develop, edit, and distribute a final video as way to communicate sexual health and self-advocacy (p. 911). When using art to promote self-advocacy, the participants can become co-investigators into the issues that impact their lives (Sitter, 2015, p. 916).

The artwork can also provide healing for those who witness it. Participants witnessing their artworks and their relations to others works can create connections that reorganize how they feel about their own experiences and highlight the breadth of the issue. Rogers (2016) discovered when she danced out her emotions in front of an empathic and accepting witness, her affect and awareness shifted (p. 232). Sharing in the process of creation and witnessing can offer and invitation that enables a group to struggle together (Williams & Tripp, 2016, p. 420). Vick (2016) adds that the members of marginalized groups can be figuratively and literally 'seen' by others in the group (p. 832).

Art therapy groups can have a cohesive identity as well as negotiate the multiple identities within the group (Simplican & Leader, 2015, p. 725). This may be difficult to balance and requires self-reflection and feedback from all group members. Sitter (2015) found that it can

be challenging to balance time, choice and agreement in regards to the artwork and what will be presented (p. 922). Williams and Tripp (2016) comment that deciding how to use the space and time should be one of the group's first decisions (p. 242). Sitter (2015) discovered early on that the more vocal and articulate participants dominated overshadowed the other participants (p. 922). Art therapists can find ways to honour the individual voices throughout the process by offering a variety of different ways to contribute their opinions. In Sitter (2015) each member was asked what they wanted to keep in and take out of the project, and final decisions were made through ongoing group discussions (p. 922). Community art engages participants in a collective process of creativity, reflection, and reciprocity (Barndt, 2008; Macoretta, 2017).

Art therapy can help create community, which helps connect people with disabilities. Williams and Tripp (2016) believe "With appropriate group membership and enough time for trust to develop, a rational process-oriented art therapy group can be an agent of change" (p. 426). The hope is that collaborations can spark more conversations and actions amongst researchers, educators, therapists, artists and service care providers (Sajnani et al., 2017, p. 61).

Positionality of art therapists. Although art therapists understanding of aesthetic and relational processes are valuable for supporting social and personal change. Sajnani et al. (2017) propose that this role can be less definitive (p. 61). The authors call for flexibility amongst the profession and counteracting potential barriers to participation (p. 61). Ferguson (2017) believes that disability can be reduced through environmental design (p. 3). This is because it is the external forces which create conditions that do not match the needs of individuals and set them at a disadvantage. Carney et al. (2007) maintains that "the social model views all learners as part of a continuum with a variety of needs, and supports the belief that the learning environment should be modified to meet those needs" (as paraphrased by Ostrowski, 2018, p. 19). Grandin (2008) adds that support should be based on learning profile, personality, strengths, and weaknesses (p. 10). Dorozenko et al. (2016) mentioned using simplistic language, bullet points, illustrations, and repetition (p. 201), while Hilton et al. (2017) added that they include images of people with differing abilities and make information available in other formats for people with vision impairments (p. 903) and Yeh et al. (2016) included materials in bigger fonts and offered assistive listening devices, captioning, sign language and translators (p. 1948).

It is essential that art therapists support ideas that originate within the communities. Art therapists "need to cultivate environments where their artistic expression is truly welcome and

not shaped to meet the needs of the therapist or the public” (Sajjani et al., 2017, p. 61). Grandin (2008) maintains that talents and unique abilities should be nurtured (p. 27). Art therapists can investigate how power dynamics influences the practice of art therapy. Keselman and Awais (2018) suggest that therapists should let the participants direct what they need help with (p. 82). This can require the therapist to relinquish their power, as being the ‘expert’ can be counterproductive (Vick, 2016, p. 836). The therapist can remain open to learning from the community and should be aware that individuals have their own intentions for their art that may or may not include self-advocacy. There is no right or wrong way to make art in therapy. Creating environments that accept and allow mistakes can be restorative, as the right to make mistakes is rarely given to people with disabilities (Sitter, 2015, p. 919).

