UNIVERSITY OF EDUCATION, WINNEBA

TEXTILE ART AS AN EFFECTIVE VOCATIONAL TOOL FOR REHABILITATING DISCHARGED MENTAL PATIENTS

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AUGUST, 2018

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A THESIS IN THE DEPARTMENT OF MUSIC EDUCATION, SCHOOL OF CREATIVE ARTS, SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES, UNIVERSITY OF EDUCATION, WINNEBA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DOCTOR OF PHILOSOPHY (ARTS AND CULTURE) DEGREE.

AUGUST, 2018

DECLARATION

STUDENT'S DECLARATION

I, Philomena Obu, declare that this thesis, with the exception of quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted, either in part or whole, for another degree elsewhere.

SIGNATURE:……

DATE: ……

SUPERVISOR'S DECLARATION

I hereby declare that preparation and presentation of this work was supervised in accordance with the guidelines for supervision of Thesis as laid down by the University of Education, Winneba.

NAME OF SUPERVISOR: Dr. Frimpong Duku

SIGNATURE: ……

DATE: ……

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ABSTRACT

The research sought to find out the art of the discharged mental patients who were once inmates of the Kumasi rehabilitation centre Cheshire Home Edwenase, who were taught art activities in textiles by the researcher and has been discharged to their respective communities. The scope of the research was limited tothe art of the discharged mental patients which involves a follow up of some selected discharged mental patients who were once inmates in theKumasi Rehabilitation Centre (Cheshire Home) Edwenase whom I taught some art activities in textiles at the rehabilitation centre from the year 2008-2010, now living within the southern part of the country (Kumasi, Cape Coast, Accra, Sunyani, and Takoradi). To solve this problem, an in-depth interview with the discharged mental patients, the administrator, Chief Psychiatric Nurse and staff of the home were conducted. Participant and non-participant observation as well as experiments were made. The main findings of the research which have been expounded by photographs of selected works of the discharged mental patientsshow that the environment, their state and their intensity of illness did not affect their creativity. Then the government can make a policy that all mentally challenged patients should be given a vocational training at the various psychiatric hospitals and units. This will reduce the stress that they will go through if they are bored and idle in the house and may end up back to the psychiatric Hospital.The findings and recommendation made on these patients will serve as a useful source of information for the psychiatric hospitals, rehabilitation centers and occupational therapist in the country and the general public.

CHAPTER ONE

INTRODUCTION

1.1 Overview

This chapter deals with the background of the study, followed by the statement of the problem and the objectives of the study. The research questions and the delimitation come next. The definition of terms, importance of the study and the arrangement of the rest of the text conclude the chapter.

1.2 Background to the Study

Mental illness refers to a wide range of mental health conditions – disorders that affect your mood, thinking and behaviour. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviours. (Mayo Clinic Staff, 2015)

Mental illness is any disease or condition that influences the way a person thinks, feels, behaves and / or relates to others and to his or her surroundings. Although the symptoms of mental illness can range from mild to severe and are different depending on the type of mental illness, a person with an untreated mental illness often is unable to cope with life's daily routines and demands. (Mayo Clinic Staff, 2015)

Gombilla (as cited in Obu 2010) stated that mental patients appear dishevelled as patients tend to neglect themselves as shown in careless dressing. They are untidy and unclean as a result of failure to take care or their personal hygiene like bathing and

washing clothes. Some of them tend to talk more than usual, faster and louder and about things that do not concern them; they are also inscrutable, diffident and importunate. Facial expressions may suggest anxiety, depression or lack of interest in the surroundings, they are sometimes fixed and unchanging unnecessarily violent and some have a sense of persecution and suicidal tendencies. Most of them sleep very little or not at all and wake up early to start working, talking or moving about.

The outward signs of a mental illness are often behavioural. A person may be extremely quiet or withdrawn. Conversely, he or she may burst into tears, have great anxiety or have outbursts of anger. The outward signs of a mental illness are often behavioural. A person may be extremely quiet or withdrawn. Conversely, he or she may burst into tears, have great anxiety or have outbursts of anger.

Even after treatment has started, some individuals with a mental illness can exhibit anti-social behaviours. When in public, these behaviours can be disruptive and difficult to accept. The next time you and your family member visit your doctor or mental health professional, discuss these behaviours and develop a strategy for coping. Your family member's behaviour may be as dismaying to them as it is to you. Ask questions, listen with an open mind and be there to support them. Gombilla (as cited in Obu, 2010)

The following are signs that your loved one may want to speak to a medical or mental health professional according to National Institute of Mental Health **(NIMH 2008)** Information Resources and Inquiries Branch. Handling unusual behaviour;

In adults: confused thinking, prolonged depression (sadness or irritability), feelings of extreme highs and lows, excessive fears, worries and anxieties, social withdrawal, dramatic changes in eating or sleeping habits, strong feelings of anger, delusions or hallucinations, growing inability to cope with daily problems and activities, suicidal thoughts, denial of obvious problems, numerous unexplained physical ailments and substance abuse are some of traits exhibited.

In older children and pre-adolescents, the following causes and signs are exhibited. These are; substance abuse; inability to cope with problems and daily activities, changes in sleeping and/or eating habits, excessive complaints of physical ailments, defiance of authority, truancy, theft, and/or vandalism, Intense fear of weight gain, prolonged negative mood, often accompanied by poor appetite or thoughts of death, frequent outbursts of anger.

In younger children the following changes and signs are exhibited. These are: changes in school performance, poor grades despite strong efforts, excessive worry or anxiety (i.e. refusing to go to bed or school), hyperactivity, persistent nightmares, persistent disobedience or aggression and frequent temper tantrums.

Obu (2010) opined that discharged mental patients is a mentally ill person, treated in a hospital or clinic, discharged and referred by a medical doctor to a rehabilitation centre, prior to re-integration into society or return to the family.

Yeboah (as cited in Obu 2010 p. 25) stated that rehabilitation is a word which describes an active process in which at least two people are involved that is the person with a disability and the helper. Rehabilitation is a building activity which attempts to "restore a person's physical and mental capacities and improve the quality of his life to a level which is near as possible to that which existed prior to his illness". During rehabilitation, the disabled or discharged mental patients are provided with an agreeable craft and skills such as needlework, shoe making, basketry, drawing, weaving, tie and die, carpentry and modelling.

The goal of this rehabilitation centre is to assume that the person who had a psychiatric disability can perform the physical, emotional or intellectual skills needed to live, learn and work in his or her own community with the least possible amount of support from agents of the helping profession. Since the individual do not imitate activities he gains strength and stature, the belief in his own powers and self-respect which make artistic activity constructive in the growth of his personality.

Obu (2010) asserted that is rehabilitation involves the process where the disabled are treated medically and provided an agreeable craft for an idle moment in the centre. Rehabilitation takes place at the psychiatric hospital as occupational therapy or after the discharge from the psychiatric hospital to a rehabilitation home which is known as the aftercare.

Textiles can be used in rehabilitating discharged mental patients, because when discharged mental patients are not taught any vocational skills and they are discharged from the rehabilitation centre they become lonely, bored and restless and may return back to the psychiatric hospitals. Textiles as a form of art and vocational skills is used in

rehabilitating the discharged mental patients for them to acquire skills and as a form of rehabilitation because, if a discharged mental patient is able to remember the processes in tie and dye and batik production, which involves the correct calculation in mixing the chemicals, the correct amount of Caustic Soda (Sodium Hydroxide) and Hydros (Sodium hydrosulphite) depending on the fabric being used, and the ability of the discharged mental patient to produce intricate designs which are aesthetically good for assessment, then the discharged mental patient is assessed as fit to be released. (Obu, 2010).

Also, textiles are used as a form of employment for these discharged mental patients when they are discharged from these rehabilitation centres. Because of the stigma attached to mental patients, companies and institutions are not willing to employ them, and this makes them unemployed and dependent on the family. Therefore, they become idle and lonely and may return back to the psychiatric hospital. If the family is not able to feed them, they become restless and depressed and may end up in the rehabilitation centre. Therefore, when they are trained in textiles, it serves as a form of self-employment. They are able to generate income and financial support for themselves as a form of selling this product, this occupy them and prevent them from being idle and returning back to the psychiatric hospital. (Obu,2010).

The Kumasi Cheshire Home is located in Edwenase in the Ashanti Region. The Home was established in 1986 by Most Rev. Arch Bishop Emeritus of Kumasi, the Assistance of leaders of other Christian Denominations, comprising of the Anglican, Presbyterian and Salvation Army as well as two resident graduates from the shoe-making section of the home and the Education wing of the Drug Abuse Department. (Adjei, 2010).

Being not an institution nor a hospital, it Home provides half-way Home for past psychiatric patients declared fit, sound and discharged to go back to their respective homes in their communities. These discharged patients remain stigmatized and discriminated against whilst living within their families. The social conditions tend to cause relapse.

The Home has an occupational therapy department where residents are trained or retrained to become useful citizens in their various communities. Training departments consist of sections of tailoring, where female residents learn dressmaking, shoe making where male residents learn designing and production of shoes and sandals. There is also an art department where residents learn drawing, painting, designing and textiles.(Obu, 2010).

The main aims of the occupational therapy departments of the Home therefore are to counteract boredom, channel energies into socially useful activities which might otherwise find outlet in violence and other behavioural disturbances, develop interest, self-confidence, pride in self-achievement, as well as encourage togetherness by allowing residents to work together on group projects. It is hopeful that these various training will bring about a greater degree of social interaction and tolerance to people whose mental illnesses have made them become friendless and isolated and that the residents would become subsequently and co operational when the training given to them. (Adjei, 2010).

It is also the hope of The Kumasi rehabilitation centre, Cheshire Home, to rehabilitate the discharged Psychiatric patients to return to their respective communities safe and sound. Therefore, the Home admits Adult Psychiatric patients between the ages of eighteen and fifty -five (18-55) both male and females are

admitted. The percentage of males to females is always about higher than the females. There are nineteen (19) females, 32 males with females mostly admitted from mood trigger or depression (Schizophrenia in families and Psychosis disorder). The males by drug abuse (hard drugs like cocaine, wee, marijuana and alcohol) (Adjei, 2010).

Most inmates of Cheshire Home have not learnt any employable skills in tie and dye and Batik production. In – service vocational training in tie and dye and batik is not frequent in the Cheshire Home. It is necessary to teach these discharged mental patients art activities at the rehabilitation Centre to acquire basic skills in textiles so that when they are discharged to their various communities they can utilize the skills in the production of batik and tie and dye fabrics as a source of self-employment to reduce their mental stress that they will go through when bored and idle in the house otherwise, there is the possibility that they may end up back to the psychiatric hospital. (Adjei, 2010).

It is therefore important to rehabilitate all discharged mental patients to enable them fit into their communities. They should be equipped with vocational skills, supported financially by the government, and their family, so that they can continue to produce these fabrics to be self-employed, which will occupy them and prevent them from being idle and relapsing back to the psychiatric hospital, a follow up should be made by this Organisation to monitor their improvement, and their states in their various societies and communities, and educate the family and societies on discharged mental patients living with them. It is within this content that the textile art is seen as an effective vocational tool for rehabilitating discharged mental patients discharged from the Kumasi rehabilitation centre -Cheshire Home between 2008 -2010.

1.3 Statement of the Problem

Research indicates that Ghana's population in the year 2011 was 24,965,816 million. About 1 to 5 persons have some mental disorder although about 97% do not have treatment, according to Osei (2013). The World Health Organization's (WHO 2007) estimates that approximately 650,000 persons in Ghana suffer from a severe mental disorder and further 2.17 million from moderate to mild mental disorders with a treatment gap of 98%.

The World Health Organization's report (2007) on mental health indicated that out of the 21.6 million people living in Ghana, 650,000 were suffering from severe mental disorders and 2,166, 000 were suffering from moderate to mild mental disorders. While the burden of mental health care is a public health concern worldwide Prince et al (2007), there is a significant gap between the level of mental health needs and the availability of quality services to aptly address these needs Faydi et al., (2011). For middle-income countries like Ghana, mental health is often given the lowest health priority by authorities Ofori-Atta, Read & Lund, (2010) and this could deepen the stigma and discrimination faced by this population.

Scholars such as (Forster, 1962; Read, Adiibokah & Nyame, 2009) have argued that political apathy towards mental health combined with widespread stigma, hinders the progress of mental health care in Ghana. The stigmatization of mental illness is a serious issue given that it adversely affects patients and their relatives as well as institutions and health care personnel working with persons with mental illness (Barke, Nyarko &Klecha, 2011). People who have or are perceived to have mental disorders may find it difficult to

access services due to stigma and discrimination and these reactions obstruct prevention and treatment efforts and intensify the impact of the mental health disabilities

There are nine psychiatric hospitals in Ghana. When discharged these mental patients are denied the skills and opportunity to improve their lives and participate in the economic, social and political activities. They become dependent on their family and a burden on the country as they roam about restlessly. They therefore represent a number of the under based human resource that could be available to foster economic growth for the benefit of the country. These people need to be rehabilitated to be equipped with job opportunities to make them productive, independent and acceptable in the society.

Textile art can be regarded as a medium for rehabilitating discharged mental patients and therefore must be regarded as capable of providing discharged mental patients at the Edwenase Rehabilitation Centre -Cheshire Home (Kumasi) living within their respective homes in their communities.

1.4 Objectives

i. Identify the state of the discharged mental patients and examine the role of textile art in the rehabilitation of discharged mental patients.

ii. Examine the nature of vocations studied as inmates.

iii. Determine whether textile art produced by the discharged mental patients are effective vocations that prevent them from returning to the psychiatric hospital.

iv. Evaluate the competitive standard of textile art produced by the discharged mental patients.

1.5 Research questions

1. What is the state of the discharged mental patients and what role does textile art play in the rehabilitation of the discharged mental patients?
2. What is the nature of vocations studied as inmates in the rehabilitation centre?
3. Is the textile art produced by the discharged mental patient's effective vocations that prevent them from returning to the psychiatric Hospital?
4. Can the textile art produced by the discharged mental patient meet standard competition?

1.6 Significance of the Study

The study will provide a guide to those expects who are engaged in providing art training skills to discharged mental patients in their lives. It provides discharged mental patients with life time vocation. It reduces mental stress.

1.7 Delimitation

The research deal only with the textile programme designed for the discharged mental patients in Kumasi rehabilitation centre Edwenase, 2008-2010. It is one of the mental homes in Ghana. The studies will also concentrate on only the discharged mental

patients living within the southern part of the country namely (Kumasi, Cape Coast, Accra and Takoradi).

1.8 Importance of the study

It empowers the government to demand art training skills as vocation for mentally challenged patients in all Ghana's psychiatric hospitals.

1.9 Definition of Terms

Psychiatry	the study and treatment of disease of the mind.
Psychiatrist	A psychiatrist is a medical doctor that specializes in mental health conditions and, in many areas, is the only mental health professional licensed to prescribe medications.
Psychologists	A psychologist is not a medical doctor but holds a doctoral degree in psychology. In many areas, psychologists are the only mental health professionals certified to administer testing such as IQ tests and personality tests.
Textiles	the manufacture of cloth and all the materials that can be found or have been formed into yarns or fabricated into cloth.
Dye	Dye is a coloured substance that has an affinity to the substrate to which it is being applied.

Mental illness	Is a condition which causes serious disorder in a person's behaviour or thinking. Mental illness refers to a wide range of mental health conditions disorders that affect your mood, thinking and behaviour.
Discharged Mental Patient	is a mentally ill person, treated in a hospital or clinic, discharged and referred by a medical doctor to a rehabilitation centre, prior to re-integration into society or return to the family.

1.10 Organisation of the rest of texts

Chapter one is the introduction of the study. It covers the background to the study, the statement of the problem, objectives, Research questions, delimitations, and definition of terms, importance of the study and the arrangement of the rest of texts.

Chapter two reviews the related literature on the topic. Under it, definition of mental illness, metal patients, discharged mental patients, art therapy, art therapy and mental health, art and mental illness, art by the metal ill, social care and after care of the mentally ill, art therapy helping veterans as expressed by different authors were reviewed.

Chapter three is the methodology and it discusses the research activities that were undertaken. Topics under discussion were as follows; research design, library research, population, sampling and sampling techniques, instrumentation, validation

of instruments, administration of Instruments, primary and secondary sources of data, data collection procedures and data analysis plan. Chapter four dealt with result and discussions. Chapter five is summary of the main findings of the study, conclusions arrived at, and the recommendations made. References and Appendices were also stated. Referencing was done in citation, books, and it was divided into four parts. Part one looked at books that were reviewed, the second part spelt out the websites that were contacted. Thirdly, mention was made of the newspaper publications that were reviewed and finally, the dissertations which were consulted.

In the coming chapter, the researcher reviewed what some authorities have written on mental illness, metal patients, discharged mental patients, art, art therapy and mental health, art and mental illness, art by the metal ill, social care and aftercare of the mentally ill, and how these topics are related to the study.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Overview

To gain an understanding of the topic under discussion "Art of the discharged mental patient" pertinent literature related to the topic was reviewed. Thus were reviewed literature on, art, textile art, mental illness, metal patients, discharged mental patients, rehabilitation, vocational rehabilitation, art therapy, art therapy and mental health, art and mental illness, art by the metal ill, social care and after care of the mentally ill, and summary of the chapter.

- Art
- Textile Art
- What is mental illness
- Mental patients
- Discharged mental patients
- Rehabilitation
- Vocational rehabilitation
- Art therapy
- Art therapy and mental health
- Art and mental illness

2.2 What is Art?

According to Carroll (2000) Art can connote a sense of trained ability or mastery of a medium. Art can also simply refer to the developed and efficient use of a language to convey meaning with immediacy and or depth. Art is an act of expressing feelings, thoughts, and observations. There is an understanding that is reached with the material as a result of handling it, which facilitates one's thought processes.

Arthur (2003) opines that art is a diverse range of human activities and the products of those activities; this article focuses primarily on the visual arts, which includes the creation of images or objects in fields including painting, sculpture, printmaking, photography, and other visual media. Architecture is often included as one of the visual arts; however, like the decorative arts, it involves the creation of objects where the practical considerations of use are essential—in a way that they are usually not for a painting, for example. Music, theatre, film, dance, and other performing arts, as well as literature, and other media such as interactive media are included in a broader definition of art or the arts. Until the 17th century, *art* referred to any skill or mastery and was not differentiated from crafts or sciences, but in modern usage the fine arts, where aesthetic considerations are paramount, are distinguished from acquired skills in general, and the decorative or applied arts.

Art has been characterized in terms of mimesis, expression, communication of emotion, or other values. During the Romantic period, art came to be seen as "a special faculty of the human mind to be classified with religion and science". Though the definition of what constitutes art is disputed and has changed over time, general

descriptions mention an idea of human agency and creation through imaginative or technical skill. The nature of art, and related concepts such as creativity and interpretation, are explored in a branch of philosophy known as aesthetics.

Arthur (2003) by a broad definition of art, artistic works have existed for almost as long as humankind: from early pre-historic art to contemporary art; however, some theories restrict the concept to modern Western societies. The first and broadest sense of *art* is the one that has remained closest to the older Latin meaning, which roughly translates to "skill" or "craft." A few examples where this meaning proves very broad include *artifact*, *artificial*, *artifice*, *medical arts*, and *military arts*. However, there are many other colloquial uses of the word, all with some relation to its etymology.

Artistic works may serve practical functions, in addition to their decorative value.

In medieval philosophy, John Chrysostom held that "the name of art should be applied to those only which contribute towards and produce necessaries and mainstays of life." Thomas Aquinas, when treating the adornment of women, gives an ethical justification as to why: "In the case of an art directed to the production of goods which men cannot use without sin, it follows that the workmen sin in making such things, as directly affording others an occasion of sin; for instance, if a man were to make idols or anything pertaining to idolatrous worship. But in the case of an art the products of which may be employed by man either for a good or for an evil use, such as swords, arrows, and the like, the practice of such an art is not sinful. These alone should be called arts." Aquinas held that art is nothing else than "the right reason about certain works to be made," and that it is commendable, not for the will with which a craftsman does a work,

"but for the quality of the work. Art, therefore, properly speaking, is an operative habit." Aristotle and Aquinas distinguish it from the related habit of prudence.

According to Davies (1991) the second and more recent sense of the word *art* is as an abbreviation for *creative art* or *fine art* and emerged in the early 17th century. Fine art means that a skill is being used to express the artist's creativity, or to engage the audience's aesthetic sensibilities, or to draw the audience towards consideration of the *finer* things.

The word *art* can refer to several things: a study of creative skill, a process of using the creative skill, a product of the creative skill, or the audience's experience with the creative skill. The creative arts (*art* as discipline) are a collection of disciplines that produce *artworks* (*art* as objects) that are compelled by a personal drive (art as activity) and convey a message, mood, or symbolism for the viewer to interpret (art as experience). Art is something that stimulates an individual's thoughts, emotions, beliefs, or ideas through the senses. Artworks can be explicitly made for this purpose or interpreted on the basis of images or objects. Although the application of scientific knowledge to derive a new scientific theory involves skill and results in the "creation" of something new, this represents science only and is not categorized as art (Davies, 1991).

Often, if the skill is being used in a common or practical way, people will consider it a craft instead of art. Likewise, if the skill is being used in a commercial or industrial way, it may be considered commercial art instead of fine art. On the other hand, crafts and design are sometimes considered applied art. Some art followers have argued that the difference between fine art and applied art has more to do with value judgments

made about the art than any clear definitional difference. However, even fine art often has goals beyond pure creativity and self-expression. The purpose of works of art may be to communicate ideas, such as in politically, spiritually, or philosophically motivated art; to create a sense of beauty (see aesthetics); to explore the nature of perception; for pleasure; or to generate strong emotions. The purpose may also be seemingly nonexistent.(Davies, 1991).

The nature of art has been described by philosopher Richard Wollheim as "one of the most elusive of the traditional problems of human culture". Art has been defined as a vehicle for the expression or communication of emotions and ideas, a means for exploring and appreciating formal elements for their own sake, and as *mimesis* or representation. Art as mimesis has deep roots in the philosophy of Aristotle. Goethe defined art as an*other* resp. a *second nature*, according to his ideal of a style founded on the basic fundaments of insight and on the innermost character of things. Leo Tolstoy identified art as a use of indirect means to communicate from one person to another. Benedetto Croce and R.G. Collingwood advanced the idealist view that art expresses emotions, and that the work of art therefore essentially exists in the mind of the creator. The theory of art as form has its roots in the philosophy of Immanuel Kant, and was developed in the early twentieth century by Roger Fry and Clive Bell. More recently, thinkers influenced by Martin Heidegger have interpreted art as the means by which a community develops for itself a medium for self-expression and interpretation. George Dickie has offered an institutional theory of art that defines a work of art as any artifact upon which a qualified person or persons acting on behalf of the social institution

commonly referred to as "the art world" has conferred "the status of candidate for appreciation" (Davies, 1991).

Mithen (1999) asserts that Many great traditions in art have a foundation in the art of one of the great ancient civilizations: Ancient Egypt, Mesopotamia, Persia, India, China, Ancient Greece, Rome, as well as Inca, Maya, and Olmec. Each of these centers of early civilization developed a unique and characteristic style in its art. Because of the size and duration of these civilizations, more of their art works have survived and more of their influence has been transmitted to other cultures and later times. Some also have provided the first records of how artists worked. For example, this period of Greek art saw a veneration of the human physical form and the development of equivalent skills to show musculature, poise, beauty, and anatomically correct proportions.

In Byzantine and Medieval art of the Western Middle Ages, much art focused on the expression of Biblical and religious truths, and used styles that showed the higher glory of a heavenly world, such as the use of gold in the background of paintings, or glass in mosaics or windows, which also presented figures in idealized, patterned (flat) forms. Nevertheless, a classical realist tradition persisted in small Byzantine works, and realism steadily grew in the art of Catholic Europe.(Mithen, 1999).

Renaissance art had a greatly increased emphasis on the realistic depiction of the material world, and the place of humans in it, reflected in the corporeality of the human body, and development of a systematic method of graphical perspective to depict recession in a three-dimensional picture space. (Mithen, 1999).

Robertson and McDaniel, (2005) asserted a common view is that the epithet "art", particular in its elevated sense, requires a certain level of creative expertise by the artist, whether this be a demonstration of technical ability, an originality in stylistic approach, or a combination of these two. Traditionally skill of execution was viewed as a quality inseparable from art and thus necessary for its success; for Leonardo da Vinci, art, neither more nor less than his other endeavors, was a manifestation of skill. Rembrandt's work, now praised for its ephemeral virtues, was most admired by his contemporaries for its virtuosity. At the turn of the 20th century, the adroit performances of John Singer Sargent were alternately admired and viewed with skepticism for their manual fluency, yet at nearly the same time the artist who would become the era's most recognized and peripatetic iconoclast, Pablo Picasso, was completing a traditional academic training at which he excelled.

Purpose of art

According to Holly and Moxey (2002) Art has had a great number of different functions throughout its history, making its purpose difficult to abstract or quantify to any single concept. This does not imply that the purpose of Art is "vague", but that it has had many unique, different reasons for being created. Some of these functions of Art are provided in the following outline. The different purposes of art may be grouped according to those that are non-motivated, and those that are motivated (Levi-Strauss).

Non-motivated functions of art

The non-motivated purposes of art are those that are integral to being human, transcend the individual, or do not fulfill a specific external purpose. In this sense, Art, as creativity, is something humans must do by their very nature (i.e., no other species creates art), and is therefore beyond utility.

1. *Basic human instinct for harmony, balance, rhythm.* Art at this level is not an action or an object, but an internal appreciation of balance and harmony (beauty), and therefore an aspect of being human beyond utility.

   "Imitation, then, is one instinct of our nature. Next, there is the instinct for 'harmony' and rhythm, meters being manifestly sections of rhythm. Persons, therefore, starting with this natural gift developed by degrees their special aptitudes, till their rude improvisations gave birth to Poetry." -Aristotle

2. *Experience of the mysterious.* Art provides a way to experience one's self in relation to the universe. This experience may often come unmotivated, as one appreciates art, music or poetry.

   "The most beautiful thing we can experience is the mysterious. It is the source of all true art and science." -Albert Einstein

3. *Expression of the imagination.* Art provide a means to express the imagination in non-grammatic ways that are not tied to the formality of spoken or written language. Unlike words, which come in sequences and each of which have a

definite meaning, art provides a range of forms, symbols and ideas with meanings that are malleable.

4. *Ritualistic and symbolic functions.* In many cultures, art is used in rituals, performances and dances as a decoration or symbol. While these often have no specific utilitarian (motivated) purpose, anthropologists know that they often serve a purpose at the level of meaning within a particular culture. This meaning is not furnished by any one individual but is often the result of many generations of change, and of a cosmological relationship within the culture.

"Most scholars who deal with rock paintings or objects recovered from prehistoric contexts that cannot be explained in utilitarian terms and are thus categorized as decorative, ritual or symbolic, are aware of the trap posed by the term 'art'." -Silva Tomaskova

Motivated functions of art

Mithen (1999) explains that motivated purposes of art refer to intentional, conscious actions on the part of the artists or creator. These may be to bring about political change, to comment on an aspect of society, to convey a specific emotion or mood, to address personal psychology, to illustrate another discipline, to (with commercial arts) to sell a product, or simply as a form of communication.

1. *Communication.* Art, at its simplest, is a form of communication. As most forms of communication have an intent or goal directed toward another individual, this is a motivated purpose. Illustrative arts, such as scientific illustration, are a form

of art as communication. Maps are another example. However, the content need not be scientific. Emotions, moods and feelings are also communicated through art.

"[Art is a set of] artifacts or images with symbolic meanings as a means of communication." – (Steve Mithen, 1999)

2. *Art as entertainment*. Art may seek to bring about a particular emotion or mood, for the purpose of relaxing or entertaining the viewer. This is often the function of the art industries of Motion Pictures and Video Games.
3. *The Avante-Garde. Art for political change.* One of the defining functions of early twentieth century art has been to use visual images to bring about political change. Art movements that had this goal—Dadaism, Surrealism, Russian Constructivism, and Abstract Expressionism, among others—are collectively referred to as the *avante-garde* arts.

"By contrast, the realistic attitude, inspired by positivism, from Saint Thomas Aquinas to Anatole France, clearly seems to me to be hostile to any intellectual or moral advancement. I loathe it, for it is made up of mediocrity, hate, and dull conceit. It is this attitude which today gives birth to these ridiculous books, these insulting plays. It constantly feeds on and derives strength from the newspapers and stultifies both science and art by assiduously flattering the lowest of tastes; clarity bordering on stupidity, a dog's life." -André Breton (Surrealism)

4. *Art for psychological and healing purposes.* Art is also used by art therapists, psychotherapists and clinical psychologists as art therapy. The Diagnostic Drawing Series, for example, is used to determine the personality and emotional functioning of a patient. The end product is not the principal goal in this case, but rather a process of healing, through creative acts, is sought. The resultant piece of artwork may also offer insight into the troubles experienced by the subject and may suggest suitable approaches to be used in more conventional forms of psychiatric therapy.
5. *Art for social inquiry, subversion and/or anarchy.* While similar to art for political change, subversive or deconstructivist art may seek to question aspects of society without any specific political goal. In this case, the function of art may be simply to criticize some aspect of society.

   Graffiti art and other types of street art are graphics and images that are spray-painted or stencilled on publicly viewable walls, buildings, buses, trains, and bridges, usually without permission. Certain art forms, such as graffiti, may also be illegal when they break laws (in this case vandalism).

6. *Art for social causes.* Art can be used to raise awareness for a large variety of causes. A number of art activities were aimed at raising awareness of autism, cancer, human trafficking, and a variety of other topics, such as ocean conservation, human rights in Darfur, murdered and missing Aboriginal women, elder abuse, and pollution. Trashion, practiced by artists such as Marina DeBris is one example of using art to raise awareness about pollution.

7. *Art for propaganda, or commercialism.* Art is often utilized as a form of propaganda, and thus can be used to subtly influence popular conceptions or mood. In a similar way, art that tries to sell a product also influences mood and emotion. In both cases, the purpose of art here is to subtly manipulate the viewer into a particular emotional or psychological response toward a particular idea or object.
8. *Art as a fitness indicator.* It has been argued that the ability of the human brain by far exceeds what was needed for survival in the ancestral environment. One evolutionary psychology explanation for this is that the human brain and associated traits (such as artistic ability and creativity) are the human equivalent of the peacock's tail. The purpose of the male peacock's extravagant tail has been argued to be to attract females (see also Fisherian runaway and handicap principle). According to this theory superior execution of art was evolutionary important because it attracted mates.

According to Reynolds and Prior (2003) on 'Disability and rehabilitation' it came out that about half of the participants had taken up their preferred artist occupation since the onset of illness. Participant described their artwork as contributing to their health and well-being in many diverse ways. Art filled occupational voids, distracted thoughts away from illness, promoted the experience of flow and spontaneity, enabled the expression of grief maintained a positive identity, and extended social networks. Its value was conceptualized by one participant as a "life style coat-hanger" organizing numerous further roles and activities gave purpose to life. Art was more than cathartic. It offered a

versatile means of overcoming the restrictions imposed by illness on self and lifestyle, in many causes creating a more enriched lifestyle than before.

The functions of art described above are not mutually exclusive, as many of them may overlap. For example, art for the purpose of entertainment may also seek to sell a product, i.e. the movie or video game. Art is an expression of thought through a visible medium. It is about looks and appearance. It is about pleasing or displeasing the eye. This means that, how something is depicted is as important as what is depicted. It is a means of communicating a thought, an idea, a feeling, or a conviction. A viewer's opinion of a work is influence by his own past personal experiences when something is depicted. The artist can only hope to make an impact but cannot create an opinion for the viewer.

2.3 What is Textile Art?

According to Adu-Akwaboa (1994) textiles is defined as the manufacture of cloth and all the material that can be formed or have been formed into yarns or fabricated into cloth. According to Merriam-Webster (2012) a textile or cloth is a flexible woven material consisting of a network of natural or artificial fibres often referred to as thread or yarn. Yarn is produced by spinning raw fibres of wool, flax, cotton, or other material to produce long strands. Textiles are formed by weaving, knitting, crocheting, knotting, or pressing fibres together (felt).

A Textile is a flexible material consisting of a network of natural or artificial fibres (yarn or thread). Yarn is produced by spinning raw fibres of wool, flax, cotton,

hemp, or other materials to produce long strands. Textiles are formed by weaving, knitting, crocheting, knotting, or felting. (Merriam-Webster, 2011).

The related words fabric and cloth are often used in textile assembly trades (such as tailoring and dressmaking) as synonyms for textile. However, there are subtle differences in these terms in specialised usage. A textile is any material made of interlacing fibres, including carpeting and geotextiles. A fabric is a material made through weaving, knitting, spreading, crocheting, or bonding that may be used in production of further goods (garments etc.). Cloth may be used synonymously with fabric but is often a piece of fabric that has been processed. The word 'textile' is from Latin, from the adjective textilis, meaning 'woven', from textus, the past participle of the verb texere, 'to weave'. (Merriam-Webster,2011).

History of clothing and textiles

The discovery of dyed flax fibres in a cave in the Republic of Georgia dated to 34,000 BCE suggests textile-like materials were made even in prehistoric times. The production of textiles is a craft whose speed and scale of production has been altered almost beyond recognition by industrialization and the introduction of modern manufacturing techniques. However, for the main types of textiles, plain weave, twill, or satin weave, there is little difference between the ancient and modern methods. (Merriam-Webster, 2011).

Uses

Textiles have an assortment of uses, the most common of which are for clothing and for containers such as bags and baskets. In the household they are used in carpeting, upholstered furnishings, window shades, towels, coverings for tables, bed, and other flat surfaces, and in art. In the workplace they are used in industrial and scientific processes such as filtering. Miscellaneous used include flags, backpacks, tents, nets, handkerchiefs, cleaning devices such as balloons, kites, sails, and parachutes; textiles are also used to provide strengthening in composite materials such as fibreglass and industrial geotextiles. Textiles are used in many traditional crafts such as sewing, quilting and embroidery. (Merriam-Webster, 2011).

Textiles for industrial purposes, and chosen for characteristics, other than their appearance, are commonly referred to as technical textiles. Technical textiles include textile structures for automotive applications, medical textiles (example implants), geotextiles (reinforcement of embankments), agro textiles (textiles for crop protection), protective clothing (example against heat and radiation for fire fighter clothing, against molten metals for welders, stab protection, and bullet proof vests. In all these applications stringent performance requirements must be met. Woven of threads coated with Zinc Oxide nanowires, Laboratory fabric has been shown capable of "self-powering nanosystems" using vibrations created by everyday actions like wing or body movements. (Merriam-Webster, 2011).

Sources and types

Textiles art are from many materials, with four main sources: animal (wool, silk), plant (cotton, flax, jute), mineral (asbestos, glass fibre), and synthetic (nylon, polyester, acrylic). The first three are natural. In the 20th century, they were supplemented by artificial fibres made from petroleum. (Merriam-Webster, 2011).

Textiles are made in various strengths and degrees of durability, from the finest microfiber made of strands thinner than one denier to the sturdiest canvas. Textile manufacturing terminology has a wealth of descriptive terms, from light gauze – like gossamer to heavy grosgrain cloth and beyond. (Merriam-Webster, 2011).

Animal

Animal textiles are commonly made from hair, fur, skin or silk (in the silkworms' case). Wool refers to the hair of domestic goat or sheep, which is distinguished from other types of animal hair in that the individual strands are coated with scales and tightly crimped, and the wool as a whole is coated with a wax mixture known as lanolin (sometimes called wool grease), which is waterproof and dirt proof. Woollen refers to a bulkier yarn produced from carded, non –parallel fibre, while worsted refers to a finer yarn spun from longer fibres which have been combed to be parallel. Wool is commonly used for warm clothing. Cashmere, the hair of the Indian cashmere goat, and mohair, the hair of the North African angora goat, are types of wool known for their softness. (Merriam-Webster, 2011).

Other animal textiles which are made from hair or fur are alpaca wool, vicuna wool, llama wool, and camel hair, generally used in the production of coats, jackets, ponchos, blankets, and other warm coverings. Angora refers to the long, thick, soft hair of the angora rabbit, Qiviut is the fine inner wool of the muskox. Wadmal is a coarse cloth made of wool, produced Scandinavia, mostly 1000- 1500 CE.(Merriam-Webster, 2011).

Silk is an animal textile made from the fibres of the cocoon of the Chinese silk worm which is spun into a smooth fabric prized for its softness. There are two main types of the silk: 'mulberry silk' produced by the Bombyx Mori and 'wild silk' such as Tussah silk. Silkworm larvae produce the first type if cultivated in habitats with fresh mulberry leaves for consumption, while Tussah silk is produced by silkworms feeding purely on oak leaves. Around four-fifths of the world's silk production consists of cultivated silk. (Merriam-Webster, 2011).

Plant

Grass, rush, hemp, and sisal are all used in making rope. In the first two, the entire plant is used for this purpose, while in the last two, only fibres from the plant are utilized, Coir (coconut fibre) is used in making twine and also in floor mats, doormats, brushes, mattresses, floor tiles and sacking. (Merriam-Webster, 2011).

Straw and bamboo are both used to make hats, straw, a dried form of grass, is also used for stuffing, as is Kapok. Fibres from pulpwood trees, cotton, rice, hemp, and nettle are used in making paper. (Merriam-Webster, 2011).

Cotton, flax, jute, hemp, modal and even bamboo fibre are all used in clothing. Pina (pineapple fibre) and ramie are also fibres used in clothing, generally with a blend of other fibres such as cotton. Nettles have also been used to make a fibre and fabric very similar to hemp or flax. The use of milkweed stalk fibre has also been reported but it tends to be somewhat weaker than other fibres like hemp or flax. (Merriam-Webster, 2011).

The inner bark of the lacebark tree is a fine netting that has been used to make clothing and accessories as well as utilitarian article such s rope. Acetate is used to increase the shininess of certain fabrics such as silks, velvets, and taffetas. (Merriam-Webster,2012).

Seaweed is used in the production of textiles: a water-soluble fibre known as alginate is produced and is used as a holding fibre; when the cloth is finished, the alginate is dissolved, leaving an open area. (Merriam-Webster, 2011).

Lyocell is a synthetic fabric derived from wood pulp. It is often described as a synthetic silk equivalent; it is a tough fabric that is often blended with other fabrics – cotton, for example.Fibres from the stalks of plants, such as hemp, flax, and nettles, are also known as ‘bast’ fibres. (Merriam-Webster, 2011).

Mineral

Asbestos and basalt fibre are used for vinyl tiles, sheeting and adhesives, “transite” panels and siding, acoustical ceilings, stage curtains, and fire blankets. Glass fibre is used in the production of ironing board and mattress covers, ropes and cables,

reinforcement fibre for composite materials, insect netting, flame-retardant and protective fabric, soundproof, fireproof, and insulating fibres. Glass fibre are woven and coated with Teflon to produce beta cloth, a virtually fireproof fabric which replaced nylon in the outer layer of United States space suits since 1968. (Merriam-Webster, 2011).

Metal fibre, metal foil, and metal wire have a variety of uses, including the production of cloth-of-gold and jewellery. Hardware cloth (US term only) is a coarse woven mesh of steel wire, used in construction. It is much like standard window screening, but heavier and with a more open weave. (Merriam-Webster, 2011).

Minerals and natural and synthetic fabrics may be combined, as in emery cloth, a layer of emery abrasive glued to a cloth backing. Also “sand cloth” is a U.S. term for fine wire mesh with abrasive glued to it, employed like emery cloth or coarse sandpaper. (Merriam-Webster, 2011).

Synthetic textiles are used primarily in the production of clothing, as well as the manufacture of geotextiles. Polyester fibre is used in all types of clothing, either alone or blended with fibres such as cotton. Aramid fibre (example Twaron) is used for flame-retardant clothing, cut-protection, and armour. Acrylic is a fibre used to imitate wool, including cashmere, and is often used in replacement of them. Nylon is a fibre used to imitate silk; it is used in the production of pantyhose. Thicker nylon fibres are used in rope and outdoor clothing. (Merriam-Webster, 2011).

Spandex (trade name Lycra) is a polyurethane product that can be made tight-fitting without impeding movement. It is used to make activewear, bras, and swimsuits.

Olefin fibre is a fibre used in activewear, linings, and warm clothing. Olefins are hydrophobic, allowing them to dry quickly. A sintered felt of olefin fibres is sold under trade name Tyvek. (Merriam-Webster, 2011).

Ingeo is a polylactide fibre blended with other fibres such as cotton and used in clothing. It is more hydrophilic than most other synthetics, allowing it to wick away perspiration.

Lurex is a metallic fibre used in clothing embellishment. Milk proteins have also been to create synthetic fabric. Milk or casein fibre cloth was developed during World War I in Germany, and further developed in Italy and America during the 1930s. Milk fibre fabric is not very durable and wrinkles easily but has a pH similar to human skin and possesses anti-bacterial properties. It is market as biodegradable, Carbon fibre is mostly used in composite materials, together with resin, such as carbon fibre reinforced plastic. The fibres are made from polymer fibres through carbonization. (Merriam-Webster, 2011).

Weaving is a textile production method which involves interlacing a set of longer threads (called the warp) with a set of crossing threads (called the weft). This is done on a frame or machine known as a loom, of which there are a number of types. Some weaving is still done by hand, but the vast majority is mechanized. (Merriam-Webster, 2011).

Knitting, looping, and crocheting involve interlacing loops of yarn, which are formed either on a knitting needle, needle, or on a crochet hook, together in a line. The processes are different in that knitting has several active loop on the needle. Knitting can

be performed by machine but crochet can only be performed by hand. (Merriam-Webster, 2011).

Spread Tow is a production method where the yarn is spread into thin tapes, and then the tapes are woven as warp and weft. This method is mostly used for composite materials; spread tow fabrics can be made in carbon, aramide, etc. (Merriam-Webster, 2011).

Braiding or plaiting involves twisting threads together into cloth. Knotting involves tying threads together and is used in making macramé. Lace is made by interlocking threads together independently, using a backing and any of the methods described above, to create a fine fabric with open holes in the work. Lace can be made by either hand or machine. (Merriam-Webster, 2011).

Carpets, rugs, velvet, velour, ad velveteen are made by interlacing a secondary yarn through woven cloth, creating a tufted layer known as a nap or pile. Felting involves pressing a mat of fibres together and working them together until they become tangled. A liquid, such as soapy water, is usually added to lubricate the fibres, and to open up the microscopic scales on strands of wool. (Merriam-Webster, 2011).

Nonwoven textiles are manufactured by the bonding of fibres to make fabric. Bonding may be thermal or mechanical, or adhesives can be used. Bark cloth is made by pounding bark until it is soft and flat. (Merriam-Webster, 2011).

Treatments

Textiles are often dyed, with fabrics available in almost every colour. The dyeing process often requires several dozen gallons of water for each pound of clothing. Coloured designs in textiles can be created by weaving together fibres of different colours (tartan or Uzbek Ikat), adding coloured stitches to finished fabric (embroidery), creating patterns by resist dyeing methods, tying off areas of cloth and dyeing in between them (batik), or using various printing processes on finished fabric. (Merriam-Webster, 2011).

Woodblock printing, still used in India and elsewhere today, is the oldest of these dating back to at least 220 CE in China. Textiles are also sometimes bleached, making the textile pale or white. Textiles are sometimes finished by chemical processes to change their characteristics. In the 19th century and early 20th century starching was commonly used to make clothing more resistant to stains and wrinkles. (Merriam-Webster, 2011).