It is also important for the practice of art therapy to go through the process of critical analysis. Sajjani et al. (2017) notices the tension between accounting for the art therapists’ identity while critically analyzing the norms that get attached to this profession (p. 61). Art therapists need to be aware of systemic influences on practice so they can avoid re-traumatizing the people they work with (Keselman and Awais, 2018; Nadal, 2017). They may also need to recognize how practices can be connected to dominant discourses and systems of society (Keselman & Awais, 2018; Sajjani et al., 2017). This includes understanding how language can reinforce inequity (Morris & Willis-Rauch, 2014, p. 29). This can help them to avoid unintentional microaggressions with their participants.

Morris and Willis-Rauch (2014) acknowledge that the medical model is often at odds with the fundamental values of art therapy (p. 28). This includes not accepting a person’s diagnosis as it’s central discourse. Labels should never define an individual (Grandin, 2008, p. 27). Instead art therapy can offer alternatives and new ways of inhabiting communities (Sajjani et al., 2017, p. 56). Kupperts (2016) upholds that people with differing abilities are seen as makers, consumers, and critics of a shared art world (p. 96). It also acknowledges the struggles of people with differing abilities and validates and normalizes them as being a valuable psychological experience (Dirth & Branscombe, 2018; Kupperts, 2016). This acknowledgment includes recognizing intersectionality and better integration of multiculturalism and diversity, as well as being aware of social cultural factors on micro and macro levels (Keselman & Awais, 2018, p. 85). Understanding structural inequalities can help art therapists to increase their support for diverse populations and ingrate better advocacy into their practice (p. 78).

Ableism can perpetuate biases and clouds a person from being viewed as multidimensionally. Art therapy can help support self-advocacy by being aware of these biases and reframe from asking leading questions. This requires ongoing self-reflection and an inner dialogue of the art therapist. In Dorozenko et al. (2016) the researchers recognized that they were coaching responses from the study's participants. This revealed the authors held biases that view people with differing abilities as eternal children or as people with limited interests and emotions. These perceptions influenced how they elaborated on their original questions. The authors also discovered that social aspects of a directive always seem to be promoted, yet basic information, such as what the task involved, was left out (p. 205). Instead art therapists can take the time to explain the directive in simple and easy to understand language. Art therapists can also provide more time or alternative directives so that the discussions are self-generated.

Sajnani et al. (2017) suggests that art therapies can take action against social exclusion and its influence on mental health, and position social justice and diversity as healing agents (p. 54). Social mobility creates access to status, resources, and opportunities (Dirth & Branscombe, 2018, p. 1309). Creating opportunities for those with a lower status disability the potential to move to a higher status can counter the unequal treatment and reduce negative stereotyping (Dirth & Branscombe, 2018, p. 1309). Art therapists can adopt enabling strategies to help mobilize their participants towards self-advocacy (p. 20). Hutchinson et al. (2018) suggest strategies such as affirmed sense of worth, and creating engagement and opportunity (p. 193). The art therapist requires self-reflexivity in regards to maximizing full social participation (Dirth & Branscombe, 2018, p. 1315). They can provide adaptations to practical techniques to ensure equitable participation and help to ensure participants are able to express themselves in a safe and effective manner (Sitter, 2015, p. 914).

Rubins (2016b) stresses that a therapeutic alliance with participants is imperative for creating change (p. 85). Kattari et al. (2018) posit that establishment of trust is important so that participants do not feel like they are being pathologized or marginalized (p. 480). The art therapist can offer human compassion and empathy, which may help provide a corrective experience to past injustices (Kattari et al., 2018, p. 486).

Supporting autonomy and resistance Art therapist can position themselves as the observer or facilitator. When art therapists acknowledge their limitations and support participants in realizing they are the experts of their own realities. The art therapist can “meeting them where

they are” and support their self-direction (Keselman & Awais, 2018, p. 81). Macoretta (2017) expresses that “self-directed learning and reflection also fosters a more personal and deeper engagement with experiences” (p. 17). Wolfensberger (2000) connects the importance of decision making and control for devalued individuals to the Social Role Valorization theory. The art therapist embraces all forms of expression and allows for spontaneity, experimentation, and flow without imposing their own ideas or cultural norms (Keselman & Awais, 2018; Sajjani et al., 2017).