Since the 1990s, with advances in technologies such as permanent press process, finishing agents have been used to strengthen fabrics and make them wrinkle free. More recently, nanomaterials research has led to additional advancements, with companies such as Nano-Tex and NanoHorizons developing permanent treatments based on metallic nanoparticles for making textiles more resistant to things such as water, stains, wrinkles, and pathogens such as bacteria and fungi. (Merriam-Webster, 2011).

More so today than ever before, textiles receive a range of treatments before they reach the end-user. From formaldehyde finishes (to improve crease-resistance) to biocidic

finishes and from flame retardants to dyeing of many types of fabric, the possibilities are almost endless. However, many of these finishes may also have detrimental effects on the end user. A number of disperse, acid and reactive dyes (for example have) have been shown to be allergenic to sensitive individuals. Further to this, specific dyes within this group have also been shown to induce purpuric contact dermatitis. (Merriam-Webster, 2011).

Although formaldehyde levels in clothing are unlikely to be at levels high enough to cause an allergic reaction, due to the presence of such a chemical, quality control and texting are of utmost importance. Flame retardants (mainly in the brominated form) are also of concern where the environment, and their potential toxicity, are concerned. Testing for these additives is possible at a number of commercial laboratories, it is also possible to have textiles texted for according to the Oeko- tex certification standard which contains limits levels for the use of certain chemicals in textiles products. (Merriam-Webster, 2011).

Textile arts are arts and crafts that use plant, animal, or syntheticfibres to construct practical or decorative objects.Textiles have been a fundamental part of human life since the beginning of civilization, and the methods and materials used to make them have expanded enormously, while the functions of textiles have remained the same. The history of textile arts is also the history of international trade. Tyrian purpledye was an important trade good in the ancient Mediterranean. The Silk Road brought Chinese silk to India, Africa, and Europe. Tastes for imported luxury fabrics led to sumptuary laws during the Middle Ages and Renaissance. The Industrial Revolution was a revolution of

textiles technology: the cotton gin, the spinning jenny, and the power loom mechanized production and led to the Luddite rebellion.(Gillow and Bryan, 2018).

The word *textile* is from Latin*texere* which means "to weave", "to braid" or "to construct". The simplest textile art is felting, in which animal fibres are matted together using heat and moisture. Most textile arts begin with twisting or spinning and plyingfibres to make yarn (called *thread* when it is very fine and *rope* when it is very heavy). The yarn is then knotted, looped, braided, or woven to make flexible *fabric* or *cloth*, and cloth can be used to make clothing and soft furnishings. All of these items – felt, yarn, fabric, and finished objects – are collectively referred to as *textiles*. (Arnold, 2018).

The textile arts also include those techniques which are used to embellish or decorate textiles – dyeing and printing to add colour and pattern; embroidery and other types of needlework; tablet weaving; and lace-making. Construction methods such as sewing, knitting, crochet, and tailoring, as well as the tools employed (looms and sewing needles), techniques employed (quilting and pleating) and the objects made (carpets, kilims, hooked rugs, and coverlets) all fall under the category of textile arts. .(Arnold, 2018).

From early times, textiles have been used to cover the human body and protect it from the elements; to send social cues to other people; to store, secure, and protect possessions; and to soften, insulate, and decorate living spaces and surfaces.(Arnold, 2018).

The persistence of ancient textile arts and functions, and their elaboration for decorative effect, can be seen in a Jacobean era portrait of Henry Frederick, Prince of Wales by Robert Peake the Elder (above). The prince's capotainhat is made of felt using the most basic of textile techniques. His clothing is made of woven cloth, richly embroidered in silk, and his stockings are knitted. He stands on an oriental rug of wool which softens and warms the floor, and heavy curtains both decorate the room and block cold drafts from the window. Gold work embroidery on the tablecloth and curtains proclaim the status of the home's owner, in the same way that the felted fur hat, sheer linenshirt trimmed with reticella lace, and opulent embroidery on the prince's clothes proclaim his social position. (Arnold, 2018).

Textiles as art

Traditionally the term art was used to refer to any skill or mastery, a concept which altered during the Romantic period of the nineteenth century, when art came be seen as “a special faculty of the human mind to be classified with religion and science”. This distinction between craft and fine art is applied to the textile arts as well, where the term fibre art is now used to describe textile-based decorative objects which are not intended for practical use.(Arnold, 2018).

Popular Techniques in Textile Art

Textile art is broad term that can encompass many types of approaches.

1. Weaving

It is one of the earliest techniques. Here, threads are laced together on a loom at intersecting angles to form cloth. This is commonly seen in garments, but weavings can also be made into display artwork.

2. Embroidery

Is another popular form, in which Artists use thread to stitch decorative designs onto fabric? Often referred to as hoop art, the images mostly stay within the confines of the circular frame. But contemporary embroidery has no rules, so it is not unusual to see fabric and thread spill from the hoop.

3. Knitting and Crocheting

Knitting and crocheting are two other techniques for working with textiles. In both, large needles are used. Double and single, respectively-to twist thread into different stitches, which in turn create large patterns. These approaches are extremely common in your favourite sweater or blanket, but artists have co-opted as a means of expression.

Basics of Textile Art

Textile art is the process of creating something using fibres gained from sources like plants, animals, insects (think silkworms), or synthetic materials. Making textiles is an extremely old art form. Textile fragments have been found dating back to prehistoric times and there is a good reason for this. Think of how cold winter can be. How would

you feel if you didn't have warm clothing? People developed textiles to keep warm, to protect surfaces and to insulate dwellings. Examples of such textile include tapestries, rugs, quilts, and of course clothing. People also used textiles to make objects that signalled status or commemorated important events. Examples of this type of textile include things like flags, military uniforms, or ceremonial banners.(Merriam-Webster, 2011).

Many cultures around the world have distinct methods of making textiles by using materials available to them, and some have become famous over the century like Chinese silks or Turkish mugs. Taking, many contemporary artists work with fibres and textiles in new and exciting ways. Let's look at a few methods of making textile art. (Merriam-Webster, 2011).

Yarns and Threads

Textile are often made through traditional methods like sewing, weaving and knitting these methods all have a basic principle in common. They use thread or yarn to make or connect pieces of fabric. In sewing, a single needle and thread stitches pieces of cloth together and also adds surface ornament. Embroidery, covering the surface of a textile with decorative pictures and colourful patterns, is a form of sewing.

Weaving involves interlacing two sets of threads. They are the warp which runs vertically, and the weft, which runs horizontally. Weaving requires using a piece of equipment called a loom. The warp threads are held tight and the weft threads are fed

through them. Merging the two together is the process of weaving. (Merriam-Webster, 2011).

According to Reynolds (2004) reviews previous research into the meanings of textile art –making for people living with long –term illness. Qualitative accounts of the creative process suggest that textile art-making is a multi-dimensional experience. Some practitioners fill regard textile art work as a means of coping with discomfort and other symptoms. For a minority, it enables expressions of anxiety and feelings about loss.

Nevertheless, participants place more emphasis on the role of textile art – making in rebuilding a satisfactory identity and restoring autonomy and quality to life. It fills occupational voids following early retirement and enables social contacts. Textile artwork also stimulates learning and personal development. It remains possible that any creative occupational delivers such benefits. (Reynolds, 2004).

It accepts the use of assistive technology, thereby enabling people with a variety of physical impairments to produce 'mainstream' art. It draws upon rich social traditions, facilitating social contact. Many forms of textile art –making art highly time -consuming, fostering a future orientation and the creative process is often socially visible within the home, with positive consequences for self-image. (Reynolds, 2004).

Theorizing about the relationships between health and creative occupation is still at an early-stage and there is a continuing need to examine the subjective effects of meaningful occupations on well-being. From the art therapy literature, we can infer that art-making may benefit patients with physical illness through enhancing the experience

of control and through offering a means of self-expression particularly about feelings that are too overwhelming to describe in words. (Reynolds, 2004)

Because of the wide range of textile art forms that are available, people with physical impairments may find at least one form of textile artwork suited to their abilities and interests. Thus, the research findings may be of interest to considerable numbers of people living with chronic health problems who are seeking a meaningful leisure activity that is feasible within the context of their physical impairments. (Reynolds, 2004).

If we are to appreciate how art-making may make a difference to quality of life during long –term illness, we need to acknowledge the impact of illness not only upon physical but also psychological and social well-being looking beyond the obvious discomfort and functional limitations that illness brings about, many studies have shown that people with chronic health problems often experience a shrinkage of social roles, withdrawal from valued occupations, loss of choice and control over lifestyle, and threats to self and identity. Illness can become a 'master status' in the person's life, penetrating every aspect of personal experience as well as influencing the reactions of others. (Reynolds, 2004).

How may a creative occupation such as textile art challenge the 'master status' of illness? From a limited body of previous work, we may infer that textile art can be restorative, through its tactile qualities and through the quiet and focused nature of the occupation. It can also provide a measure of comfort and security through linking practitioners to previous traditions and rituals. Given that people often feel cut adrift from their previous lives and relationships when diagnosed with a serious health condition,

such reconnection with long – standing social traditions may be highly supportive. Case studies suggest that some individuals use textile art to symbolize their journey through a healing process. (Reynolds, 2004).

Reynolds (2004) states, a participant described how her art work helped her through treatment for breast cancer by focusing 'her attention elsewhere:

And I was working for an exhibition and at the same time making cards and I was a bit manic about it, I thought I've got to do all these things, and it took my mind off chemotherapy, and so it was a great help to me

Another participant with multiple sclerosis viewed art-making as helping to block out her symptoms:

When you're working creatively, you're not thinking about things that hurt, or pains, or aching…incontinence

In addition to psychological benefits, participants in both research studies, referred to improvements in physical functioning. Those who lived with conditions that restricted joint movement, such as arthritis, generally regarded their sewing as improving their manual dexterity. (Reynolds, 2004).

Diener, Lucas & Oishi reviewed a wide range of studies and concluded that positive well-being is associated with the following subjective states:

- Positive emotions (example joy, satisfaction)
- Optimism

- Self-esteem- close match between ideal self and perceived self
- Experiencing an acceptable degree of autonomy –choice over lifestyle, activities
- Feeling able to pursue valued goals and opportunities for learning and personal development
- Opportunities for flow-engaging in skillful activities to a high standard
- Positive social relationships –experiencing oneself as having a valued place in a social network.

Reynolds & Prior (2003) found in the interviews that many practitioners experienced their textile art – making as delivering many of the psychological and social benefits outlined by Diener et al. although illness had in most cases ended participants' professional careers with consequent period of emotional turmoil, it had also catalysed the discovery of a more satisfying lifestyle, enabling them to acquire new skills, interests and identities. Because they had experienced such personal growth in relation to art – making, some had re-interpreted their illness as having brought about positive changes in their lives, as well as stressful limitations.

According to Reynolds (2003) Textile art had encouraged almost all participant to develop new skills and, in many cases, to study for formal qualifications (for example, taking city & Guilds courses). The strong emphasis on skills development in the interviews resonates with the findings of Dickie who noted repeated references to learning in her study of quilt –makers in the U.S. Participants' experience of control and choice were enhanced as they could focus on current level of physical functioning.

However, in addition to enhancing control, textile art provided some with an exhilarating experience of adventure.

Reynolds (2004) states that; Loss of previous career threatened many of the participants' identities. Yet by gaining skills and social contacts through their textile art, the women found that their status and self-esteem could be restored, illness tends to have profound effects on family relationships, particularly when family members feel obliged to take on more care-giving roles. Some of the participants referred to the satisfaction that they gained from being able to return some of this care, through hand-made cards and gifts. For example, one mother with multiple sclerosis who had a young family explained:

> *I find doing the embroidery gives you a little bit of dignity because I feel I can give back because I don't want to keep from life. I want to give as well*

Through their engagement in textile art, the participants expanded their lives in many ways, including gaining satisfaction, and further skills, from researching design books, courses and the internet, from visiting museums and exhibitions, from visiting the countryside for inspiration.

According to Reynolds (2004) Most had expanded their social networks as a result of their interests, for example through joining needlework classes and community art projects. People with long -term conditions generally find their social network shrinking, and there is a wealth of evidence showing that loss of social support undermines health. Hence the finding that most practitioners gained new friends and

acquaintances through their involvement in textile art has remarkable implications for health promotion. Such social contacts provide a potent source of self-esteem.

One participant summed up the multiple influences of textile art on her positive well – being by describing it as a 'lifestyle coat hanger' that supported many other enjoyable activities. Many of the therapeutic benefits of art –making that participants have recounted are associated with filling occupational voids productively and enjoyable, relegating illness to the background of life, and making new social contacts based on shared interests rather than illness and care –giving. (Reynolds, 2004).

According to Reynolds (2004) however, does the self-expressive aspect of textile art also promote well-being? Whilst not, a dominant motive for art –making, some textile artists have described a selection of their artwork as expressing and symbolizing their feelings about illness.

According to Reynolds (2004) they reflected that their artwork tended to have this function in early stages after diagnosis, when feelings of loss and grief predominated. Through their choice of colour, texture and image, these women felt enabled to discharge the feelings of entrapment and fear that their illnesses had generated. Yet most participants emphasized that textile art –work primarily strengthened their connections with 'normal' life, rather than expressing their concerns about illness. For example, it encouraged observation and appreciation of the natural world outside the home. Some enjoyed stitching country side and floral scenes, as these provided a bridge with the wide world outside the home. Such connections with the natural world were valued especially by those who had mobility problems.

Participants also described many other sources of inspiration for their artwork, including architecture, museums, fantasy, geometric patterns and previous artists' work. Some had found that they could express their professional interest, familiar identities, and special knowledge in their artwork, thus preserving their self-image. For example, a participant who had felt pressured to retire from teaching geography because of arthritis described the images that she favoured in her embroideries:

Because I'm a geographer I like spatial thing, I like colour, I like pattern, lovely crystals……

In summary, studies have shown that women textile artists who lived with long-term illness regarded their art –making as promoting the self-management of many illnesses related problems, furthermore, they gained higher levels of well-being through a range of experiences including flow, mastery and control. Positive emotions such as joy and deep satisfaction were associated with art-making, and these to at least some extent countered the worry and frustration of illness. Overtime, textile art – making helped, many of the participants to restore a positive self –image, and to cope with the loss of a valued career. (Reynolds, 2004).

Stimulating new relationships, based on mutual interest and equal status rather than pity, illness or caregiving, enlivened daily life provided support and enhanced self – esteem. Almost all of participants expressed a commitment to further learning and skills development, and many had seen their talents unfold to a degree that would have surprised them in earlier years. (Reynolds, 2004).

Most were firmly planning many future projects, as well as considering further art courses and possible exhibitions. Such plans and unfinished projects could be a vital and means of warding off depression and hopelessness. (Reynolds, 2004).

2.4 What is mental illness?

A mental illness is a disease that causes mild to severe disturbances in thought and/or behaviour, resulting in an inability to cope with life's ordinary demands and routines the (National Institute of Mental Health **NIMH** 2008**).**

There are more than 200 classified forms of mental illness. Some of the more common disorders are depression, bipolar disorder, dementia, schizophrenia and anxiety disorders. Symptoms may include changes in mood, personality, personal habits and/or social withdrawal.(Mental Health America (MHA) 2018).

Mental health problems may be related to excessive stress due to a particular situation or series of events. As with cancer, diabetes and heart disease, mental illnesses are often physical as well as emotional and psychological. Mental illnesses may be cause by a reaction to environmental stresses, genetic factors, biochemical imbalances, or a combination of these. With proper care and treatment many individuals learn to cope or recover from a mental illness or emotional disorder. (Mental Health America (MHA), 2018).

Warning Signs and Symptoms

It is especially important to pay attention to sudden changes in thoughts and behaviours. Also keep in mind that the onset of several of the symptoms below, and not just any one change, indicates a problem that should be assessed. The symptoms below should not be due to recent substance use or another medical condition. (Mental Health America (MHA), 2018).

The following are signs that your loved one may want to speak to a medical or mental health professional according to National Institute of Mental Health **(NIMH 2008)** Information Resources and Inquiries Branch. Handling unusual behaviour;in adults**:**confused thinking,prolonged depression (sadness or irritability), feelings of extreme highs and lows, excessive fears, worries and anxieties, social withdrawal,dramatic changes in eating or sleeping habits,strong feelings of anger,delusions or hallucinations,growing inability to cope with daily problems and activities,suicidal thoughts,denial of obvious problems,numerous unexplained physical ailments,substance abuse.

In older children and pre-adolescents: substance abuse, inability to cope with problems and daily activities, changes in sleeping and/or eating habits, excessive complaints of physical ailments, defiance of authority, truancy, theft, and/or vandalism, intense fear of weight gain, prolonged negative mood, often accompanied by poor appetite or thoughts of death, frequent outbursts of anger.(NIMH, 2008).

In younger children: changes in school performance, poor grades despite strong efforts, excessive worry or anxiety (i.e. refusing to go to bed or school), hyperactivity, persistent nightmares, persistent disobedience or aggression, frequent temper tantrums. (Mental Health America (MHA), 2018).

Handling unusual behaviour

The outward signs of a mental illness are often behavioural. A person may be extremely quiet or withdrawn. Conversely, he or she may burst into tears, have great anxiety or have outbursts of anger. (Mental Health America (MHA), 2018).

Even after treatment has started, some individuals with a mental illness can exhibit anti-social behaviours. When in public, these behaviours can be disruptive and difficult to accept. The next time you and your family member visit your doctor or mental health professional, discuss these behaviours and develop a strategy for coping. Your family member's behaviour may be as dismaying to them as it is to you. Ask questions, listen with an open mind and be there to support them. (Mental Health America (MHA), 2018).

Establishing a support network

Whenever possible, seek support from friends and family members. If you feel you cannot discuss your situation with friends or other family members, find a self-help or support group. These groups provide who are experiencing the same type of problems. They can listen and offer valuable advice.

Seeking Counselling

Therapy can be beneficial for both the individual with mental illness and other family members. A mental health professional can suggest ways to cope and better understand you loved one's illness. (Mental Health America (MHA), 2018).

When looking for a therapist, be patient and talk to a few professional so you can choose the person that is right for you and your family. It may take time until you are comfortable, but in the long run you will be glad you sought help. (Mental Health America (MHA), 2018).

Taking time out

It is common for the person with the mental illness to become the focus of family life. When this happens, other members of the family may feel ignored or resentful. Some may find it difficult to pursue their own interests. If you are the caregiver, you need some time for yourself. Schedule time away to prevent becoming frustrated or angry. If you schedule time for yourself, it will help you to keep things in perspective and you may have more patience and compassion for coping or helping your loved one. Being physically and emotionally healthy helps you to help others.

"many families who have a loved one with mental illness share similar experiences".

It is important to remember that there is hope for recovery and that with treatment many people with mental illness return to a productive and fulfilling life. (Mental Health America (MHA), 2018).

Mental illness is nothing to be ashamed of. It is a medical problem, just like heart disease or diabetes. (National Institute of Mental Health (NIMH) and Substance Abuse and Mental Health Service Administration (SAMSHA), 2015).

Mental illnesses are health conditions involving changes in thinking, emotion or behaviour (or a combination of these). Mental illnesses are associated with distress and / or family activities. Mental illness is common. In a given year:

- Nearly one in five (19 percent) U.S. adults experience some form of mental illness
- One in 24 (4.1 percent) has a serious mental illness
- One in 12 (8.5 percent) has a substance use disorder.

Mental illness is treatable. The vast majority of individuals with mental illness continue to function in their daily lives.(National Institute of Mental Health (NIMH) and Substance Abuse and Mental Health Service Administration (SAMSHA), 2015).

Mental Health involves effective functioning in daily activities resulting in

- Productive activities (work, school, caregiving)
- Healthy relationships
- Ability to adapt to change and cope with adversity.

Mental illness refers collectively to all diagnosable mental disorders-health conditions involving

- Significant changes in thinking, emotion and/ or behaviour
- Distress and/or problems functioning in social, work or family activities.

Mental health is the foundation for thinking, communication, learning, resilience and self-esteem. Mental health is also key in relationships, personal and emotional well-being and contribution to community or society.(National Institute of Mental Health (NIMH) and Substance Abuse and Mental Health Service Administration (SAMSHA), 2015).

Many people who have mental illness do not want talk about it. But mental illness is nothing to be ashamed of! It is a medical condition, just like heart disease or diabetes. And mental health conditions are treatable. We are continually expanding our understanding of how the human brain works, and treatments are available to help people successfully manage mental health conditions. (National Institute of Mental Health (NIMH) and Substance Abuse and Mental Health Service Administration (SAMSHA), 2015).

Mental illness does not discriminate; it can affect any one regardless of your age, gender, income, social status, race/ethnicity, religion/spirituality, sexual orientation, background or other aspect of cultural identity. While mental illness can occur at any age, three-fourths of all mental illness begins by age 24. (National Institute of Mental Health (NIMH) and Substance Abuse and Mental Health Service Administration (SAMSHA), 2015).

Mental illnesses take many forms. Some are fairly mild and only interfere in limited ways with daily life, such as certain phobias (abnormal fears). Other mental health conditions are so severe that a person may need care in a hospital. (National Institute of Mental Health (NIMH) and Substance Abuse and Mental Health Service Administration (SAMSHA), 2015).

Serious mental illness is a mental behavioural or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Examples of serious mental illness include major depressive disorder, schizophrenia and bipolar disorder.(National Institute of Mental Health (NIMH) and Substance Abuse and Mental Health Service Administration (SAMSHA), 2015).

Mental disorders according to Schacter, Gilbert & Wegner (2010) are classified as a psychological condition marked primarily by sufficient disorganization of personality, mind, and emotions to seriously impair the normal psychological and often social functioning of the individual. Individuals diagnosed with mental disorders are typically deemed unable to function in society. Mental disorders occasionally consist of a combination of affective, behavioural, cognitive and perceptual components. The acknowledgement and understanding of mental health conditions has changed over time and across cultures, and there are still variations in the definition, classification, and treatment of mental disorders.