Rubins (2016b) suggests working with individuals as freely as possible and lending support only where it seems most critical- by intervening constructively or, inviting to witness what is happening so that one may increase their understanding of it (p. 84). A non-directive approach allows members to discover their own artistic and verbal process without professional influence (Sajjani et al., 2017, p. 56). This approach includes voluntary participation in both art-making and discussions, active engagement, collaborative decision making, self-chosen processes, and facilitation rather than structured direction (Morris & Willis-Rauch, 2014, p. 28). This method allows for themes to emerge through the process. This also positions the participants as active agents of change in their lives (Pacheco and McConnell, 2017, p. 502). This is important because it levels out the intrinsic hierarchy that exists between the art therapist and the people they work with. In Morris and Willis-Rauch (2014) they began making with the participants to lessen the distinction between the therapist and participant (p. 31).

Human agency provides participants with authority and the power to make decisions (Sitter, 2015, p. 918). Macoretta’s (2017) research supports that “informal learning situations are opportunities for individuals to take control of their own learning, building autonomy and self-efficacy” (p. 16). These informal sites allow the participants to learn and take risks through the experiential. For example, in research by Sitter (2015) participants decided what the film was going to be about, who they wanted to invite, and who they would interview to tell their stories (p. 918). Ferguson (2017) notes that “this sudden autonomy can be a real shift following years of assistance with advocacy and/or support” (p. 5).

In a study by Morris and Willis-Rauch (2014), their goals include empowering participants as artists, collaborative decision making, and reduction of stigma through a voluntary artwork exhibition. Their groups would vote on what art media to use, operational guidelines, and what features the group would have (p. 30). They also offered optional portfolio

reviews where the members decided whether they wanted emotional reactions, aesthetic critiques, or artistic suggestions as feedback and whether or not other members could touch their work (p. 32). Participants were encouraged to connect their images to their experiences and the exhibit was used as a platform for participants to educate their community (p. 30). Additionally the participants decided how individual and collaborative pieces should be displayed together, whether outside work could be included, and if the pieces were for sale and what they could be priced at (p. 34).

Art therapy can also help people with differing abilities advocate for the right to refuse. Dirth and Branscombe (2018) observe that this population may be unable to refuse because of fear of judgement for being ungrateful (p. 1301). It is important that involvement be optional and that members of the group can stop at any time. It is also important to remind them of that choice throughout the process. Hutchinson et al. (2018) found that selectivity in socializing was considered helpful in managing how individuals were defined and treated by others (p. 189). People with differing abilities can be supported in choosing who they interact with and reminding them that they have the right to refuse people who negatively impact their lives. Participants also have the choice on whether or not they want to educate others. In a study by Kattari et al. (2018) a 55-year-old woman reported she enjoyed the role of educator when it was her choice, but felt frustrated when she was put in the role (p. 483). Facilitating a space where they are actively making choices about when and who they are participating with can help foster their own self-direction and determination.

Art can reveal previous narratives in which they may have resisted oppression (Pacheco and McConnell, 2017, p. 505). These narratives can include resisting, opposing, withstanding, identifying, and speaking out against stereotypes, objectification, microaggressions and ableism (Collins, 1986; Pacheco & McConnell, 2017). It can also include reconstructing and valuing their own self-defined perspective based on their personal experiences (Collins, 1986; Pacheco & McConnell, 2017). In Pacheco and McConnell (2017) they discovered stories of women with intellectual disabilities resisting against forces of domination, control, coercion, and violence (p. 507). By sharing their stories of resistance the women were able to recognize and embrace a greater self-image (p. 507).