Mental illness refers to a wide range of mental health conditions — disorders that affect your mood, thinking and behaviour. Examples of mental illness include depression,

anxiety disorders, schizophrenia, eating disorders and addictive behaviours. (Mayo Clinic Staff, 2015).

Mental Health is a level of psychological well-being, or an absence of mental illness. It is the "psychological state of someone who is functioning at a satisfactory level of emotional and behavioural adjustment". From the perspective of positive psychology or holism, mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience. According to the World Health Organization (WHO), mental health includes "subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self – actualization of one's intellectual and emotional potential, among others." The WHO further states that well-being of an individual is encompassed in the realization of their abilities, coping with normal stresses of life, productive work and contribution to their community. Cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined. (National Institute of Mental Health (NIMH), 2015).

Mental health and Mental illness

According to the U.K. surgeon general (1999), mental health is the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and providing the ability to adapt to change and cope with adversity. The term mental illness refers collectively to all diagnosable mental disorders – health conditions characterized by alterations in thinking, mood, or behaviour associated with distress or impaired functioning. (National Institute of Mental Health, 2011).

A person struggling with their mental health may experience this because of stress, loneliness, depression, anxiety, relationship problems, death of a loved one, suicidal thoughts, grief, addiction, ADHD, various mood disorders, or other mental illnesses of varying degrees, as well as learning disabilities. Therapists, psychiatrists, psychologists, social workers, nurse practitioners or physicians can help manage mental illness with treatments such as therapy, counselling, or medication.

History of mental disorders

In the mid-19th century, William Sweetser was the first to coin the term "mental hygiene", which can be seen as the precursor to contemporary approaches to work on promoting positive mental health. Isaac Ray, one of the founders and the fourth president of the American Psychiatric Association, further defined mental hygiene as "the art of preserving the mind against all incidents and influences calculated to deteriorate its qualities, impair its energies, or derange its movements,". (National Institute of Mental Health, 2011).

Dorothea Dix (1802-1887) was an important figure in the development of "mental hygiene" movement. Dix was a school teacher who endeavoured throughout her life to help people with mental disorders and bring to light the deplorable conditions into which they were put. This was known as the "mental hygiene movement." Before this movement, it was not uncommon that people affected by mental illness in the 19th century would be considerably neglected, often left alone in deplorable conditions, barely even having sufficient clothing. Dix's efforts were so great that there was a rise in the number of patients in mental health facilities, which sadly resulted in these patients

receiving less attention and care, as these institutions were largely understaffed. (National Institute of Mental Health, 2011).

Emil Kraepelin in 1896 developed the taxonomy of mental disorders which has dominated the field for nearly 80 years. Later the proposed disease model of abnormality was subjected to analysis and considered normality to be relative to the physical, geographical and cultural aspects of the defining group. (National Institute of Mental Health, 2011).

At the beginning of the 20th century, Clifford Beers founded the mental health America-National Committee for Mental Hygiene after publication of his accounts from lived experience in lunatic asylums "A mind that found itself" in 1908 and opened the first outpatient mental health clinic in the United States. (National Institute of Mental Health, 2011).

A mental hygiene movement, related to the social hygiene movement, had at times been associated with advocating eugenics and sterilisation of those considered too mentally deficient to be assisted into productive work and contented family life. In the post –WWII years, references to mental hygiene were gradually replaced by the term 'mental health' due to its positive aspect that evolves from the treatment of illness to preventive and promote areas of healthcare.

Marie Jahoda described six major, fundamental categories that can be used to categorize mentally healthy individuals: a positive attitude towards the self, personal growth, integration, autonomy, a true perception of reality, and environmental mastery,

which include adaptability and healthy interpersonal relationships. (National Institute of Mental Health, 2011).

Significance

Mental illnesses are more common than cancer, diabetes, or heart disease. Over 26 percent of all Americans over the age of 18 meet the criteria for having a mental illness. A WHO report estimates the global cost of mental illness at nearly $2.5 trillion (two –thirds in indirect costs) in 2010, with a projected increase to over $ 6 trillion by 2030. (Heary, 2017).

Evidence from the World Health Organization suggests that nearly half of the world's population are affected by mental illness with an impact on their self-esteem, relationships and ability to function in everyday life. An individual's emotional health can also impact physical health and poor mental health can lead to problems such a substance abuse. ("the world health report 2001-Mental Health: New Understanding, New Hope"2014).

Maintaining good mental health is crucial to living a long and healthy life. Good mental health can enhance one's life, while poor mental health can prevent someone from living an enriching life. According to Richards, Campania, & Muse-Burke, "There is growing evidence that is showing emotional abilities are associated with prosocial behaviours such as stress management and physical health." Their research also concluded that people who lack emotional expression are inclined to anti-social behaviours (example; drug and alcohol abuse, physical fights, vandalism), which are a

direct reflection of their mental health and suppress emotions. Adults and children with mental illness may experience social stigma, which can exacerbate the issues. (National Alliance for the Mentally ill, 2011).

Mental well-being

Mental health can be seen as an unstable continuum, where an individual's mental health may have many different possible values. Mental wellness is generally viewed as a positive attribute, even if the person does not have any diagnosed mental health condition. This definition of mental health highlights emotional well-being, the capacity to live a full and creative life, and the flexibility to deal with life's inevitable challenges. Some discussions are formulated in terms of contentment or happiness. Many therapeutic systems and self-help books offer methods and philosophies espousing strategies and techniques vaunted as effective for further improving the mental wellness. Positive psychology is increasingly prominent in mental health. ((National Institute of Mental Health, 2011).

A holistic model of mental health generally includes concepts based upon anthropological, educational, psychological, religious and sociological perspectives, as well as theoretical perspectives from personality, social, clinical, health and developmental psychology. (Keyes, 2002).

An example of a wellness model includes one developed by Myers, Sweeney and Witmer. It includes five life tasks-essence or spirituality, work and leisure, friendship, love and self –direction – and twelve sub tasks- sense of worth, sense of control, realistic

beliefs, emotional awareness and coping, problem solving and creativity, sense of humour, nutrition, exercise, self-care, stress management, gender identity, and cultural identity – which are identified as characteristics of healthy functioning and a major component of wellness. The components provide a means of responding to the circumstances of life in a manner that promotes healthy functioning. (Witmer, 1992).

The tripartite model of mental well-being views mental well-being as encompassing three components of emotional well-being, social well-being, and psychological well-being. Emotional well-being is defined as having high levels of positive emotions, where as social and psychological well-being are defined as the presence of psychological and social skills and abilities that contribute to optimal functioning in daily life. The model has received empirical support across culture. The mental Health Continuum-Short Form (MHC-SF) is the most widely uses scale to measure the tripartite model of mental well-being. (National Institute of Mental Health, 2011).

Children and young adults

Mental health and stability is a very important factor in a person's everyday life. Social skills, behavioural skills, and someone's way of thinking are just some of the things that the human brain develops at an early age. Learning how to interact with others and how to focus on certain subjects are essential lessons to learn from the time we can talk all the way to when are so old that we can barely walk. (National Institute of Mental Health, 2011).

However, there are some people out there who have difficulty with these kinds of skills and behaving like an average person. This is a most likely the cause of having a mental illness is a wide range of conditions that affect a person's mood, thinking, and behaviour. About 26% of people in the United States, ages 18 and older, have been diagnosed with some kind of mental disorder. However, not much is said about children with mental illnesses even though there are many that will develop one, even as early as age three.

The most common mental illnesses in children include, but are not limited to, ADHD, autism and anxiety disorder, as well as depression in older children and teens. Having a mental illness at a younger age is much different from having one in your thirties. Children's brains are still developing and will continue to develop until around the age of twenty-five. When a mental illness is thrown into the mix, it becomes significantly harder for a child to acquire the necessary skills and habits that people use throughout the day. For example, behavioural skills don't develop as fast as motor or sensor skills do. So when a child has an anxiety disorder, they begin to lack proper social interaction and associate many ordinary things with intense fear. This can be scary for the child because they don't necessarily understand why they act and think the way that they do. Many researchers say that parents should keep an eye on their child if they have any reason to believe that something is slightly off. If the children are evaluated earlier, they become more acquainted to their disorder and treating it becomes part of their daily routine. This is opposed to adults who might not recover as quickly because it is more difficult for them to adapt.(National Institute of Mental Health, 2011).

Mental illness affects not only the person themselves, but the people around them. Friends and family also play an important role in the child's mental health stability and treatment. If the child is young, parents are the ones who evaluate their child and decide whether or not they need some form of help. Friends are a support system for the child and family as a whole. Living with a mental disorder is never easy, so it's always important to have people around to make the days a little easier. However, there are negative factors that come with the social aspect of mental illness as well. (National Institute of Mental Health, 2011).

Parents are sometimes held responsible for their child's own illness. People also say that the parents raised their children in a certain way or they acquired their behaviour from them. Family and friends are sometimes so ashamed of the idea of being close to someone with a disorder that the child feels isolated ad thinks that they have to hide their illness from others. When in reality, hiding it from people prevents the chid from getting the right amount of social interaction and treatment in order to thrive in today's society. (Lee, 2014).

Stigma is also a well-known factor in mental illness. Stigma is defined as "a mark of disgrace associated with a particular circumstance, quality, or person." Stigma is used especially when it comes to the mentally disabled, people have this assumption that everyone with a mental problem, no matter how mild or sever, is automatically considered destructive or a criminal person. Thanks to the media, this idea has been planted in our brains from a young age. (Hinshaw, 2005).

Watching movies about teens with depression or children with Autism makes us thing that all of the people have mental illness are like the ones on TV. In reality, the media displays an exaggerated version of most of most illnesses. Unfortunately, not many people know that, so they continue to belittle those with disorders. In a recent study, a majority of young people associate mental illness with extreme sadness or violence. Now that children are becoming more and more open to technology and the media itself, future generations will then continue to pair mental illness with negative thoughts. The media should be explaining that many people with disorders like ADHD and anxiety, with the right treatment, can live ordinary lives and should not be punished for something they cannot help.(National Institute of Mental Health, 2011).

Sueki, (2013) carried out a study titled "The effect of suicide-related internet use on users' mental health: A longitudinal Study." This study investigated the effects of suicide-related internet use on user's suicidal thoughts, predisposition to depression and anxiety and loneliness. The study consisted of 850 internet users; the data was obtained by carrying out a questionnaire amongst the participants. This study found that browsing websites related to suicide, and methods used to commit suicide, had a negative effect on suicidal thoughts and increased depression and anxiety tendencies the study concluded that as suicide-related internet use adversely affected mental health of certain age groups it may be prudent to reduce or control their exposure to these websites. These finding certainly suggest that the internet can indeed have a profoundly negative impact on our mental health.

Psychiatrist Thomas Szasz compared that 50 years ago children were either categorized as good or bad, and today "all children are good, but some are mentally healthy and others are mentally ill". The social control and forced identity creation is the cause of many mental health problems among today's children. A behaviour or misbehaviour might not be an illness but exercise of their free will and today's immediacy in drug administration for every problem along with the legal over-guarding and regard of a child's status as a dependent shake their personal self and invades their internal growth. (Sueki, 2013).

Prevention

Mental health is conventionally defined as a hybrid of absence of a mental disorder and presence of well-being. Focus is increasing on preventing mental disorders. Prevention is beginning to appear in mental health strategies, including the 2004 WHO report "prevention of Mental Disorders", the 2008 EU "Pact for Mental Health" and the 2011 US National Prevention Strategy. Some commented have argued that a pragmatic and practical approach to mental disorder prevention strategy. Some commentators have argued that a pragmatic and practical approach at work would be to treat it the same way as physical injury prevention. (The World Mental Health Survey Initiative, 2016).

Prevention of a disorder at young age may significantly decrease the chances that a child will suffer from a disorder later life and shall be the most efficient and effective measure from a disorder later in life and shall be the most efficient and effective measure from a public health perspective. Prevention may require the regular consultation of a

physician for at least a year to detect any signs that reveal any mental health. (National Research Council; Institute of Medicine, 2009).

Cultural and religious considerations

Mental health is a socially constructed and socially defined concept;that is, different societies, groups, cultures, institutions and professions have very different ways of conceptualizing its nature and causes, determining what is mentally healthy, and deciding what interventions if any are appropriate. Thus, different professionals will have different cultural, class, political and religious backgrounds, which will impact the methodology applied during treatment. (National Institute of Mental Health, 2011).

Research has shown that there is stigma attached to mental illness. In the United Kingdom, the Royal College of Psychiatrists organized the campaign Changing Minds (1998-2003) to help reduce stigma. Due to this stigma, responses to a positive diagnosis may be display of denialism.(National Institute of Mental Health, 2011).

Many mental health professionals are beginning to, or already understand, the importance of competency in religious diversity and spirituality. The American Psychological Association explicitly states that religion must be respected. Education in spiritual and religious matters is also required by the American Psychiatric Association. (National Institute of Mental Health, 2011).

Emotional improvement

Unemployment has been shown to have negative impact on an individual's emotional well-being, self-esteem and more broadly their mental health. Increasing unemployment has been shown to have a significant impact on mental health, predominantly depressive disorders. This is an important consideration when reviewing the triggers for mental health disorders in any population survey. In order to improve your emotional mental health, the root of the issue has to be resolved. "Prevention emphasizes the avoidance of risk factors; promotion aims to enhance an individual's ability to achieve a positive sense of self-esteem, mastery, well-being, and social inclusion." It is very important to improve your emotional mental health by surrounding yourself with positive relationships. We as humans, feed off companionships and interaction with other people. Another way to improve your emotional mental health is participating in activities that can allow you to relax and take time for yourself. According to a study on well-being by Richards, Campania and Muse-Burke, "mindfulness is considered to be a purposeful state, it may be that those who practice it believe in its importance and value being mindful, so that valuing of self-care activities may influence the intentional component of mindfulness." (National Institute of Mental Health, 2011).

Emotional Issues

Emotional mental disorders are a leading cause of disabilities worldwide. Investigating the degree and severity of untreated emotional mental disorders throughout

the world is a top priority of the World Mental Health (WMH) survey initiative, which created in 1998 by World Health Organization (WHO).

"Neuropsychiatric disorders are the leading causes of disability worldwide, accounting for 37% of all healthy life years lost through disease. These disorders are most destructive to low and middle-income countries due to their inability to provide their citizens with proper aid. Despite modern treatment and rehabilitation for emotional mental health disorders, "even economically advantaged societies have competing priorities and budgetary constraints". (Bobowik, 2014)

The World Mental Health survey initiative has suggested a plan for countries to redesign their mental health care systems to best allocate resources. "A first step is documentation of services being used and the extent and nature of unmet needs for treatment. A second step could be to do a cross- national comparison of service use and unmet needs in countries with different mental health care systems. Such comparisons can help to uncover optimum financing, national policies, and delivery systems for mental health care." ((National Institute of Mental Health, 2011).

Knowledge of how to provide effective emotional mental health care has become imperative worldwide. Unfortunately, most countries have insufficient data to guide decisions, absent or competing visions for resources ad near constant pressures to cut insurance and entitlements. WMH surveys were done in Africa (Nigeria, South Africa), the Americas (Colombia, Mexico, United States), Asia and the Pacific (Japan, New Zealand, Beijing and Shanghai in the People's Republic of China), Europe (Belgium, France, Germany, Italy, Netherlands, Spain, Ukraine), and the middle east (Israel,

Lebanon). Countries were classified with World Bank criteria as low-income (Nigeria), lower middle-income (China, Colombia, South Africa, Ukraine), higher middle-income (Lebanon, Mexico), and high-income. (National Research Council; Institute of Medicine, 2009).

The coordinated surveys on emotional mental health disorders, their severity, and treatments were implemented in the aforementioned countries. These surveys assessed the frequency, types, and adequacy of mental health service use in 17 countries in which WMH surveys are complete. The WMH also examined unmet needs for treatment in strata defined by the seriousness of mental disorders. Their research showed that "the number of respondents using any 12-month mental health service was generally lower in developing than in developed countries, and the proportion receiving services tended to correspond to countries' percentages of gross domestic product spent on health care". High levels of unmet need worldwide are not surprising, since WHO Project ATLAS' findings of much lower mental health expenditures than was suggested by the magnitude of burdens from mental illnesses. Generally, unmet needs in low-income and middle-income countries might be attributable to these nations spending reduced amounts (usually < 1%) of already diminished health budgets on mental health care, and they rely heavily on out -of –pocket spending by citizens who are ill equipped for it". (National Institute of Mental Health, 2011).

Modern Methods of Treatment

Physical Activity

Physical activity is a very good way to help improve your mental health as well as your physical health. Playing sports and doing any form of physical activity can trigger the production of endorphins. Endorphins are natural mood enhancers. (National Research Council; Institute of Medicine, 2009).

Activity therapies

Activity therapies, also called recreation therapy and occupational therapy, promote healing through active engagement. Making crafts can be a part of occupational therapy. Walks can be a part of recreation therapy. In recent years colouring has been recognised as an activity which has been proven to significantly lower the levels of depressive symptoms and anxiety in many studies. (Lee, 2014).

Expressive therapies

Expressive therapies are a form of psychotherapy that involves the arts or art-making. These therapies include music therapy, art therapy, dance therapy, drama therapy, and poetry therapy. It has been proven that Music therapy is an effective way of helping people who suffer from a mental health disorder. (National Research Council; Institute of Medicine, 2009).

Psychotherapy

Psychotherapy is the general term for scientific based treatment of mental health issues based on modern medicine. It includes a number of schools, such as gestalt therapy, psychoanalysis, cognitive behavioural therapy. Group therapy involves any type of therapy that takes place in a setting involving multiple people. It can include psychodynamic groups, activity groups for expressive therapy, support groups (including the Twelve – step program), problem-solving and psychoeducation groups. (National Institute of Mental Health, 2011).

Meditation and Mindfulness-based cognitive therapy

The practice of mindfulness meditation has several mental health benefits, such as bringing about reductions in depression, anxiety and stress. Mindfulness meditation may also be effective in treating substance use disorders. Further, mindfulness meditation appears to bring about favourable structural changes in the brain. (National Institute of Mental Health, 2011).

The Heartfulness meditation program has proven to show significant improvements in the state of mind of health –care professionals. A study posted on the US National Library of Medicine showed that these professionals of varied stress levels were able to improve their conditions after this meditation program was conducted. They benefited in aspects of burnouts and emotional wellness. (National Institute of Mental Health, 2011).

People with anxiety disorders participated in a stress-reduction program conducted by researchers from the Mental Health Service Line at the W.G Hefner Veterans Affairs Medical Center in Salisbury, North Carolina. The participants practiced mindfulness meditation. After the study was over, it was concluded that the "mindfulness meditation training program can effectively reduce symptoms of anxiety and panic and can help maintain these reductions in patients with generalized anxiety disorder, panic disorder, or panic disorder with agoraphobia." (National Institute of Mental Health, 2011).

Spiritual Counselling

Spiritual counsellors meet with people in need to offer comfort and support and to help them gain a better understanding of their issues and develop a problem-solving relation with spirituality. These types of counsellors deliver care based on spiritual, psychological and theological principles. (National Institute of Mental Health, 2011).

Social work in mental health

Social work in mental health, also called psychiatric social work, is a process where an individual in a process where an individual in a setting is helped to attain freedom from overlapping internal and external problems (social and economic situations, family and other relationships, the physical and organizational environment, psychiatric symptoms, etc.). It aims for harmony, quality of life, self-actualization and personal adaptation across all systems. Psychiatric social workers are mental health professional that can assist patients and their family members in coping with both mental

health issues and various economic or social problems caused by mental illness or psychiatric dysfunctions and to attain improved mental health and well-being. They are vital members of the treatment teams in Departments of Psychiatric dysfunctions and to attain improved mental health and well-being. They are vital members of the treatment teams in Departments of Psychiatry and Behavioural Sciences in hospitals. They are employed in both outpatient and inpatient settings of a hospital, nursing homes, state and local governments, substance abuse clinics, correctional facilities, health care services. (National Association of Social Workers, 2011).

In psychiatric social work there are three distinct groups. One made up of the social workers in psychiatric organizations and hospitals. The second group consists of members interested with mental hygiene education and holding designations that involve functioning in various mental health services and the third group consist of individuals involved directly with treatment and recovery process. (Shook, John R., ed. 2012)

In the United States, social workers provide most of mental health services. According to government sources, 60 percent of mental health professionals are clinically trained social workers, 10 percent are psychiatrists, 23 percent are psychologist, and 5 percent are psychiatric nurses. ((National Institute of Mental Health, 2011).

Mental health social workers in Japan have professional knowledge of health and welfare and skills essentials for person's well-being. Their social work training enables them as a professional to carry out Consultation assistance for mental disabilities and social reintegration; Consultation regarding the rehabilitation of the victims; Advice and guidance for post-discharge residence and re-employment after hospitalized care, for

major life events in regular life, money and self-matters in order to equip them to adapt in daily life. Social workers provide individual home visits for mentally ill and do welfare services available, with specialized training a range of procedural services are coordinated for home, workplace and school. In an administrative relationship, Psychiatric social workers provide consultation, leadership, conflict management and work direction. Psychiatric social workers who provides assessment and psychosocial interventions function as a clinician, counsellor and municipal staff of the health centers. (National Alliance for the Mentally ill, 2011).

Roles and functions

Social workers play many roles in mental health settings, including those of case manager, advocate, administrator, and therapist. The major functions of a psychiatric social worker are promotion and prevention, treatment, and rehabilitation. Social workers may also practice:

- Counseling and psychotherapy
- Case management and support services
- Crisis intervention
- Psychoeducation
- Psychiatric rehabilitation and recovery
- Care coordination and monitoring
- Program management/ administration
- Program, policy and resource development
- Research and evaluation

Psychiatric social workers conduct psychosocial assessments of the patients and work to enhance patient and family communications with the medical team members and ensure the inter-professional cordiality in the team to secure patients with the best possible care and to be active partners in their care planning. Depending upon the requirement, social workers are often involved in illness education, counselling and psychotherapy. In all areas, they are pivotal to the aftercare process to facilitate a careful transition back to family and community. ((National Institute of Mental Health, 2011).

Global mental health

Evidence suggests that 450 million people worldwide are impacted by mental health, major depression ranks fourth among the top 10 leading causes of disease worldwide. Within 20 years, mental illness is predicted to become the leading cause of disease worldwide. Women are more likely to have mental illness than men. One million people commit suicide ever year and 10 to 20 million attempt it. (National Institute for Mental Health, 2011).

Many people have mental health concerns from time to time. But a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function.

A mental illness can make you miserable and can cause problems in your daily life, such as at work or in relationships. In most cases, symptoms can be managed with a combination of medications and counselling (Psychotherapy) (Mayo Clinic Staff, 2015).

Mental health problems may be related to excessive stress due to a particular situation or series of events. As with cancer, diabetes and heart disease, mental illnesses are often physical as well as emotional and psychological. Mental illnesses may be caused by a reaction to environmental stresses, genetic factors, biochemical imbalances, or a combination of these. With proper care and treatment many individuals learn to cope or recover from a mental illness or emotional disorder.(Mayo Clinic Staff, 2015).

Graham's (2005) basic idea is that mental illnesses are "capacity-tethered rationality impairments" (p.137). This means that in mental disorder fundamental human mental faculties are, as he says, "gummed-up" through a mixture of intentional causes and brute ones; conspiracies of mental and non-mental states interfere with the normal operation of our basic human psychology. How do we know what that psychology is? Not through scientific inquiry, but by reflecting on the ends or purposes that all human beings share -- it is the psychology that you need to live a decent life (p. 139). Graham puts philosophical psychopathology squarely in the philosophy of mind and embeds philosophy of mind within a broader moral psychology. The aspects of the mind we care about are the ones that help us flourish. It is deliberation on the ends of life, not the science of the mind, which tells us what is psychologically important. So, Graham's list of basic psychological faculties does not include working memory or perception or language comprehension, but things like (pp. 147-150) emotional commitment, the ability to act in the world, to form goals and shape our behaviour to fit them, make choices, and so on.

What makes these capacities mental (and therefore distinguishes them from the wider set of human capacities necessary for wellbeing) is that their exercise involves states that are conscious or that possess intentionality (Ch. 2). Mental disorders come about when these capacities get "gummed up" in such a way that one is harmed -- because one lacks a capacity necessary for flourishing -- against one's will, and in a way that usually requires treatment by others (Ch. 3). We think this is too vague, however. Lots of things inhibit our ability to flourish and are beyond our unaided powers to mitigate but are not diseases -- physical ugliness and illiteracy are examples. We need to know about the specific forms of being worse off that illnesses involve. Suppose I am very inattentive, and I often forget things or miss deadlines, and my life goes worse than it might as a result. Am I mentally disordered with a gummed-up mind, or just absentminded? (Graham, 2005)

Mental illness does not exist; it is a myth. Such a sceptical claim is paradigmatically philosophical and one of the main proponents of anti-psychiatry, the psychiatrist Thomas Szasz, put forward a number of philosophical arguments in support of it. These turned on the fact that psychiatric diagnosis is essentially evaluative. From this he concluded that, unlike physical illness, it could not be medically treated because as illness it was not real. (The apparent reality of mental illness is best explained, according to Szasz, as the reality of non-medically treatable life problems.)

Szasz's sceptical arguments spurred responses by both psychiatrists and philosophers questioning whether diagnosis is, after all, essentially evaluative and, if it is,

whether Szasz's conclusions followed. Thus, the analysis of mental illness, and the role of valuesin that analysis, lies at the heart of recent philosophy of psychiatry.

In addition to the importance of values, two further key areas of mental health care prompt immediate philosophical questioning. Firstly, psychiatry since Jaspers has sought to balance two key elements: investigation of the bio-medical facts and empathic investigation of subjects' experiences. Both bio-medical facts and meanings (broadly construed to include experiences, beliefs and utterances) need somehow to be integrated into mental health care. This marks a sharp delineation from other areas of medicine where subjects' experiences are subordinate to the physically described symptoms and organic pathology with which they present. By contrast, psychiatric disorders seem to involve problems of the 'self' (however this is construed) in which experiences, behaviour and beliefs play a fundamentally important role in the onset, course and recovery of symptoms (Graham, 2005).

This raises questions of both the nature of the *distinction* between explanation according to the canons of the natural sciences (the 'realm of law') and understanding meaningful connections (in the 'space of reasons') and the *relationship* between natural scientific facts and meanings. If there is a clear distinction and meanings are conceptually irreducible to biomedical facts, efforts to understand the nature of this relationship become all the more philosophically interesting.(Graham, 2005).

Secondly, there has been much work by psychiatrists since the Second World War to develop psychiatric classification or taxonomy. This has, historically, been in response to a concern about a lack of agreement or reliability about psychiatric diagnosis. More

recently, there has been growing concern that reliability has been improved but only at the cost of validity, or underlying truth, of classificatory schemas. The worry is that psychiatric diagnostic systems may not 'carve nature at the joints'. This concern has also been reflected in philosophy of psychiatry as an instance of a broader question of the role of science in mental health care. Thus, the nature of the facts in question is still very much up for grabs.(Graham, 2005).

It is exactly this point that Szasz tries to make in his work. He tries to argue that there is something deeply wrong with the notion of "mental illness" and with any claim that it can be treated through medical means. We will look at three arguments he makes to this effect. The first rejects any attempts to subsume mental illness within the class of brain illnesses; the second casts a suspicious eye over the diagnosis and definition of mental illnesses; and the third, and most important, presents a general account of illness and medical treatment, and tries to show how mental illness falls outside of its scope (Graham, 2005).

1. **Szasz and the Myth of Mental Illness**

   Although anti-psychiatry has a long pedigree, and although exponents of the view can be found in many walks of life, Thomas Szasz's contribution to this field is particularly noteworthy. Szasz is a trained psychiatrist who, in the 1960s, penned a famous and influential critique of his own profession.

   Indeed, one thing that is noticeable about Szasz's work is that it is slightly more nuanced, and slightly less declaratory in its academic presentations than in its public ones.

2. Mental Illnesses are not Brain Illness

There is such things as brain illnesses. That much is uncontroversial. If I have a tumour in a particular region of my brain or if I have a virus that affects certain parts of my brain, or if I have a degenerative brain disease like MS or ALS, then I can be rightly and fairly said to have an illness that needs medical care and attention. But if that's right, then what's the big deal about mental illness? The mind is a product of the brain. So why can't all mental illnesses simply be subsumed into the category of brain illnesses?

To state this argument more formally:

- (1) Brain illnesses are real illnesses.
- (2) The mind is constituted by the brain.
- (3) Therefore, all mental illnesses are brain illnesses (from 2).
- (4) Therefore, mental illnesses are real illnesses.

The first premise is problematic in two respects: (i) the nature of the general class of brain illnesses is unclear; and (ii) the sense in which the word "real" is being used is unclear. The former is a problem in so far as the argument may over-rely on obvious cases of brain illness and assume that all cases are as uncontroversial as these. The latter is a problem that plagues this entire debate. For now, we can simply assume that "real" means that there is widespread, inter

subjective agreement about when the illness is present or not. But if we accept that, then it's no longer clear that mental illnesses are"unreal".

The second premise assumes a strong form of mind-body monism. That will be objectionable to some people. And the thing is, the strong form is needed if the rest of the argument is to work. If you accepted that the mind was dependent on the brain in certain respects, then you might be able to account for *some* mental illnesses in terms of the brain, but not all.

That said even if you accepted mind-body monism, there might still be problems. This is where Szasz's original critique comes into play. He points out that the ability to account for mental illnesses in strictly neurological terms is limited. The relationship between the brain and the mind is a complex on. Even if we accept that mind and body are made of the same stuff, it does not follow that talk of mental illnesses can be reduced to talk of brain illnesses.

Now, Szasz thinks that there is a deeper reason for this: one that links to how mental illnesses are defined and diagnosed. We'll get to that later. In the meantime, I'd be willing to agree with the gist of his critique. In other words, I would be willing to question the inference from premise (2) to (3). Although we know much more about the mechanics of the brain, and the connection between the mental and neurophysiological, than we did when Szasz penned his original critique, I still agree that we are a long way from replacing mind-talk with brain-talk.

More generally, I would object to the basic strategy underlying this argument. I don't think we have to analogise mental illness to brain illness in order to determine

whether it is real or not. (This is something that will come up several times in this series). (Graham, 2005).

3. The Reification -Causation Argument

Typically, diseases and illnesses are diagnosed by means of *symptoms*. The symptoms are externally observable and testable indicators of the underlying disease. For example, a rash with itchy red blotches on the skin is a classic symptom of chicken pox (a viral infection). The illness is the underlying cause of the symptoms. It is by treating these causes that medicine earn sits bread.

Szasz's second argument claims that this relationship between symptom and disease is subverted in the case of mental illnesses. In other words, that a mental illness is simply a descriptive label we apply to a collection of symptoms, not an underlying cause of those symptoms. Take depression as an example. This is diagnosed by means of symptoms: low mood, anxiety, sleep disturbance, poor appetite, loss of energy etc. If you exhibit a sufficient number of these symptoms, you are diagnosed with "depression". But depression is not the name for an underlying illness or cause of the symptoms — we don't know what the underlying mechanism is -rather "depression" is a label for those symptoms. (Graham, 2005).

The problem then, as Szasz sees it, is that this label becomes "reified". That is to say, we are tricked into thinking that the label is itself a "thing" with causal powers. This leads us to believe that it is an illness much like any other; that it is something toward which we can direct our medical interventions. The reality is quite different.

You may well wonder whether this is a significant problem. After all, it sounds like something we do all the time, even in relation to other illnesses, without thereby undermining the legitimacy of research into that descriptively defined category, or the plausibility of crafting medical interventions to address the symptoms. (Graham, 2005)

What might be going on here is that Szasz is trying to highlight the absurdity of treating mental illnesses through medical means, and that he thinks the reification of a descriptive label is one way in which this absurdity manifests itself. If so, his argument is problematic. This becomes clear once we look at his main argument against the legitimacy of mental illness.

4. Szasz's Central Argument

Szasz's main argument against the legitimacy of mental illness works from a general account of the nature of disease and medical treatment, and then purports to show that mental illness falls outside the scope of that account.

The starting point is a norm-based account of "illness". As Szasz sees it, an illness is a deviation from some kind of norm. In the case of medical illnesses *properly-so-called*, the norms in question are biological and physiological. There is some pathological tissue (e.g. a tumour) or pathogenic organism (e.g. HIV), who's presence disrupts the normal biological structure and functioning of the body. Pathological disturbances of this sort are objectively discernible, and capable of being treated through pharmacological or other medical means.

Medical Illnesses Properly-so-called: X is a medical illness, properly-so-called, if it involves the deviation from a biological or physiological norm of the human body. (The appellation "properly-so-called" is added to indicate that it is properly an object of medical diagnosis and treatment).

The problem is that mental illnesses do not involve normative deviations of this sort. Though we have searched for some underlying mechanism for many mental illnesses, they remain elusive and dimly understood. Indeed, the literature is overflowing with multiple proposed pathological explanations for "illnesses" like schizophrenia, depression and psychopathy. Szasz thinks that the main reason for this is that mental illnesses are primarily defined in terms of social or political norms, not biological/physical ones. In other words, that a person is classed as a "schizophrenic", "depressive" or "psychopath" because their thoughts and behaviours do not conform with socially acceptable standards. This is why mental illnesses are so politicised: their very essence is determined by reference to politicized norms. (Graham's, 2005).

Hence, mental illnesses are not medical illnesses, and it is absurd to treat them as such:

Since medical interventions are designed to remedy only medical problems, it is logically absurd to expect that they will help to solve problems whose very existence have been defined and established on non-medical grounds.

Szasz, (1972, p. 17 Ideology and Insanity) to distil all of this into a formal argument:

- (5) Medical illnesses (i.e. those properly diagnosed and treated through medical means) involve the deviation from some biological or physiological norm of the human body.

- (6) Mental illnesses involve deviations from social/political/ethical norms, not biological or physiological ones.

- (7) It would be absurd to treat deviations from one set of norms with the tools for treating deviations from another set of norms.

- (8) Therefore, mental illnesses are not medical illnesses and it would be absurd to treat them as if they were.

2.5 Mental Patients

Gombilla (as cited in Obu, 2010) states that mental patients appear dishevelled as patients tend to neglect themselves as shown in careless dressing. They are untidy and unclean as a result of failure to take care or their personal hygiene like bathing and washing clothes. Some of them tend to talk more than usual, faster and louder and about things that do not concern them; they are also inscrutable, diffident and importunate. Facial expressions may suggest anxiety, depression or lack of interest in the surroundings, they are sometimes fixed and unchanging unnecessarily violent and some have a sense of persecution and suicidal tendencies. Most of them sleep very little or not at all and wake up early to start working, talking or moving about.

The outward signs of a mental illness are often behavioural. A person may be extremely quiet or withdrawn. Conversely, he or she may burst into tears, have great anxiety or have outbursts of anger.

Even after treatment has started, some individuals with a mental illness can exhibit anti-social behaviours. When in public, these behaviours can be disruptive and difficult to accept. The next time you and your family member visit your doctor or mental health professional, discuss these behaviours and develop a strategy for coping. Your family member's behaviour may be as dismaying to them as it is to you. Ask questions, listen with an open mind and be there to support them. Gombilla (as cited in Obu, 2010)

Schizophrenia Overview

According to National Institute of Mental Health Schizophrenia (2008) is a complex, severe and disabling brain disorder that alters how a person perceives the world, marked by a disconnection from reality. Confusion and fear may cause withdrawal or abnormal behavior.

According to National Institute of Mental Health (2008) this disorder usually presents between a person's late teens or early twenties, but it can occur in children or later adulthood. One percent of the American population will be diagnosed with this condition during their lifetime, which represents 2 million people. Read more in this Schizophrenia patient education guide.

Common early warning signs include: paranoia, suspiciousness, hostility, inappropriate emotional display with crying or laughing, lack of expression of happiness or sorrow, depression, sleep disorders (insomnia or sleeping throughout the day), irrational or inappropriate statements, loss of memory, lack of focus, withdrawal from friends, family and society, lack of personal hygiene, flat gaze, decline of mental acuity, increased confusion, inability to take criticism (reacting with hostility). (National Institute of Mental Health, 2008)).

Just as with other medical illnesses, early intervention can make a crucial difference in preventing what could become a lifelong and potentially disabling psychiatric disorder.

Commons Signs and Symptoms of Major Mental Illnesses

According to the Community Psychiatric Clinic (2011) Information and Resources Below are specific symptoms associated with common mental health disorders. These lists are very brief – there are many and varied symptoms that can occur depending on the disorder someone is experiencing and the severity of their illness. However, these should serve as a guide to the types of symptoms associated with many common forms of mental illness. According to the Community Psychiatric Clinic - Information and Resources - Signs and Symptoms of mental illness are as follows.

Depression

Clinical depression lasts for at least two weeks and affects a person's emotions, thinking, behavior and physical wellbeing.

Symptoms:

- *Emotional* – Sadness, anxiety, guilt, anger, mood swings, lack of emotional responsiveness, helplessness, hopelessness
- *Psychological* – Frequent self-criticism, self-blame, pessimism, impaired memory and concentration, indecisiveness and confusion, tendency to believe others see you in a negative light, thoughts of death and suicide
- *Behavioural*– Crying spells, withdrawal from others, worrying, neglect of responsibilities, loss of interest in personal appearance, loss of motivation, drug or alcohol use
- *Physical* – Chronic fatigue, lack of energy, sleeping too much or too little, overeating or loss of appetite, constipation, weight loss or gain, irregular menstrual cycle, loss of sexual desire, unexplained aches and pains.

Anxiety

An anxiety disorder differs from normal stress and anxiety. It is more severe and long-lasting and interferes with work and relationships. Anxiety disorders include Generalized Anxiety Disorder, Panic Disorder, Social Phobia, Post-Traumatic Stress Disorder, and Obsessive/Compulsive Disorder.

Symptoms:

- *Physical* – Heart palpitations, chest pain, rapid heartbeat, flushing, hyperventilation, shortness of breath, dizziness, headache, sweating, tingling and

numbness, choking, dry mouth, nausea, vomiting, diarrhoea, muscle aches, restlessness, tremors/shaking

- *Psychological* – Unrealistic and/or excessive fear and worry, mind racing or going blank, decrease concentration and memory, indecisiveness, irritability, impatience, anger, confusion, restlessness or feeling "on edge" or nervousness, tiredness, sleep disturbance, vivid dreams
- *Behavioural* – Avoidance of situations, obsessive or compulsive behaviour, distress in social situations, phobic behaviour

Bi-Polar Disorder

According to the Community Psychiatric Clinic (2011) Bi-Polar Disorder is characterized by extreme mood swings. A person with Bi-Polar disorder may have periods of depression, mania, and normal mood, but must have episodes of both depression and mania to be diagnosed as having Bi-Polar Disorder. Bi-Polar Disorder used to be called Manic-Depressive Disorder. Symptoms include those for both depression and mania.

Symptoms**:**

- *Depressive Symptoms* - Sadness, anxiety, guilt, anger, lack of emotional responsiveness, helplessness, hopelessness, self-criticism, self-blame, pessimism, impaired memory and concentration, indecisiveness and confusion, thoughts of death and suicide, crying spells, withdrawal from others, worrying, neglect of

responsibilities, loss of interest in personal appearance, loss of motivation, chronic fatigue, lack of energy, overeating or loss of appetite, constipation, weight loss or gain, loss of sexual desire

- *Manic Symptoms* – Increased energy and over activity, elated mood, needing less sleep than usual, rapid thinking and speech, lack of inhibitions, grandiose delusions, lack of insight.

Psychotic Disorders

Psychosis is a mental disorder in which a person has lost some contact with reality. There may be severe disturbances in thinking, emotions or behavior. Psychotic disorders are not as common as depression and anxiety disorders, affecting just over 1% of the population. Psychotic disorders include Schizophrenia, Psychotic Mania, Psychotic Depression, Schizoaffective Disorder and Drug-Induced Psychosis.

Symptoms:

- *Changes in Emotion and Motivation* – Depression, anxiety, irritability, suspiciousness, blunted, flat or inappropriate emotion, change in appetite, reduced energy and motivation.
- *Changes in Thinking and Perception* – Difficulties with concentration or attention, sense of alteration of self, others or the outside world (e.g. feeling that self or others have changed or are acting different in some way), strange ideas, unusual perceptual experiences (such as a reduction or greater intensity of smell, sound or colour), delusions, hallucinations

- *Changes in Behaviour* – Sleep disturbance, social isolation or withdrawal, reduced ability.

2.6 Discharged mental patients

Obu (2010) opines that discharged mental patients is a mentally ill person, treated in a hospital or clinic, discharged and referred by a medical doctor to a rehabilitation centre, prior to re-integration into society or return to the family.

In Ghana, there is a strong stigma and family shame attached to having a mental ill patient or discharged mental patient due to misunderstanding of mental health matters and the idea that mental illness must be attributed to spiritual or demonic causes and therefore the families of such discharged patients are not readily able to take them back. They suffer relapses and end up in the streets.

Fredman and Kaplan as cited in Obu (2010 p.3) observed that mental patients and discharged mental patients become restless when they are alone or had nothing doing. This therefore suggests that when various vocations are introduced to mental institutions, it would occupy them.

These people need rehabilitation before going back to their families and to the community. Fortunately, since 1993 the Kumasi Cheshire Home has begun offering a number of services to people. For example, people who have experienced mental break-downs treated and discharged form psychiatry hospitals before going back to their families and to the community.

2.7 Rehabilitation

According to Dictionary.com (2015) rehabilitation is to restore to a condition of good health, ability to work, or the like. Rehabilitation can also use as Salvage, restore, recondition, reconstruct, refurbish.

According to Collins English Dictionary (2012) rehabilitate is to help (a person who has acquired a disability or addiction or who has just been released from prison) to readapt to society or a new job, as by vocational guidance, retraining, or therapy or to restore to a former position or rank.

The American Heritage Stedman's Medical Dictionary (2002) says rehabilitate in medicine means to restore to good health or useful life, as through therapy and education.

Yeboah (as cited in Obu 2010) states, that rehabilitation is a word which describes an active process in which at least two people are involved that is the person with a disability and the helper. Rehabilitation is a building activity which attempts to "restore a person's physical and mental capacities and improve the quality of his life to a level which is near as possible to that which existed prior to his illness". During rehabilitation, the disabled or discharged mental patients are provided with an agreeable craft and skills such as needlework, shoe making, basketry, drawing, weaving, tie and die, carpentry and modelling.

The goal of this rehabilitation centre is to assume that the person who had a psychiatric disability can perform the physical, emotional or intellectual skills needed to live, learn and work in his or her own community with the least possible amount of support from agents of the helping profession. Since the individual do not imitate

activities he gains strength and stature, the belief in his own powers and self-respect which make artistic activity constructive in the growth of his personality.

Obu (2010) asserted that Rehabilitation involves the process where the disabled are treated medically and provided an agreeable craft for an idle moment in the centre. Rehabilitation takes place at the psychiatric hospital as occupational therapy or after the discharge from the psychiatric hospital to a rehabilitation home which is known as the aftercare.

Psychiatric services in this country, in particular have undergone a transformation in their resources and efficiency. The mental hospitals have now far more attractive appearances than they used to have, there is a greater activity in the treatment and rehabilitation of their patients and the quality of life, which patients in these hospitals can enjoy, has been immensely improved. It is unfortunately; correct to state that despite the positive changes which have resulted from better medical care and higher living standards of Ghanaians, the number of handicapped and mentally disturbed persons is on the increase.

One of the ways of coping with this problem is in the development of rehabilitation services which can contribute to the well-being of handicapped and mentally discharged persons, as well as the socio-economic progress of the country. The growth of rehabilitation services should not mean merely their expansion in volume, but their development through the acceptance and utilization of new concepts which should be appropriate enough to emerge with local situation and needs, and present indigenous rehabilitation concepts typical of Ghanaian demands and opportunities.