Chapter 5: Findings

This section is a summary of findings based on the research question how can art therapists help those with differing abilities self-advocate within their communities-of-care. I divided the research question into different components; art therapists and the disability community, self-advocacy, and communities-of-care. Initial searches were conducted through PsychINFO, using different combinations of keywords. This resulted in twenty-five articles related to the topic of art therapy, disabilities, and advocacy. The reference lists from these texts were used to find twenty-six additional sources related to the topic. Key themes from the literature review were used to generate codes that were applied to the literature. The themes that arose through the codes included supportive initiatives of art therapists, enhancing autonomy and providing choice, benefits of the art process and product, and facilitating positive change through advocacy and art therapy.

To answer the first part of the research question, data was collected by collecting specific statements on how art therapists aid, assist, empower, encourage, facilitate, help, support, serve, observe, and validate people with differing abilities. The literature demonstrates that support needs to be appropriate (Bailey, 2016; Vick, 2015) and individualized (Copeland, Luckasson, & Shauger, 2014; Herzog-Rodriguez, 2015). Art therapists seem to increase their attunement to participants reactions and provide authentic and reliable responses (Copeland et al., 2014; Feen-Calligan, 2018; Herzog-Rodriguez, 2015). The literature contained themes of physical and emotional supports; including utilizing concrete and supportive language, providing orienting and reflective questions, having auditory feedback, encouraging boundary setting and providing a safe, supportive, relaxed and consistent environment (Bailey, 2016; Callus, 2017; Herzog-Rodriguez, 2015; Kramer, 2015; Morris & Willis-Rauch, 2014; Vick, 2015). These supporting factors seem to foster creativity and art-making (Herzog-Rodriguez, 2015).

Art therapists also appear to accommodate, adapt, and change in order to the needs of people with differing abilities. Research reflected that art therapists may use exploratory dialogues and alternative methods of communication (Bailey, 2016; Vick, 2015). This includes providing information that is accessible and accommodates to the different ways of learning (Anderson, 2016; Friedman et al., 2014). Based on the literature art therapists also seemed to provide adaptive art materials and environments (Anderson, 2016; Bailey, 2016; Herzog-Rodriguez, 2015). These not only accommodate mobility issues, but increase safety and convenience (Herzog-Rodriguez, 2015, p. 36). Bailey (2016) believes that all art materials can be

adapted to meet the needs of any individual (p. 323). Accommodating specific needs of individuals seems to be correlated with reduced anxiety, frustration, and maladaptive behaviours (Bailey, 2016, p. 323). These adaptations require education, awareness, and creativity of practitioners (Bailey, 2016, p. 326).

After careful review of the literature, I determined that autonomy and choice were important factors that needed further investigation. Data was collected by finding specific statements regarding agency, autonomy, choice, and independence. Promotion of autonomy has resulted in enhanced self-determination and empowerment (Herzog-Rodriguez, 2015; Morris & Willis-Rauch, 2014; Bailey, 2016; Wehmeyer & Shogren, 2017). Autonomy is related to selfhood and includes gaining control, making choices and self-expression (Bailey, 2016; Wexler & Derby, 2015). Autonomy includes questioning or accepting values, beliefs and experiences (Aston, Breau, and MacLeod, 2014, p. 4). Choice is the ability to act purposely, as opposed to passively accept the choices made by others (Friedman et al., 2014, p. 520). Choice-making can support independence, foster human development, increase motivation, demonstrate adult responsibilities, acknowledge decision-making skills, and improve quality of life (Bailey, 2016; Friedman et al., 2014). Providing choices can demonstrate respect and provide participants with a sense of control (Copeland et al., 2014; Friedman et al., 2014; Wehmeyer & Shogren, 2017). Additionally, McLain and Walus (2015) found that participants desired more compelling self-advocacy and community inclusion, with encouragement, support, and learning that fosters self-sufficiency (p. 238).