It is vital to understand the rehabilitation needs of the discharged mental patients for any effective rehabilitation programme. The psychiatric condition of these ex-patients discharged from hospitals and clinics might be stabilized by drug therapy as is sometimes the case with schizophrenic patients who now have different concerns, ranging from severe depressive or manic states to psychotic states, dementia and self-neglect. These ex-patients now become people with different sorts of problems in terms of their unsociability and inability to cope with community life. (Obu, 2010).

Rehabilitation is considered essential to make these ex-patients acceptable in society and community. Bollinger and Krambeck (1987) consider rehabilitation as re-integration and post treatment efforts. This includes all measures which serve the medical restoration, vocational re-qualification and the social re-integration of the ex-patients.

2.8 Vocational rehabilitation

According to Vocational Rehabilitation Association of the UK (2014) Vocational rehabilitation is a process which enables persons with functional, psychological, developmental, cognitive and emotional impairments or health conditions to overcome barriers to accessing, maintaining or returning to employment or other useful occupation.

This vocational rehabilitation is based on the premise that work is good for mental health. For many patients who have never learnt vocational skill, the feeling of competence and productivity resulting from a trade produces positive psychological reinforcement. The importance of vocational rehabilitation has been emphasized by Kissim and Begleiter as stated in Obu (2010) “it has become evident that emotional or

social rehabilitation is often ineffective without major attention to vocational rehabilitation".

According to Vocational Rehabilitation Association of the UK (2014) Vocational rehabilitation can require input from a range of health care professionals and other non-medical disciplines such as disability employment advisers and career counsellors. Techniques used can include:

- assessment, appraisal, programme evaluation and research.
- goal setting and intervention planning.
- provision of health advice and promotion, in support of returning to work.
- support for self-management of health conditions.
- making adjustments to the medical and psychological impact of a disability.
- case management, referral, and service co-ordination.
- psychosocial interventions.
- career counselling, job analysis, job development, and placement services.
- functional and work capacity evaluations.

Vocational rehabilitation practitioners are often governed by standards of practice.

Fischler, Gary and Nan Booth (1999) defines Vocational rehabilitation (VR) is a set of services offered to individuals with mental or physical disabilities. These services are designed to enable participants to attain skills, resources, attitudes, and expectations needed to compete in the interview process, get a job, and keep a job. Services offered

may also help an individual retrain for employment after an injury or mental disorder has disrupted previous employment.

Purpose of vocational rehabilitation

- Vocational rehabilitation services prepare qualified applicants to achieve a lifestyle of independence and integration within their workplace, family and local community. This transition is achieved through work evaluation and job readiness services, job counseling services, and medical and therapeutic services. For individuals with psychiatric disabilities, situational assessments are generally used to evaluate vocational skills and potential.

Precautions

- Vocational rehabilitation as operated by state agencies is not an entitlement program. Only individuals considered eligible can receive VR services. Eligibility criteria require that an individual be at least 16 years old, unemployed or under-employed, and have a physical or mental disability that results in a substantial barrier to employment, such as psychotic disorders, alcohol and other drug abuse dependence, mental and emotional disorders, attention deficit disorders, specific learning disabilities, and physical and sensory disabilities. In addition, the individual must be able to benefit from VR services. An individual also need help to prepare for, find, and succeed in paid employment. When resources are limited, individuals with the most significant disabilities must be served first.

Description

- Vocational rehabilitation services are based on individual needs and defined as any goods or services an individual might need to be employable, such as assistive technology devices and services. For instance, a person who is blind would need screen reading software to access a computer and people with a cognitive or mental disability might need a talking electronic reminder device programmed to prompt them when it is time to perform certain tasks.
- According to Fischler, Gary and Nan Booth (1999) Vocational rehabilitation can be provided by private organizations but is not typically funded under **managed care** arrangements. Thus, most people apply to state vocational rehabilitation agencies that are funded through federal and state monies. Typically, state agencies have offices in their state's major cities and towns. State VR agencies do not necessarily offer the same services or deliver services in the same way in every state, so individuals seeking services must learn how to access the VR program in their own state. The federal VR component is administered by the U.S. Department of Education Rehabilitation Services Administration and authorized by the Rehabilitation Act of 1973 as amended in the 1988 reauthorization.
- Most vocational rehabilitation services are free for eligible applicants; however, applicants may be asked to use other benefits, such as: insurance, Pell grants or other financial aid for training or higher education, to pay part of program costs.
- Best practices in vocational rehabilitation include individual choice, person-centered planning, integrated setting, natural supports, rapid placement, and

career development. The term *integrated setting* refers to placing individuals in usual employment situations rather than making placements into sheltered workshops or other segregated settings. Natural supports are the person's already existing support network, including family members, service providers, and friends, who can help the person, reach a goal, such as the employment of their choice. Person-centered planning is a technique in which a plan for a person's future is developed by a team consisting of the person and his or her natural supports, and the team develops a practical plan based on the person's wishes and dreams. Each team member agrees to perform certain tasks identified in the plan to help the person reach goals. Unfortunately, not all VR programs incorporate all of these best practices.

Preparation

- Vocational rehabilitation transition planning services are required for all public and private education students aged 16 and over, who have Individualized Education Plans (IEPs) or Rehabilitation Act Section 504 Plans. Transition services help students make the transition from school to employment, training or higher education. Older individuals who have acquired disabilities and are applying for VR services must undergo medical and psychological assessments at their local VR office to determine the extent of their disabilities, except for individuals receiving SSDI or SSI who are presumed eligible without assessments. Applicants may receive treatment and counseling, if needed, before training and employment. All VR services are described in an applicant's

Individualized Plan for Employment (IPE). Applicants may design the IPE either on their own or with the assistance of their assigned VR counselor, usually a person with a master's degree in rehabilitation counseling.

Aftercare

- A vocational rehabilitation counselor will assist an applicant gain access to an employment agency to help locate a job. Counselors may provide support (supported employment programs) if applicants need support to keep a job. This support may include job coaching, which includes working with the person in the workplace until the person is comfortable with the work. The counselors also act as resources if a job does not work out by assessing what happened and counseling the person on how to improve performance or change habits that were not perceived favorably in the workplace.

Risks

- Applicants may not be satisfied with the pace of progress toward their employment goal through VR or they may not believe their wishes or talents and skills are being taken seriously. Applicants wanting to start their own businesses or engage in telecommuting may not be successful in receiving vocational rehabilitation assistance. Applicants may find that VR counselors tend to recommend low-level and low-paying jobs traditionally recommended for VR applicants, such as food service and janitorial work. Applicants may also be turned away by VR counselors because the counselors decide the applicant's

disability is too severe for the person to benefit from VR services. An additional risk for individuals with mental disorders is a usual lack of coordination between VR and mental health systems.

- To address these problems in the VR system, the United States Congress passed the Ticket to Work Act. Under this Act, persons with mental or physical disabilities will receive a ticket worth a certain amount of money. They may take this ticket to any private or public entity that provides job training and placement, including state VR programs. The entities providing the employment-related services will be able to redeem the tickets only after the person is gainfully employed for a certain period of time. States are on a staggered schedule to begin implementing the program; persons in the first states started receiving tickets in 2001. All states will be instituting the Ticket to Work Act by 2004.

Normal results

- Individuals with mental or physical disabilities will receive the assessments, counseling, training, placement, accommodations and long-term supports needed to allow them to engage in the gainful employment of their choice.

Abnormal results

- Individuals with mental or physical disabilities remain unemployed or under employed. More than 70% of people with disabilities are unemployed; for people with mental disorders that percentage ranges from 70-90%.

2.9 Art therapy

The Oxford Advanced Learner's Dictionary (2009) asserts that, therapy is any treatment designed to improve a health problem or a disability or to cure an illness. Therapy might include exercise, splinting, positioning, using compression garments, transparent face masks or learning about how best to help to heal after a burn injury.

Therapy in Greek or treatment is the attempted remediation of a health problem, usually following a diagnosis. Therapy is any measures taken to treat a disease that is a metal or physical disease or treatment of a disability. It may also be defined as a generic term used to describe the application of any medical, psychological or alternative designed to promote health and well – being.

The Cambridge International Dictionary of English (2009) defines that therapy is a treatment which helps someone feels better, grow stronger especially from illness.

Art therapy offers an opportunity to explore these intense or painful thoughts and feelings in a supportive environment. It involves using a wide variety of art materials for example the use of craftworks like paintings, clay and batik, to create a visual representation of thought and feelings.

Arts therapy is based on the belief that the process of engaging creatively in drama, movement or art-making, within a therapeutic relationship, supports changes in the client's inner world, and helps them to develop a more integrated sense of self, with increased self-awareness and acceptance. It assists with improving the client's personal growth and insight, processing of traumatic experiences, and resolving of inner conflicts. Arts therapy provides a unique opportunity for the use of non-verbal communication,

allowing clients to express feelings safely so that they can cope better with stress, improve their judgment and have healthy relationships.(Australian and New Zealand Art Therapy Association, 2015).

The artwork or creative response in each session is a confidential record showing patterns of feelings, thoughts and behaviours. The arts therapist and client work together to understand the creative product of each session, and this product is seen as a reflection of the meaning for that person, through their own discovery. The arts therapist provides a safe, non-threatening space and invites the individual (or group) to explore their issues by using whatever variety of media he or she feels is appropriate and comfortable during the session. Arts therapists have specialised training that reflects their interdisciplinary practice and prepares them to provide such a space.(Australian and New Zealand Art Therapy Association, 2015).

Art therapy is a mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well-being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behaviours, reduce stress, increase self-esteem and self-awareness, and achieve insight. Art therapy integrates the fields of human development, visual art (drawing, painting, sculpture, and other art forms), and the creative process with models of counseling and psychotherapy.(Wikipedia, the free encyclopedia,2009).

Art therapy integrates psychotherapeutic techniques with the creative process to improve mental health and well-being. The American Art Therapy Association describes art therapy as "a mental health profession that uses the creative process of art making to

improve and enhance the physical, mental and emotional well-being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behaviour, reduce stress, increase self-esteem and self-awareness, and achieve insight." Kendra Cherry.(Wikipedia, the free encyclopaedia,2009).

American Art Therapy Association (2009) defines art therapy as the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma or challenges in living, and by people who seek personal development. Through creating art and reflecting on the art products and processes, people can increase awareness of self and others cope with symptoms, stress and traumatic experiences; enhance cognitive abilities; and enjoy the life-affirming pleasures of making art.Wikipedia, the free encyclopedia (2009).Australian National Art Therapy Association (ANATA) was established.

According to Obu (2007) Art therapy combines traditional psychotherapeutic theories and techniques with specialized knowledge about the psychological aspects of the creative process especially the affective properties of different art materials. As a mental health profession, art therapy is employed in many different clinical settings with many different types of patients. Art therapy is present in non- clinical settings as well, such as in art studios and workshops that focus on creativity development.

According to Wikipedia (2007) “therapy” literally means curing, or healing. That is how art therapy is used in Art. “Art therapy is a deliberate use of art – making to address psychological and emotional needs. Art therapy uses art media and creative

process to help in areas such as but not limited to: fostering self – expression, enhancing coping skills, managing stress, and strengthening a sense of stress" according to Art therapy alliance.

According to International art therapy organization (2009), Art therapy encourages self-expression, self-discovery and emotional growth; for these reasons, it has been used in the treatment of mental illness for almost 100 years. As a form of psychotherapy, art therapy often involves both the creation of art and the discovery of its meaning. Individuals are encouraged to visualize, and then create, the thoughts and emotions that they cannot talk about. For other people with mental illness or disabilities, the creative process of art making becomes the therapy. During the 20th century, art therapy was popular as a form of milieu therapy at psychiatric institutions and was an important influence on the development of art therapy in the United States. Milieu therapies focus on putting the patient in a therapeutic social setting that provides opportunities to develop self-confidence and interact with others in a positive way.

Art therapy is an ancient art form which was used as part of the treatment on the Mental retarded patients and is still being practiced but with much improvements and modern technology. Art therapy is an exercise and it involves creating art, viewing it and talking about it provides a way for people to cope with emotional conflicts, increase self-awareness, and express unspoken often unconscious concerns about their illness. The art therapist uses pictures, art supplies, and visual symbols as well as an understanding of behaviour to help patient address their own personal concerns and conflicts.

According to Kendra Cherry (2015) Art can be an effective tool in mental health treatment. What could art possibly have to do with psychotherapy? As an expressive medium, art can be used to help clients communicate, overcome stress, and explore different aspects of their own personalities. In psychology, the use of artistic methods to treat psychological disorders and enhance mental health is known as art therapy.

Art therapy integrates psychotherapeutic techniques with the creative process to improve mental health and well-being. The American Art Therapy Association describes art therapy as "a mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well-being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behaviour, reduce stress, increase self-esteem and self-awareness, and achieve insight."

According to International art therapy organization (2009),"Art Therapy is about using art as a tool for communication and through the therapeutic relationship, emotional, psychosocial and developmental needs are addressed with the intention of effecting lasting change." Hong Kong Association of Art Therapists (HKAAT)

Therapist determines the individual goal, a customized intervention to improve the person’s ability to perform daily activities and reach his / her goal and outcomes evaluation to monitor progression towards meeting the client’s goals.

Kendra Cherry (2015) express that “While people have been using the arts as a way to express, communicate, and heal for thousands of years, art therapy only began to formalize during the middle of the 20th-century. Doctors noted that individuals suffering

from mental illness often expressed themselves in drawings and other artworks, which led many to explore the use of art as a healing strategy. Since then, art has become an important part of the therapeutic field and is used in some assessment and treatment techniques".

According to Wikipedia the American Art Therapy Association (2007) defines art therapy as: the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma or challenges in living, and by people who seek personal development. Through creating art and reflecting on the art products and processes, people can increase awareness of self and others cope with symptoms, stress and traumatic experiences; enhance cognitive abilities; and enjoy the life-affirming pleasures of making art.

An art therapist may use a variety of art methods including drawing, painting, sculpture, and collage with clients ranging from young children to the elderly. Clients who have experienced emotional trauma, physical violence, domestic abuse, anxiety, depression, and other psychological issues can benefit from expressing themselves creatively. Hospitals, private mental health offices, schools, and community organizations are all possible settings where art therapy services may be available (Kendra Cherry, 2015).

Art therapy may involve learning skills or art techniques, the emphasis is generally first on developing and expressing images that come from inside the person, rather than those he or she sees in the outside world," explains Cathy Maldiochi in *The Art Therapy Sourcebook*. "And while some traditional art classes may ask you to paint or draw from

your imagination, in art therapy, your inner world of images, feelings, thoughts, and ideas are always of primary importance to the experience "Kendra Cherry, 2015).

2.10 Art Therapy and Mental Health

According to International Art Therapy Organization (IATO 2009), Art therapy encourages self-expression, self-discovery and emotional growth; for these reasons, it has been used in the treatment of mental illness for almost 100 years. As a form of psychotherapy, art therapy often involves both the creation of art and the discovery of its meaning. Individuals are encouraged to visualize, and then create, the thoughts and emotions that they cannot talk about. For other people with mental illness or disabilities, the creative process of art making becomes the therapy. During the 20th century, art therapy was popular as a form of milieu therapy at psychiatric institutions and was an important influence on the development of art therapy in the United States. Milieu therapies focus on putting the patient in a therapeutic social setting that provides opportunities to develop self-confidence and interact with others in a positive way.

Some practitioners consider art expression as a way to understand the inner worlds of people with mental illness. Michael opines that Attention Deficit Hyperactive Disorder ADHD is a problem that affects a lot of people. It really makes it difficult to be productive and focused. It has to do with the synapses in the brain. I've heard it described as having wires that have the insulation stripped off. Just whatever part of the brain that would make it easy for you to stay focused just doesn't seem to work.

One way to treat is through a stimulant, which is what he takes. He takes Adderall. It stimulates the part of the brain that would normally not function correctly. If it seems to some people that he just has mild Attention Deficit Hyperactive Disorder ADHD believe me, that's only because over many long years I've learned to deal with it better. That being said, it has been very rough.

For him, if I don't take my medicine I have very hard time focusing on school work or productive efforts. Although sometimes he does experience flow in the sense that what he doing is challenging, but he sees clear goals and rewards.

So when he is working on something like this, he gets in the zone or in flow or whatever psychologists call it these days. He is able to focus on that even without medication, but you know it's so hard to have that happen. Even when it does happen, you lose track of time. You forget to eat. So it's two sides of the same coin, but it doesn't make life any easier.

Ashley led a happy childhood but faced sadness, depression and panic attacks in her adolescence. These extreme emotions continue, but she has found an outlet in acting. Being on stage and taking on the personality of different characters gives her a chance to express her feelings and to connect with people in the audience. She brings great enthusiasm to all aspects of theatre and is happy with this passion.

In trying to understand the success the young person's experienced, it may be helpful to establish some parameters. According to brain science, the teenage and early adult years are when there is a tremendous speeding up of brain development: change can

occur either toward health or toward illness. The high end of mental illness such as the psychiatric disorder of schizophrenia is not represented.

So, it might be said that these outstanding young people were able to harness the energies inherent in their developing brains toward an integration that produced health. Somehow, the expression of their inner processes helped them to find an identity, a place to stand according.

2.11 Art and Mental Illness

Scientists have long studied the link between creativity and mental illness, and the lines between the two are often blurred. Studies suggest that creative people often share more personality traits with the mentally ill than "normal" people in less creative pursuits. One Stanford University study compared patients with bipolar disorder with a group of healthy people. They found that graduate students in creative disciplines shared more personality traits with the bipolar patients than with their healthy but less creative peers, according to a study published last year in The Journal of Affective Disorders.

Experiencing and creating art on a base level can have a positive impact on a person's mental health as well. Creative expression itself is uplifting. Art therapy has been used for over hundred 100 years as an integral part of many health care practices. Art in its entirety contributes to a physiological wellbeing for people whether they have a mental disorder or not. Martin Seligman, who is considered to be

the “father of positive psychology”, coined five different elements of psychological well-being in his book, “Flourish”. The five elements include: positive emotion, engagement, accomplishment, positive relationships, and meaning. Art, in any form, can provide all five of these elements for a person.

For a person with a mental disorder, art can help provide a voice to express different scopes of their internal self that are usually left in silence. In other words, through art therapy, individuals can shape their own identity in a society not yet 100% welcoming of mental illness. Most individuals with mental illness desperately need an outlet and art therapy encourages patients to first visualize and then create, which, allows for thoughts and emotions not capable of expression to come to surface. As a result, art therapies for patients with mental disorders have been used as a diagnostic tool to identify specific types of mental illness in those otherwise non-responsive. (Coppens, 2013).

Figure 1: an art therapist with a mental ill person expressing herself through art.

CHAPTER THREE

METHODOLOGY

3.1Overview

This chapter deals with the systematic procedure which the researcher used in the conduct of the study. It discusses the research design, library research, the population, the sample population, sampling procedure, data collection instruments, data collection procedures and methods of data presentation and analysis.

3.2 Research Design

The qualitative research approach was adopted and this involves an in – depth understanding of human behaviour and the reasons that govern human behaviour. It can best be explained as investigating the why and how of decision making as compared to what, where and when of qualitative research. Qualitative research is often concerned about uncovering knowledge about how people think and feel about the circumstance in which they find themselves than they are in making judgments about whether those thoughts and feelings are valid. A qualitative study usually relies on inductive process to interpret and structure the meaning that can be derived from the data. The researcher used this research design in the work textile art as an effective vocational tool for rehabilitating discharged mental patients. This unique characteristic of this type of research

made it appropriate for the study because, the study required the researcher to use multiple data collection instruments to advance appropriate data that answered the research questions of the study. Denzin and Lincoln (as in Marfo, 2007)

Qualitative research was used because the study required that the researcher collect part of the data in words so that objective considerations of the target population are accounted for during the interpretation and analysis of the data.

The researcher also adopted the qualitative research approach, specifically the descriptive method in the conduct of this research. This research method was used to get an in –depth or detailed approach to the research investigations or findings.

In this study, the descriptive research method was used to describe the textile art as an effective vocational tool for rehabilitating discharged metal patients. According to Shields, Patricia and Rangarjan, (2013) descriptive research is used to describe characteristics of a population or phenomenon being studied. It does not answer questions about how/when/why the characteristics occurred. Rather it addresses the "what" question (what the characteristics of the population or situation are being studied). The characteristics used to describe the situation or populations are usually some kind of categorical scheme also known as descriptive categories. Descriptive research cannot describe what caused a situation. Thus, descriptive research cannot be used to as the basis of a causal relationship, where one variable affects another. In other words, descriptive research can be said to have a low requirement for internal validity.

Descriptive research was used to conduct a survey investigation. The research used the descriptive method through photographs to assist prospective readers to comprehend the entire study of the data distribution. The descriptive research was used to reduce raw data to a manageable form. This is because, the data collected were from the auxiliary staff of the home, the chief psychiatric Nurse, the administrators, the parents of the discharged mental patients and the discharged mental patients so the researcher used the descriptive research to describe and depicted only the event that characterized the data collected from textile art as an effective vocational tool for rehabilitating discharged mental patients. Additional reason that compelled the use of descriptive method was that, the nature of the research required the researcher to collect data in words and through photographs means rather than numbers. Finally, it used for the interpretation of data and to, describe the processes through which the whole study was conducted.

3.3 Population of the Study

A research population is known as a well-defined collection of individuals or objects known to have similar characteristics. Web Finance Inc. (2016) confirms by way of asserting population as a group of Individuals or items that share one or more characteristics from which data can be gathered and analysed.

The population for this study involved the Parents of the discharged mental patients, the Administrator of the Home, the Chief Psychiatric Nurse of the Home,

the Nurses, the Caterers, the Cleaners, the Transport officer and the discharged mental patients who have been discharged from the home and living at their communities in Ghana. However due to the huge number of population and how these discharged mental patients are scattered around all regions of the country, the researcher concentrated on those who are located in the southern part of the country; namely, Western, Central, Greater Accra and Ashanti regions of Ghana. Besides, to assist the researcher achieves a realistic and definite information for the study, the researcher purposefully sampled the population.

3.4 Sample and Sampling technique

A sample is a proportion of an accessible population selected for the purpose of gathering data and its interpretation (Best, 1981). According to Groves et al (2010) a sampling is concerned with the selection of a subset of individuals from within a statistical population to estimate characteristics of the whole population. Each observationmeasures one or more properties (such as weight, location, colour) of observable bodies distinguished as independent objects or individuals.

In view of this the researcher used purposive sampling as the method in the study so that credible appropriate and valid data is generated. The purposive sampling technique was used to select the discharged mental patients who were available and sound at the time of research because out of the ten (10) discharged mental patients the researcher worked with at the home who have been discharged, five

(5) have relapse and returned back to street, it was only the remaining five that the researcher was able to work with them. Five (5) parents of the discharged mental patients were selected; the researcher picked one parent each of the discharged mental patients who were directly related to the patients. Three (3) Nurses who were familiar with the patients and close to them were picked by the researcher in helping to solicit information. The Chief psychiatric nurse and the administrator who have worked with them took care of them and have their background information were contacted for information about the various locations of the discharged mental patients. The Transport officer assisted the researcher to the various homes of the discharged mental patients. The two (2) auxiliary staff who are made up of the cleaner and the caterer were also contacted for more information about the inmates.The sample population for the study is eighteen (18) people.

3.5 Data Collection Instruments

This heading discusses relevant data for the research that was pursued, using unstructured interviews. However, the researcher used observation method of data collection for the study. The unstructured method was adopted for all categories of people. The unstructured questions were the open ended type. The researcher believed it could assist members in the sampled population to give valid information to answer the research questions and satisfy the objectives of the study.

Unstructured interview schedule was used because the study required comprehensive information on how textile art can be used as an effective vocational tool for rehabilitating discharged mental patients.

Since the selected sample population has different educational background the researcher thought it wise to use this strategy based on the research objectives, and research questions of the study to acquire valid information.

Direct and indirect observational methods were also used in the study. With this type of data collection instruments, the researcher had to be present to monitor what the observed does. The natural observational method was used because it involves perceiving the behaviour of the respondents as he or she does his or her work. It seeks to ascertain what people think and so by watching them in action as thy express themselves in various situation and activities. Observation is recognized as the most direct means of studying people when one is interested in their overt behaviour. In this research therefore, the researcher observed and took photographs of respondents in their natural settings, as they worked so as to obtain their reactions with the various processes they go through, as they produce the tie and dye works and how they appreciated the respondents in all categories in the sampled population based on the research questions and to satisfy the research objectives.

According informationr.net (2015) in direct observation, the researcher is the observer, recording what he or she is watching and in indirect method, the researcher must rely on the reported observations (including self- observations) of others.

In view of this the researcher made a critical observation of each of the categories before taking photograph of them as they were in their working environment. This was done so as to get the natural reactions of the discharged mental patients to the art activities in textile and that which best answer the research questions and the objectives of the study.

3.6 Data collection Procedure

The researcher used both primary and secondary data for the study. With regards to primary data, the researcher had personal interviews with the respondents and also through direct and indirect observation of the discharged mental patients as they do their tie and dye fabrics. This was to ascertain spot on photographs and information from respondents. The Institute for Work & Health (2008) stated that, an advantage of using primary data is that the researcher is collecting information for the specific purposes of her study. In essence, the questions the researcher asks are tailored to elicit the data that will help the researcher with her study. The researcher collects the data herself, using surveys, interviews and direct observations.

In view of this the researcher collected introductory letter from the Department of music education. This is a first instance was to give the researcher the opportunity to collect fresh data from all the sampled population for the study, and also to serve as a defensive cover that protected the researcher to take photographs without being booed or heckled.

Prior notices were given to the management of Cheshire Home Institution the administrator of the Home and the Chief Psychiatric Nurse. In most cases interviews were conducted before photographs were taken. An interview guide was prepared and sent to the Cheshire Home. The structure of the interview was unstructured interview. This was because of the nature of the people who work at the Home, the researcher had to use informal interview as a form of getting the data. The researcher schedule was based on the administrator of the home, because the Administrator had a busy schedule, he was always attending meetings and Seminars on Mental Health. Our meetings sometimes took place in the morning and others in the afternoon when he closes from meetings. The researcher had to always be on time otherwise our meeting would have been rearranged.

The psychiatric nurse was always busy at her office and the researcher had to wait till she closes from work after 5pm before she can attend to the researcher for our interview to take place.

The Nurses were on internship and they ran on shift, therefore they could not give detailed information on the discharged mental patients. The researcher only selected a few, who were close to the discharged mental patients, who could give some amount of information on them.

The Caterers were interviewed using informal interview because of their educational background. They were the same caterers who were there, when the researcher did the batik and tie and dye works with the inmates in 2010 so they were able to give a lot of information to the researcher concerning the inmates the

researcher worked with, and where their current location is found in the country. Only a few of the caterers have gone on retirement.

The transport officer was also of help to the researcher because he convoyed the researcher to the various locations in which these inmates were found. Some challenges were that the researcher had to fuel the vehicle because of lack of finance to the transport committee to the homes of these inmates who have been discharged from the Home.

The researcher used unstructured interview and informal interview in soliciting for information of the discharged mental patients, to create a facilitating atmosphere because of their state living in their various Homes and communities, who were once inmates of the rehabilitation centre. The researcher used Digital Camera and the interview guide as a form of data collection.

The researcher provided equipment, tools and materials to be used for the tie and dye production for each individual. The homes of these discharged mental patients did not have these tools and materials to aid in their work therefore, the researcher provided them with these tools and materials like mercerized cotton, bowls, vat dyes, scissors, plastic cups, plastic spoons, twine and gloves for the tie and dye works.

The researcher first introduced herself to the parents of the discharged mental patients before they were interviewed, so that they would know the researcher is not a stranger. The researcher interviewed the discharged mental patients to know how they were progressing, their health and how they were being

treated at home, their relationship with their siblings and parents. The researcher asks of their relationship with the society as a whole.

Some were not treated well and could not even continue their medication because of lack of finance from their parents, or relations who could not buy them their drugs. Others have showed improvement. Some too were working on their own for survival (food) because their family had ignored them. Some have relapsed as they have been ignored by their family.

Some of the discharged mental patients were isolated in their locked up rooms, lonely because there was no form of socialization within the members of their family. The researcher was able to bring, them some smiles and excitement during the interview section and were very emotional as they talk about their state when they were inmates in the home and some good things about the place. This made the interview section exciting.

The researcher used informal interview and unstructured interview to ask questions from the parents about their wards and how they were progressing at home, their relationship to others within the community and to their other family members as well.

Most of the reactions showed that they were secluded, attitude of society towards them was unfair, had no work, and were idle. Their parents could not interact with them because they had little knowledge on how to understand them and relate with them. It was the researcher who was able to induce some of these discharged mental patients to their parents. The parents brought a proposal

suggesting that, they would support the researcher to continue with the tie and dye work so as to prevent their wards from going back to the street or relapsing. It was also because they were not employed and they needed assistance for socialization of their wards to prevent them from depression since they were lonely in their rooms. They collected the researcher's contact to start a fellow up program on the tie and dye.

Interviewees' views gathered were then noted down in a note pad. The researcher believes that the answers gathered assisted in addressing the research objectives and also answered the research questions of the study.

With regard to secondary data, the researcher used library sources such books, articles, journals and periodicals. The internet also served as source to obtained second had information that was related to the study.

Furthermore, secondary data can also be helpful in the research design of subsequent primary research and can provide a baseline with which the collected primary data results can be compared to. Therefore, it is always wise to begin any research activity with a review of the secondary data.

These sources assisted the research in obtaining literature that was related to the study. The under listed libraries were visited to collect information that served as basis for the theoretical aspect of the study.

They include;

1. Libraries of University of Education, Winneba and Kumasi Campus.
2. The Balm Library Accra

3. Kwame Nkrumah University of Science and Technology Library Kumasi.

3.7 Validation of Instruments

The research tools used were first issued out to some colleagues to go through them an offer advice. After their comments, the researcher had to design another one adding a little detail to the quality of questions demanded. This time the research instruments were shown to the supervisor in charge to cross-check and ensure that it was error free. After going through it a few suggestions were added and made them ready for administration.

3.8 Data Analysis Plan

The researcher collected data from different sections by means of the studied populate ion using different methods. Responses from the interview were compared with the feedback from the observation in association with the responses produced in order to make an informed decision. These were again analyse using descriptive method.

The data from the interview were streamlined under the various component and recorded to reflect the research questions and the objectives of the study. The data were then understood and examined using descriptive method.

Judd, Charles and, McCleland, Gary (1989) stated that, analysis of data is a process of inspecting, cleaning, transforming, and modeling data with the goal of

discovering useful information, suggesting conclusions, and supporting decision-making. Data analysis has multiple facets and approaches, encompassing diverse techniques under a variety of names, in different business, science, and social science domains.

In view of the above, the content of the unstructured interview, informal interview and the photographs that were taken by the researcher were also summarised into categories. The various photographs were then presented in a pictorial description under each category. The works of tie and dye produced by each discharged mental patient was interpreted and analysed to reflect the research questions and the objectives of the study.

The significance here was to identify the work as compared to the works produced when they were in mates in the home, how it could prevent them from relapsing and returning to the street and how the standard of their work can meet the standard in the market if it will be bought.

It gave the researcher a deeper understanding to many reasons why textile art can be used as vocational skills which occupies the discharged mental patients from relapsing and going back to the street. Furthermore, the record of the interview responses was also interpreted and analysed quantitatively to reveal the research questions and objectives of the study. Finally, the major findings that were developed from the data collected were reliably discussed qualitatively. This was done to ascertain whether the research objectives and the research questions have been sizeable dealt with so that conclusion can be made and reminiscent

recommendations are given to address the research problem textile art as an effective vocational tool for rehabilitating discharged mental patients.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Overview

The research seeked to identify and interpret the textile art produced by the discharged mental patients, how textile art can be used to prevent the discharged mental patients from returning back to the psychiatric hospital and to evaluate the competitive standard of textile art produced by the discharged mental patients if they met the standard at the market. This chapter therefore presents data obtained from the set of interviews conducted and visual data which is mainly photographs taken from the various tie and dye works done by the discharged mental patients. Data from interviews conducted on the field have been presented and analysed in this chapter to answer the research questions and objectives of the study. Besides, only explicit information given by the respondents during the interviews and observations made by the researcher has also been categorically stated.

The researcher deduces from the analysis of the transcription that; textile art is an effective vocational tool for rehabilitating discharged mental patients that prevent them from relapse or returning back to the street. This is supported by Fredman and Kaplan (1972), observed that mental patients become restless when they are alone or had nothing doing. This therefore suggests that when various vocations were introduced to mental institutions, it would occupy them.

Yeboah (as cited in Obu 2010 p. 25) assert that, rehabilitation is a word which describes an active process in which at least two people are involved, that is the person with a disability and the helper. Rehabilitation is a building activity which attempts to "restore a person's physical and mental capacities and improve the quality of his life to a level which is near as possible to that which existed prior to his illness". During rehabilitation the disabled or discharged mental patients are provided with an agreeable craft and skills such as needlework, shoe making, basketry, drawing, weaving, tie and dye, carpentry and modelling.

The goal of this rehabilitation Centre is to assume that the person who had a psychiatric disability can perform the physical, emotional or intellectual skills needed to live, learn and work in his or her own community with the least possible amount of support from agents of the helping profession.

This vocational rehabilitation is based on the premise that work is good for mental health. For many patients who have never learnt vocational skill, the feeling of competence and productivity resulting from a trade produces positive psychological reinforcement. The importance of vocational rehabilitation has been emphasized by Kissim and Begleiter (1984) (as cited in Obu 2010 p. 3) "it has become evident that emotional or social rehabilitation is often ineffective without major attention to vocational rehabilitation". During rehabilitation, the disabled are treated medically and provided an agreeable craft for an idle moment while in the Centre.

Poldinger and Krambeck (1987) consider rehabilitation as re –integration and post treatment efforts. This includes all measures which serve the medical restoration, vocational requalification and the social re –integration of the ex-patients. Also art

making is a form of healing and again is a form of healing within a psychotherapeutic relationship.

The researcher is of the view that, when discharged mental patients are given a follow up after they have been released from the rehabilitation Centre and are given capital to continue their vocational skills or vocation, it will reduce the stress that they will go through if they are bored and idle in the house and may relapse and end up back to the psychiatric hospital or go back to the street.

It will occupy them, serve as a source of recreation, give them self –employment and prevent them from being idle and relapsing back to the street.

4.2 GALLERY OF TEXTILE ART (TIE AND DYE) WORKS PRODUCED BY THE DISCHARGED MENTAL PATIENTS

Overview

This chapter seeked to give interpretational analysis to the various textile art (tie and dye) fabrics produced by the discharged mental patients.

Presentation of detailed Interpretation of textile art (tie and dye) works produced by the discharged mental patients

4.2.1 Case study one

Background

He comes from Ejisu-Juaben. He was a student at the tertiary level. He is thirty (30) years of age. He stays at Atonsu- Buokrom in Kumasi, in the Ashanti Region with his grandmother and grandfather. He schooled at Catholic University College in Brong Ahafo. He was a level 200 student and studied Computer Science. He is born among two (2) siblings with mother staying in Germany whilst his father is in Accra. He has been in Cheshire Home before where he spent nine (9) months and discharged seeing massive improvement. He came back later and was admitted because of relapse.

He started smoking since Secondary School days. He did out of curiosity. He has good sense of recalling past and recent event. He normally neglects his personal hygiene duties. Case study one is oriented to place, day, time and others. He has concern for marriage. Wish to pursue his education.

Present Status

Case study one was lively and sound at the time the researcher visited him. He could speak in plain language and interact very well. He interacted with the people around him. He was looking good at the time the researcher went to his home. The researcher can confirm that he was in a good state when the researcher went there.

From the works he produced it showed how committed he was and from the quality of works he produced, there has been an improvement from his old works as compared to now, and he can sell them as it meets the standard of the market.

Works produced by discharged mental patient when he was an inmate at the rehabilitation Centre in Kumasi Cheshire Home.

Figure 2: Batik work of case study one

Figure 3: Tie and Dye fabric of inmate

Processes involved in the production of tie and dye

Tools / Materials

1. Mercerized Cotton
2. Vat Dyes –Red, Yellow, Blue
3. Twine
4. Scissors
5. Plastic Bowl or Container
6. Plastic Spoons
7. Sodium Hydroxide (Caustic Soda)
8. Sodium Hydrosulphite (Hydros)
9. Plastic Cups

Processes involved

In the tie and dye process, the discharged mental patient was taught new techniques in tie and dye to add to the existing techniques he had been taught at the rehabilitation centre. The researcher then allowed him to work on his own after the introduction. In the first process, mercerized cotton fabrics were cut to the required size 36 inches each by the discharged mental patient to be used for the tie and dye work. Mercerized cotton is used for the production of batik and tie and dye works for this purpose because the fabric has gone through mercerization which is a continuous chemical process used for cotton and cotton /polyester goods to increase dye ability, lustre, and appearance. This process, which is carried out at room temperature, causes the flat, twisted ribbon-like cotton fibre to swell into a round shape and to contract in length. This causes the fibre to become more lustrous than the original fibre, increase in strength by as much as 20 percent and increase its affinity for dyes. These fabrics were folded into the various techniques by the discharged mental patient. These techniques were marbling, folding and twisting.

In the marbling technique the discharged mental patient placed the wet fabric on a plain rubber which had been spread on the ground. He then crumpled the fabric from one edge till the whole fabric was crumpled to one whole small size in figure 3 and 4. This reduced the size of the fabric to a compact form.

In the folding technique, the fabric was folded into equal sizes in a rectangular shape. After, he folded it into a triangular shape in order to achieve a diamond shape when the fabric is produced.

The twisting technique was also used for his tie and dye fabric. This was done by holding the middle of the fabric and twisting it one end of the fabric to the other till all the fabric was exhausted.

The discharged mental patient then prepared his dye solution. Vat dyes are insoluble in water; they can be reduced to a leuco form which is soluble in dilute alkaline solution. When treated with a reducing agent Sodium Hydrosulphite (Hydros), vat dyes are changed into a reduced form (converted into 'leuco compound') which is soluble in water in the presence of an alkali example Sodium Hydroxide (Caustic Soda). The dye in this solution have an affinity for the fibre. Vat dyes have good affinity for cotton fabrics. Warm water was measured and poured into the plastic cup. Then two spoons of Sodium Hydroxide (Caustic Soda) was added to the water and stirred using the plastic spoon. Plastic spoon is used because it does not react with the caustic soda which contains acid and the vat dye which can change the colour of the dye in case a metal spoon was used. Three spoons of red vat dye were added to the caustic soda solution and stirred continuously to achieve a uniform mixture. Three spoons of Sodium Hydrosulphite (Hydros) was added to the solution and stirred to achieve an aqueous solution. The same process was used to produce a dye solution for yellow and blue vat dye solution which was used to dye the other fabrics.

The dye solution was used to dye folded fabric. He poured the red vat dye solution into a big bowl. He then added a measured quantity of water to the dye in the bowl and stirred with the plastic spoon to maintain a uniform solution. He then immersed half of the fabric into the dye while wearing his rubber gloves to prevent the dye from coming into contact with his fingers which can peel off his skin or irritate the body when

it comes into contact with the solution which contains acid which is found in the caustic soda. He immersed the fabric well to achieve an even dyeing. With the aid of the plastic spoon, he made sure the fabric has absorbed the dye without any white places to prevent patches in dyeing. He left the dyed fabric to oxidize for five to ten minutes. He then immersed the other half of the fabric into the second dye solution which was blue and dyed the other half of the fabric with the same method. He then removed the fabric and oxidized it. After oxidation, the fabric was washed in clean water and dried under a shade.

In the twisting technique, the discharged mental patient placed the fabric on a plain rubber which had been laid on the floor. He used his plastic spoon as an aid in dye application to different areas of the fabric. He then oxidized the fabric for the true colour and the design to come out. He then washed the fabric in a clean water to remove excess dyes from the fabric and dried it under a shade. He removed the fabric and ironed it.

In the marbled fabric, he used the plastic spoon as an aid in the dye application to the fabric. He used red, yellow, blue and green to dye the fabric. This is shown in figure 5. The fabric was left for five to ten minutes for further absorption of dye solution. He then spread out the fabric for oxidation to take place. The fabric was washed in clean water to remove excess dye.

After dyeing, the dyes are oxidized with an oxidizing agent example Hydrogen Peroxide, Sodium bichromate or they are exposed to the air (30-45 minutes) to restore the vat to its original insoluble state and develop the true colour of the dye. He dried the fabric under a shade. Below is the discharged mental patient using the marbling technique for his tie and dye fabric.

Figure 4: Discharged mental patient using the marbling technique in tie and dye

Figure 5: Discharged mental patient with his marbled fabric

Figure 6: Discharged mental patient dyeing his fabric

New works produced by the discharged mental patient in Fig 6 and 7

Figure 7: Produced tie and dye fabric by the discharged mental patient

Figure 8: Produced tie and dye fabric by discharged mental patient

4.2.2 Case study two

Background

He is twenty –eight (28) years of age. He was brought to the rehabilitation Centre in 2007. He comes from Koforidua. He has seven (7) siblings, three (3) girls and four (4) boys and he is the fifth (5fth) born. Her mother is a nurse but she is now on pension. His father is a contractor.

He was to have finished Secondary School at Konogo Odumasi in 2001. His dream was to become a Doctor. During the second term at the boarding school, he complained girls were worrying him so he could not concentrate on his studies therefore he was sent to Obuasi Secondary School but returned only a week after because of his strange behaviour. He started destroying the school's Television set. His eyes were reddish due to the intake of alcohol and found talking to himself and roaming about in the street. He was sent to Komfo Anokye Teaching Hospital (K.A.T.H) in 2001. But now he wants to become an electronic repairer who will repair television and radio.

Present Status

Case two was sound and interacted well when the researcher went to his house. Even though he was a reserved person, who did not like talking much as the parents reported, the sight of the researcher changed the environment as he did the talking. And also he was very enthusiastic about the work as he asked questions and discussed issues in general terms about opening a business with the support of the parents.

The works produced as compared to his previous works showed some improvements in his previous works. Batik and tie and dye fabrics produced by discharged mental patient when he was an inmate at the home rehabilitation centre.

Figure 9: Batik work produced by inmate

Figure 10: Tie and Dye fabric by inmate

Processes involved in the production of tie and dye

Tools / Materials

1. Mercerized Cotton
2. Dyes –Red, Yellow, Blue
3. Twine
4. Scissors
5. Plastic Bowl or Container
6. Plastic Spoons
7. Sodium Hydroxide (Caustic Soda)
8. Sodium Hydrosulphite (Hydros)
9. Plastic Cups

Processes involved

In the tie and dye process, the discharged mental patient was taught new techniques in tie and dye to add to the existing techniques he had been taught at the rehabilitation centre. The researcher then allowed him to work on his own after the introduction. In the first process, he cut his mercerized cotton fabric to the required size 36 inches each to be used for the tie and dye work. These fabrics were then folded into the various techniques by the discharged mental patient. These techniques were marbling, folding and spiral.

The first technique was the folding method in tie and dye. He folded a piece of fabric into equal sizes in a rectangular shape. After, he then folded it into a triangular

shape in order to achieve a diamond shape when the fabric is produced. This can be seen in fig. 10 and 11 as the discharged mental patient did this technique.

The spiral technique was the second technique he used for his tie and dye fabric. This was done by holding the middle of the fabric with his fingers and twisting it or coiling around the finger as the central point till all the fabric was exhausted. This is shown in fig. 12 and 13.