Art therapists seem to work towards reducing support and developing greater independence with their participants (Wehmeyer & Derby, 2015, p. 98). Their participants choices and decision-making appears to be enhanced through responsive environments and by providing a diverse range of art-making options (Herzog-Rodriguez, 2015, p. 23). In art therapy, the process offers choice, control, and opportunities to interact and relate to others (Bailey, 2016, p. 323). Developing a creative process may be related to increasing an individual's capacity to recognize choice (Morris & Willis-Rauch, 2014, p. 29) and problem-solving skills (Herzog-Rodriguez, 2015; Anderson, 2016). Wehmeyer and Shogren (2017) found that providing opportunities to make decisions and problem solve develops their skills in these areas (p.120).

Autonomy-supportive art therapists seem to help participants develop their independence and self-determination (Wehmeyer & Shogren, 2017, p. 120). Promoting independence may also

account for impairments and dependency (Wexler & Derby, 2015). Callus (2017) points out that providing assistance does not have to undermine people's independence (p. 10). Herzog-Rodriguez (2015) states, "Independent self-expression is unique for each child, regardless of disability" (p. 132). Communication and respect seem to suggest to participants that they are capable of making their own decisions (Friedman et al., 2014, 526).

Additionally, data was collected by collecting specific statements on how art can support people with differing abilities. Art appears to help with self-expression, self-discovery, and communication (Anderson, 2016; Bailey, 2016; Herzog-Rodriguez, 2015), which can include expressing vulnerabilities and strengths (Feen-Calligan, 2018, p. 3), thoughts and feelings (Vick, 2105, p. 834), demonstrate experiences (Morris & Willis-Rauch, 2014, p. 35), and validate feelings of trauma, loss, or grief (Cooke, 2003; Bailey, 2016; Webb, 2011). Research demonstrates the process of exploration, validation, and support in art therapy can enrich the lives of people with differing abilities (Bailey, 2016, p. 317), help bypass their limitations (Bailey, 2016; Chong, Mackey, Stott, & Broadbent, 2013; Lister & Rosales, 2009) and connect individuals to inner strengths (Kapitan, 2015; Kramer, 2015; Luzzatto et al., 2017; Morris & Willis-Rauch, 2014). It can also support patience and attention (Anderson, 2016; Kramer, 2015; Luzzatto et al., 2017) and strengthening identity and dignity (Kapitan, 2015; Luzzatto et al., 2017). Studies have shown that symbolic communication of art supports safety, trust, imagination, self-expression, confidence, and insight (Bailey, 2016; Luzzatto & Gabriel, 2000; Luzzatto et al., 2017; Morris & Willis-Rauch, 2014). Furthermore, the symbolic nature of disability identity can increase awareness of meaning and importance of social belonging (Morris & Willis-Rauch, 2014, p. 18). This can be done through collective storytelling, use of language, and continual development of the disability community (Dirth & Branscombe, 2018, p. 1317). Furthermore, research shows that art therapists encourage distancing and silent-joint looking, which can help participants connect and understand the symbolic imagery of their art (Luzzatto et al., 2017, p. 6).

Data was also collected on how art can help foster relationships. Positive social relationships are related to quality of life and happiness (Bailey, 2016, p. 321; Chadsey, 2007). Friedman (2014) states "When a relationship is healthy, self-advocates feel comfortable, loved, happy, and successful" (p. 523). Research has shown that art can lead to positive interactions (Bailey, 2016, p. 325), improved communication and socialization (Luzzatto et al., 2017, p. 9),

and greater awareness (Keselman & Awais, 2018). Art-making can also foster relationships that are collaborative, mutual, and reciprocal (Callus, 2017; Herzog-Rodriguez, 2015; Kapitan, 2015; Morris & Willis-Rauch, 2014). Research reflects that art can help individuals with differing abilities speak up within their relationships (Friedman et al., 2014, p. 521) and create a vision of the community they want to be a part of (Herzog-Rodriguez, 2015, p. 40).

The artwork becomes a way to relate, connect, and communicate within their communities-of-care (Herzog-Rodriguez, 2015; Morris & Willis-Rauch, 2014; Vick, 2016). Displaying or exhibiting artwork is a way for individuals to bring their art into the communities they belong to (Herzog-Rodriguez, 2015; Vick, 2016). Witnessing art may help increase awareness, foster empathy, and produce positive social change (Morris & Willis-Rauch, 2014; Potash & Ho, 2011). This seems to be because of the connection created between the viewer and the artist. These public art initiatives can help gather members, invite participation, and strengthen relationships (Herzog-Rodriguez, 2015). Community engagement can help reduce stigma (Bogart, Rottenstein, Lund, & Bouchard, 2017, p. 553) and lead to better inclusion practices (Herzog-Rodriguez, 2015, p. 16).

In order to answer the research question, I decided to investigate the positive impacts that advocacy can have on society and social structures. The research reflected that advocacy can help identify barriers and strategies to overcome them (Kramer, 2015, p. 30). Additionally, it can support deeper analysis, challenge stereotypes (Aston et al., 2014, p. 294), deconstruct hierarchical systems, and work towards equity (Morris & Willis-Rauch, 2014, p. 30). Studies indicate that education, knowledge, and awareness are the best ways to reduce stereotypes, labelling, and stigma (Aston et al., 2014; Bogart et al., 2017; Gibbs, Brown, & Muir, 2008; Iacono & Davis, 2003; Matziou et al., 2009; Shanley & Guest, 1995; Tracy & Iacono, 2008; Webb, 2009). The experiences and perceptions by the disability community seem to be important factors in developing strategies that help increase disability advocacy (Landmark, Zhang, Ju, McVey, and Ji, 2017), and improve services (Copeland et al., 2014, p. 1141).

In the literature, it seems that social activist art therapists acknowledge that their client's distress is connected to social inequalities, and that they commit to social transformation and advocacy (Kapitan, 2015; Kaplan, 2007). Many researchers advise art therapists to engage in advocacy both in and out of their clinical practices (Keselman, & Awais, 2018; Nadal, 2017; Ratts & Greenleaf, 2018). Research has reflected that art therapy can facilitate positive change

(Luzzatto, 2017; Morris & Willis- Rauch, 2014; Vick, 2015), including changes in personal supports (Copeland et al., 2014), awareness, attitudes, and perceptions (Fisher-Borne, Cain & Martin, 2015; Friedman et al., 2014; Kramer, 2015), as well as changes in systemic power imbalances (Fisher-Borne et al., 2015; Friedman et al., 2014; Landmark et al., 2017). Aston et al. (2014) reflects that “there is potential to move and change the status quo and ‘normal’ everyday practices by identifying and questioning what people do and how they do it” (p. 294).

Chapter 6: Discussion

This researcher thought to answer the question: how can art therapy assist people with different abilities to self-advocate in their communities-of-care? The findings indicate that art therapy can help foster well-being of individuals with differing abilities in support of them self-advocating. Art therapy has the potential to offer new perspectives and generate opportunities, which can help reduce ableism and bureaucracy. It can help individuals identify their strengths so that they know what they need to succeed and they can work towards a collective sense of justice. Art therapy can provide a platform for artists to engage with their communities-of-care and share their stories, which can create greater empathy and understanding, and decrease stigma. Art therapy can help affirm disability culture and free participants from the burden of stereotypes. It can create a supportive environment where individuals can feel empowered to make their own decisions so that they are able to represent themselves and advocate for their rights. Art therapy can also provide adaptive art materials and environments to meet the needs of people with differing abilities. When issues of accessibility are raised art therapists can help participants gain a greater understanding of the barriers, explore possible solutions and can help reduce its negative impact. It can help participants recognize their needs and help them assert their rights. Lastly, I believe that it can help individuals ask for more inclusive practices, and higher quality services within their communities-of-care.

Based on the literature review, I believe that art therapists working with people who self-identify as having a disability should preference the social model over the medical model. The medical model tends to view the person through their disability or physical condition instead of seeing them as a whole person. This narrow view fails to understand other psychological and cultural factors that can have an impact on a person’s wellbeing (Dirth & Brancombe, 2018, 1301). The social model reflects the need to make systemic changes to improve social mobility, acknowledge and value disability as an identity, and support equality and equity, regardless of a

person's impairments or difficulties (Hutchinson et al., 2018, p. 193). The social model can provide art therapists with an understanding of how ableism influences policies, procedures, and systems. From a social perspective, an art therapist can begin to think critically about the lack of accessibility as opposed to treating someone who lacks ability.

I agree with Kuri's (2017) recommendation that art therapists need to encompass an intersectional approach in the promotion of cultural and symbolic justice (p. 120). This is because people are multifaceted and have different social locators that intersect and impact their social status and access to care. It seems that a great amount of disability research fails to account for critical cultural differences amongst people with differing abilities. Drummond and Brotman (2014) adds that intersectionality can help clinicians understand the effect of occupying many different marginalized positions has on the participant's experience (p. 543).

From the literature review, one can see that 'disability' encompasses a diverse range of conditions and conceptual understandings. I have used the term, 'People with Differing Abilities,' because it does not view people as having a deficit. Art therapists working with this population need to have an understanding that not all individuals will identify with this view. They may choose to identify a different way, or reject the identity all-together. This decision may be influenced by a person's sense of self, experience, as well as culture, location, community, and political, institutional, or global contexts. I believe art therapists need to have an awareness of these influences and respect how their participants choose to identify.

Based on the literature, people with differing abilities are more likely to experience a wide range of negative outcomes than their counterparts. This may be due to exploitation, biases, and negative stereotypes that create barriers to higher quality levels of care. Additionally, it seems that North American health care systems are insufficiently responding to the needs of people with differing abilities. Recently there has been a shift in responsibility from health care systems, such as hospitals, back to communities-of-care. I believe that art therapists can help support these shifts by offering their services within these communities, and by helping individuals share their experiences and perspectives with their systems-of-care.

After reviewing the literature, I believe art therapists should adopt an eclectic approach that combines person-centred, humanistic, and positive therapy with social action art therapy. A person-centered approach supports individuals' self-determination and independence, which as the findings demonstrated can support human development and can improve quality of life

(Bailey, 2016; Friedman et al., 2014). Correspondingly positive art therapy can focus on individual strength and helps participants work towards making changes in their environments. Furthermore, this approach can support self-advocates in making their community more accessible and equitable. Finally, social action art therapy helps prioritize marginalized perspectives, which the findings reflect is needed for developing strategies to increase disability advocacy.

Kapitan (2015) acknowledges that contributing financial or in-kind support is often overlooked for activist art therapists (p. 105). Social action art therapists should think about how they can support individuals with differing abilities beyond their clinical practice. Community art programs can facilitate new perspectives, expand opportunities, encourage social transformations, and fosters community engagement and participation. The research reflects that art-making can strengthen self-expression, communication, and identity (Anderson, 2016; Bailey, 2016; Herzog-Rodriguez, 2015; Kapitan, 2015; Luzzatto et al., 2017). Therefore, art therapists can use their position and knowledge to help other professionals become responsive to issues of disability (Drummond and Brotman, 2014, p. 543).

I think art therapists need to be aware that it is likely that there are many individuals with invisible disabilities amongst the art therapy profession, which makes it more crucial for the profession to ensure more inclusive work environments. Social justice should mean practicing art therapy in the most accessible way, and bringing attention, understanding and responsiveness to issues of impairments and abilities (Kattari et al., 2018, p. 488). I believe that art therapy can help ensure that people with differing abilities can assert their viewpoints on issues that are important to them, uphold and protect their rights, be given choices, and have their decisions respected in their communities-of-care. Kuri (2017) strongly suggests that, “the profession of art therapy needs to ensure that it maintains relevance in meeting the needs of individuals and communities” (p. 120).

Barriers and Limitations

I think it is important to acknowledge the limitations that this research has for art therapists working with people with differing abilities. Benedet and Grant (2014) argue that the social model can minimize the reality of pain caused by their impairment and that these impairments may not disappear if oppressive systems are acknowledged, rejected, and changed (p. 135). This could be because people may feel that the social view diminishes their experience of their

disability. Gallagher et al. (2014) adds “when physical or sensory disability categories come into play, the social model’s application seems far more elusive” (p. 1124). This is because it can be difficult to separate the biological part from the social part, and the belief of a thing from the thing itself (Gallagher et al., 2014, p. 1126). Rather than shifting back to the medical model, Gallagher et al. (2014) recommends creating more nuanced understandings of disability under the social model (p. 1133).

Decottignies (2016) believe that the politics of inclusion are not always enough (p. 45). Kafer (2016) points out that even if a space was fully accessible, every possible format was used to communicate, what is being communicated may make it no longer tolerable to some of the members (p. 3). This means that individuals have different experiences, which can be difficult to account for. An advocacy group might be triggering for individuals who have a history of trauma. Research has shown that when self-advocates become more aware of politics it can deepen their negative perceptions of their past (Beart, Hardy, & Buchan, 2004; Simpican & Leader, 2015). Additionally, self-advocacy can incite anger or humiliation of past experiences (Simpican & Leader, 2015, p. 726). However, the Simpican and Leader (2015) believe that anger can be a critical political catalyst for social justice and their histories of oppression is paramount to the movement itself (p. 726). Even so, it is important to recognize that self-advocacy can pose a risk to people with differing abilities. Kafer (2016) suggests asking these individuals what kind of support they need in order to engage in these types of advocacy spaces (p. 2).

Art therapists need to be aware of these risks and provide enough information so that individuals with differing abilities can make informed decisions about their own capacity to participate. Additionally, participants need to be aware of the risk they take in displaying their artwork. Although all precautions may be taken, art therapists cannot control the public’s reaction to the art. Participants may experience alienation, resentment, and hostility from non-disabled group members in their communities (Dirth & Branscombe, 2018, p. 1311). It is possible that their artwork may provoke defensiveness and resistance. However, it is possible that the benefits can outweigh the costs. This is because they may already be feeling alienation from these community members. Art therapists should be prepared to step in and offer on-going support to their participants. Additionally, they may want to encourage participants to prioritize their own safety and provide them with the option of discontinuing their participation in the

exhibition (Kattari et al., 2018, p. 482). However, when advocating in communities-of-care there seems to be a level of trust that these communities are supportive of disabilities and research has shown that art displays can help reduce stigma (Potash & Ho, 2011, p. 79, Morris & Willis-Rauch, 2014, p. 30)

Lastly, there seems to be a limited amount of research that includes a diversity of perspectives. Although there seems to be a lot of research in support of intersectional practices for clinicians and researchers (Brotman, 2014; Crenshaw et al., 1995; Kattari et al., 2018; Keselman & Awais, 2018; Kuri, 2017) there is still a gap in the research experience of People of Colour (POC) and Black people who have differing abilities (Kafer, 2016). Some scholars have noted that suggestions for responding to ableist narratives is not always connected to the experience of POC and Black people (Erevelles, 2011; Kafer, 2016; Mollow, 2006). This connects back to the idea that individuals may have different trauma experiences. I believe more research needs to be conducted on how art therapists can help POC and Black people with differing abilities advocate in their communities-of-care.

Chapter 6: Conclusion

Thousands of adults with disabilities struggle with identity issues and finding their place among an ableist society. Many individuals are at a high risk for physical, sexual, economic, and psychosocial abuse. Communities-of-care provide an opportunity to counter the injustices against them. They offer a place to create prosocial relationships, give back to their community, and build autonomy and empowerment. The art-making process liberates their creativity and sublimates their energies into something they can take ownership of. It allows them to externally express what is going on internally, which can be shared within their community to promote change. Art therapists have opportunities to change the ways that communities-of-care are involved with ableist behaviours.

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