The marbling technique was used. In this process, the fabric was wet and laid on a plain rubber. The discharged mental patient then crumpled the fabric together to one whole piece. This reduced the size of the fabric to a compact form. This is shown in fig. 14 and 15.

The discharged mental patient then prepared his dye solution. Warm water was measured and poured into the plastic cup. Then two spoons of Sodium Hydroxide (Caustic Soda) were added to the water and stirred using the plastic spoon. Plastic spoon is used because it does not react with the caustic soda which contains acid, which can change the colour of the dye in case a metal spoon was used. Three spoons of red vat dye were added to the caustic soda solution and stirred continuously to achieve a uniform mixture. Three spoons of Sodium Hydrosulphite (Hydros) was added to the solution and stirred to achieve an aqueous solution as in fig.16. The same process was used to produce a dye solution for yellow, blue and green vat dye solution which was used to dye the fabrics.

The dye solution was used to dye the folded fabric. He poured the red vat dye solution into a big bowl. He then added a measured quantity of water to the dye in the

bowl and stirred with the plastic spoon to maintain a uniform solution. He then immersed half of the fabric into the dye while wearing his rubber gloves to prevent the dye from coming into contact with his fingers which can peel off his skin or irritate the body when it comes into contact with the solution which contains acid which is found in the caustic soda. He immersed the fabric well to achieve an even dyeing. This is shown in figure 17 and 18, with the aid of the plastic spoon he made sure the fabric has absorbed the dye without any white places to prevent patches in dyeing. He then left the dyed fabric for five to ten minutes as shown in fig. 19. He then dyed the other half of the fabric in blue vat dye using the same method as in fig. 20 and 21. He unfolded the fabric and oxidized it. The fabric was washed in clean water to remove excess dyes from the fabric. It was dried under a shade for ironing.

In the marbling technique the fabric was then dyed as he applied different colours of vat dyes to the fabric in fig. 22 and 23. He oxidized the fabric and washed it in clean water as in fig. 24. He then dried it under a shade.

For the spiral technique, he applied his red, yellow and blue dyes to the fabric with the plastic spoon as his medium of dye application. The fabric was left for five to ten minutes for further absorption of the dye and oxidized. The fabric was then washed and dried under a shade.

Below is the discharged mental patient using his folding, spiral and marbling techniques in tie and dye production.

Figure11: Discharged mental patient using the folding technique in tie and dye

Figure 12: Discharged mental patient using the folding technique in tie and dye

Figure 13: Discharged mental patient using the spiral technique in tie and dye

Figure 14: Discharged mental patient with his spiral fabric ready to

be dyed

Figure 15: Discharged mental patient using the marbling technique

Figure 16: Marbled fabric for dyeing

Figure 17: Discharged mental patient preparing vat dyes for the dyeing of the fabrics

Figure 18: Discharged mental patient dyeing his fabric

Figure 19: Discharged mental patient checking total absorption of his fabric

Figure 20: Discharged mental patient oxidizing his dyed fabric

Figure 21: Discharged mental patient dyeing his other side of the fabric

Figure 22: Discharged mental patient with his dyed completed fabric

Figure 23: Discharged mental patient dyeing his marbled fabric

Figure 24: Discharged mental patient with his dyed marbled fabric

Figure 25: Discharged mental patient rinsing his marbled fabric

Figure 26: Spiral tie and dye fabric produced by discharged mental patient

Figure 27: Produced folded tie and dye fabric by discharged mental patient

4.2.3 Case study three

Background

Case study three is Forty years (40) of age. She hails from Adwuna Kasi Kese in the Ashanti Region. Education is JHS. Occupation is trading. She is single. She claimed to have had confrontation from the house. There was naturally confrontation with other people and physical assault on. She was sent to Dr. Atsyor psychiatric Hospital at Pankrono in the Ashanti Region accompanied by her uncle.

Present status

Discharged mental patient communicated well with the researcher and his family members. She carried out her duties well in her home and involved herself in activities of the house and other household chores. She had a sound mind when the researcher visited her and was sociable.

Batik and tie and dye fabrics produced by discharged mental when she was an inmate at the rehabilitation centre Cheshire home.

Figure 28: Batik fabric produced by inmate

Figure 29: Tie and Dye fabric produced by inmate

Processes involved in the production of tie and dye

Tools / Materials

1. Mercerized Cotton
2. Dyes –Red, Yellow, Blue
3. Twine
4. Scissors
5. Plastic Bowl or Container
6. Plastic Spoons
7. Sodium Hydroxide (Caustic Soda)
8. Sodium Hydrosulphite (Hydros)
9. Plastic Cups

Processes involved

In the tie and dye process, the discharged mental patient was taught new techniques in tie and dye to add to the existing techniques she had been taught at the rehabilitation centre. The researcher then allowed her to work on her own after the introduction. In the first process, she cut her mercerized cotton fabrics to the required size 36 inches each to be used for the tie and dye work. These fabrics were then folded into the various techniques by the discharged mental patient. These techniques were marbling, folding and spiral.

The first technique was the folding method in tie and dye. She folded the fabric into equal sizes in a rectangular shape as in fig. 29 and 30. She tied the folded fabric with a twine to create a resist method where dyes will not penetrate when the fabric is dyed. This can be seen in fig. 31.

The discharged mental patient then prepared her dye solution. Warm water was measured and poured into the plastic cup. Then two spoons of Sodium Hydroxide (Caustic Soda) were added to the water and stirred using the plastic spoon. Plastic spoon is used because it does not react with the caustic soda which contains acid and the vat dye which can change the colour of the dye in case a metal spoon was used. Three spoons of red vat dye were added to the caustic soda solution and stirred continuously to achieve a uniform mixture. Three spoons of Sodium Hydrosulphite (Hydros) was added to the solution and stirred to achieve an aqueous solution as in fig.16. The same process was used to produce a dye solution for blue vat dye solution which was used to dye the fabric.

The dye solution was used to dye folded fabric. She applied the red and blue dyes to the fabric with the aid of the plastic spoon and she made sure the fabric has absorbed the dye without any white places to prevent patches in dyeing. This is shown in fig. 32 and 33. She then left the dyed fabric for five to ten minutes to oxidize. She removed the twine with a scissors and exposed it to air. She washed the fabric in clean water and dried the fabric under a shade as in fig. 34.

Below is the discharged mental patient using the folding technique in tie and dye production

Figure 30: Discharged mental patient using the folding technique in tie and dye

Figure 31: Discharged mental patient folding her fabric

Figure 32: Finished folded fabric tied for dyeing

Figure 33: Discharged mental patient dyeing her folded fabric with vat dye

Figure 34: Discharged mental patient dyeing her fabric with vat Dye

New work produced by the discharged mental patient in Fig.35

Figure 35: Produced Tie and Dye fabric by discharged mental patient

4.2.4 Case study four

Background

She is twenty –nine (29) years of age. She is the daughter of Mr and Mrs Forson. She hails from Atwima Foase in Ashanti Region. She is currently living at Buokrom estate. She is the third (3rd) born of her parent. According to her she dropped out of Senior High School third (3rd) year owing to the ailment.

She had never married but has one child. She is a Christian and a Methodist. She knows how to drink alcohol and drugs but has stopped because she knew it the cause of her problem.

Case four was first admitted to Komfo Anokye Teaching Hospital psychiatric unit. She was transferred to Ankaful psychiatric unit. She was transferred to Kumasi Cheshire Home. On interview she was co-operative and quick to answer questions. She speaks relevantly and cogently. She is a quiet person with quiet mood and has good judgment being asked questions.

Case four has insight about her condition, how the condition came and show positive attitude towards intake of drugs. She observes proper persoy6nal hygiene. She baths daily and maintain her oral hygiene. She also changes her clothes frequently. She does not socialize effectively. She has been seen socializing with only females. She is well oriented place and time.

Present status

She was comfortable when the researcher interacted with her. She involved herself with house hold chores and communicated well with her family. She was happy to see the researcher and talked a lot about current issues.

Batik and tie and dye works produced by discharged mental patient when she was an inmate at the Kumasi Cheshire Home.

Fig 36: Batik fabric produced by inmate

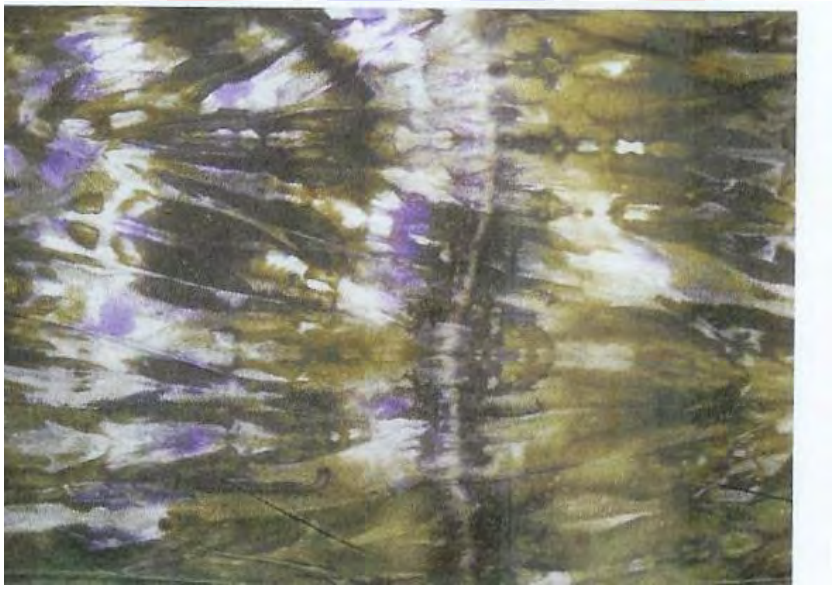

Fig 37: Tie and Dye fabric produced by inmate

Processes involved in the production of tie and dye

Tools / Materials

1. Mercerized Cotton
2. Dyes –Red, Yellow, Blue and violet
3. Twine
4. Scissors
5. Plastic Bowl or Container
6. Plastic Spoons
7. Sodium Hydroxide (Caustic Soda)
8. Sodium Hydrosulphite (Hydros)
9. Plastic Cups

Processes involved

In the tie and dye process, the discharged mental patient was taught new techniques in tie and dye to add to the existing techniques she had been taught at the rehabilitation centre. The researcher then allowed her to work on her own after the introduction. In the first process, she cut her mercerized fabrics to the required size 36 inches each to be used for the tie and dye work. These fabrics were then folded into the various techniques by the discharged mental patient. These techniques were marbling, folding and spiral.

The first technique was the folding method in tie and dye. She folded the fabric into equal sizes in a rectangular shape. After she then folded it into a triangular shape in

order to achieve a diamond shape when the fabric is produced. She used a twine to tie the fabric and divide it into two as a guide. This can be seen in fig. 37 as the discharged mental patient does this technique.

The spiral technique was the second technique she used for her tie and dye fabric. This was done by holding the middle of the fabric with her fingers and twisting it and coiling around the finger as the central point till all the fabric is exhausted.

The marbling technique was the third technique used. In this process, the fabric was wet and laid on a plain rubber. The discharged mental patient then crumpled the fabric together to one whole piece. This reduced the size of the fabric to a compact form.

The discharged mental patient then prepared her dye solution. Warm water was measured and poured into the plastic cup. Then two spoons of Sodium Hydroxide (Caustic Soda) were added to the water and stirred using the plastic spoon. Plastic spoon is used because it does not react with the caustic soda which contains acid and the vat dye which can change the colour of the dye in case a metal spoon was used. Three spoons of red vat dye were added to the caustic soda solution and stirred continuously to achieve a uniform mixture. Three spoons of Sodium Hydrosulphite (Hydros) was added to the solution and stirred to achieve an aqueous solution. The same process was used to produce a dye solution for yellow, blue, green and violet vat dye solution which was used to dye the fabrics.

The dye solution was used to dye folded fabric. She used the plastic spoon in aid of dye application and dyed the half of the fabric with blue vat dye in a big bowl she had placed the fabric in. This is shown in figure 38 and 39, with the aid of the plastic spoon

she made sure the fabric has absorbed the dye without any white places to prevent patches in dyeing. She then left the dyed fabric for five to ten minutes for further absorption of the dye liquor. She then dyed the other half of the fabric with the green vat dye using the same method. She removed the twine with a scissors and oxidized it. She then washed the fabric in clean water. She dried the fabric under a shade for use.

In the marbling technique, the vat dye solution blue, yellow and violet dyes were used to dye the fabric with the medium of a spoon which was used to sprinkle on the fabric. The fabric was then oxidized for the true colours to show. The fabric was washed to remove excess dyes from it and dried under a shade.

Below in figure 38 to 40 is the discharged mental patient using her folding technique in tie and dye production.

Fig 38: Discharged mental patient using the folding technique in tie and dye

Fig 39: Discharged mental patient dyeing her fabric

Fig 40: Discharged mental patient dyeing her fabric

New works produced by the discharged mental patient at Fig. 40 and Fig.41 at their respective homes

Fig 41: Produced folded technique tie and dye fabric by discharged mental patient.

Fig 42: Spiral technique tie and dye fabric produced by discharged mental patient.

4.2.5 Case study five

Background

She is twenty –one (21) years old and a student. She is married with two (2) children. She is the 4th child of her parents. She comes from Adwomako Brofoyedu. She is a Christian, worships at Pentecost, Konogo Freetown. She said after completion of BECE and awaiting her results, she began showing signs of illness such as hearing voices and talking to herself so her mother took her to a prayer camp at Abenkyem where the prophets kept her there for about four (4) months. In 2010, she was taken to Konogo

government hospital where she was admitted and discharged. In 2012, she was sent again to Adom clinic at Santasi on four (4) occasions, each she spent two (2) months and the last occasion she spent three (3) months. She returned because she went out of medication and transferred to Western Region and for proximity, she was sent to Ankaful Psychiatric Hospital where she was admitted for three (3) months. She was discharged and brought to this home.

Case five is able to recall past and present events. She was co-operative and friendly during the time of interview.

Present status

Case five was good at her speech and carried out her duties well in the house. She was friendly and communicated with everyone in the family. She was curious about doing the tie and dye fabrics and practice more to meet the current trend of tie and dye fabrics in the market. She was well cared for and her dream was to open up a shop to sell her tie and dye fabrics produced.

Batik and tie and dye work produced by inmate at the Kumasi Cheshire Home

Fig 43: Batik fabric produced by inmate

Fig 44: Tie and Dye fabric produced by Inmate

Processes involved in the production of tie and dye

Tools / Materials

1. Mercerized Cotton
2. Dyes – Yellow, Blue
3. Plastic Bowl or Container
4. Plastic Spoons
5. Sodium Hydroxide (Caustic Soda)
6. Sodium Hydrosulphite (Hydros)
7. Plastic Cups

Processes involved

In the tie and dye process, the discharged mental patient was taught new techniques in tie and dye to add to the existing techniques she had been taught at the rehabilitation centre. The researcher then allowed her to work on her own after the introduction. In the first process, she cut her mercerized cotton fabrics to the required size 36 inches each to be used for the tie and dye work. These fabrics were then folded into the various techniques by the discharged mental patient. These techniques were marbling, folding and spiral.

The first technique was the folding method in tie and dye. She folded the fabric into equal sizes in a rectangular shape. After she then folded it into a triangular shape in order to achieve a diamond shape when the fabric is produced. This can be seen in fig. 44 and 46 as the discharged mental patient do this technique.

The discharged mental patient then prepared her dye solution. Warm water was measured and poured into the plastic cup. Then two spoons of Sodium Hydroxide (Caustic Soda) were added to the water and stirred using the plastic spoon. Plastic spoon is used because it does not react with the caustic soda which contains acid and the vat dye which can change the colour of the dye in case a metal spoon was used. Three spoons of yellow vat dye were added to the caustic soda solution and stirred continuously to achieve a uniform mixture. Three spoons of Sodium Hydrosulphite (Hydros) was added to the solution and stirred to achieve an aqueous solution. The same process was used to produce a dye solution for blue vat dye solution which was used to dye the fabric.

The dye solution was used to dye folded fabric. She applied the yellow dye to the fabric with the aid of the plastic spoon. She made sure the fabric has absorbed the dye without any white places to prevent patches in dyeing. This is shown in fig. 47, 48 and 49. She then left the dyed fabric for five to ten minutes for further absorption of the dye solution. She then dyed the other half of the fabric using the same method. The fabric was then oxidized for true colours to show. She unfolded the fabric and washed the fabric in clean water to remove excess dye from the fabric and dried the fabric under a shade to remove excess water from it.

Fig 45: Discharged mental patient using the folding technique in tie and dye

Fig 46: Discharged mental patient with her folded fabric

Fig 47: Discharged mental patient using the vat dye in application to her fabric

Fig 48: Discharged mental patient dyeing her fabric

Fig 49: Discharged mental patient dyeing her fabric

Fig.50 and 51 are the new works produced by the discharged mental patient

Fig 50: Produced folded technique tie and dye fabric by discharged mental patient.

Fig 51: Produced tie and dye fabric by discharged mental patient.

4.3 ANALYSES AND DISCUSSIONS OF FINDINGS

Mental state of patients

There was improvement in their communication skills and their health state. Through communication with their parents and other siblings it reduces their loneliness and shows how much their family cares and loves them. This improves their mental status and inspires them that someone cares for them. One of the mental patients who always restrain from others and did not communicate with others had some improvement. At the time the researcher visited her, her pronunciations of words were clear and has improved in her socialization. She interacted more with her family and people in the

society. This prevented her from being idle or depressed or lonely which can lead her back to the psychiatric hospital.

This is supported by E. Blankson 2007; the stigmatization often leads to dramatic social consequences for the persons concerned. They either have been abandoned by their families after their discharge from the hospital and refused to readmit them to the family or even placed in special Vagrant Ward were created for patients who have been rejected by their families because of stigma. The General Secretary of the Ghanaian Medical Association estimated that a third of patients on admission in the Accra Psychiatric Hospital are patients who have been treated and discharged. The situation in other hospitals is similar. The stigmatisation of mental illness is a serious problem affecting patients and their relatives as well as institutions and health care personnel working with persons with mental illness. The more a mentally ill person feels stigmatised; the lower is the person's self-esteem, social adjustment and quality of life. Stigma can adversely affect family relationships, lead to employment discrimination and general social rejection (E. Blankson, 2007). Finally, Stigma also influences access to care, because people may be reluctant to seek help despite experiencing mental or emotional problems as this might be seen as an acknowledgement of weakness or failure. Negative and stigmatising public attitudes towards mentally ill persons therefore have direct implications for the prevention, treatment, rehabilitation and quality of life of those affected.

There was massive improvement from their tie and dye as compared to their earlier works produced in the rehabilitation centre. From the works they produced in their old works, they used light colours and simple techniques to produce their tie and dye and

batik works, as compared to their new works produced; the colours were brighter and richer. In the old woks, the discharged mental patients used raw colours like primary colours to achieve simple designs.

They used different techniques such as marbling, folding, spiral and twisting techniques in their recent fabrics. In recent works, they mixed their own colours, to achieve secondary and tertiary colours to give intricate designs. For instance, case one was able to do new techniques the researcher introduced to him with little supervision. He created his own techniques in addition to the existing knowledge he had. He experimented with the dyes using tertiary colours instead of primary colours. He produced his works with little guidance. He used the marbling technique, the folding technique and the twisting technique.

There was an evidence of learning new skills in their fabric production. They did the work with little supervision. Out of the five discharged mental patients three of the discharged mental patients chose complex techniques in their tie and dye to get intricate designs. They took their time to ensure precision were able to think creatively. This was a clear indication of their ability, to think constructively. Their colours were rich and had unique designs.

They were very neat and patient and treated all their works with greater level of maturity. Their designs express their balanced nature and expectation of multicolour. Their designs indicate a means of determining their response to treatment. Their colours were rich and good design.

This is supported by Reynolds (2004), textile art promoting well-being in long – term illness; qualitative accounts of the creative process suggest that textile art-making is a multi-dimensional experience. Some practitioners regard textile artwork as a means of coping with discomfort and other symptoms. For a minority, it enables expressions of anxiety and feelings about loss. Nevertheless, participants place more emphasis on the role of textile art-making in rebuilding a satisfactory identity, and restoring autonomy and quality to life. It fills occupational voids following early retirement and enables social contacts. Textile artwork also stimulates learning and personal development. It remains possible that any creative occupational delivers such benefits.

It accepts the use of assistive technology, thereby enabling people with a variety of physical impairment to produce 'mainstream' art. It draws upon rich social traditions, facilitating social contact. Many forms of textile art-making art highly time-consuming, fostering a future orientation and the creative process is often socially visible within the home, with positive consequences for self-image.

From the works produced, there is evidence that tie and dye works prevent the patients from relapsing back to the street or the psychiatric hospital because once they did the work, they socialize with the family and people from the society which kept them from being idle and lonely. The researcher deduced from the analysis of the transcription that, textile art is an effective vocational tool for rehabilitating discharged mental patients that prevent them from relapse or returning back to the street. This is supported by Fredman and Kaplan (1972), observed that mental patients become restless when they are alone or had nothing doing. This therefore suggests that when various vocations were introducing to mental institutions, it would occupy them.

Yeboah (as cited in Obu p.25) assert that, rehabilitation is a word which describes an active process in which at least two people are involved, that is the person with a disability and the helper. Rehabilitation is a building activity which attempts to "restore a person's physical and mental capacities and improve the quality of his life to a level which is near as possible to that which existed prior to his illness". During rehabilitation the disabled or discharged mental patients are provided with an agreeable craft and skills such as needlework, shoe making, basketry, drawing, weaving, tie and dye, carpentry and modelling.

The goal of this rehabilitation Centre is to assume that the person who had a psychiatric disability can perform the physical, emotional or intellectual skills needed to live, learn and work in his or her own community with the least possible amount of support from agents of the helping profession.

The vocational rehabilitation is based on the premise that work is good for mental health. For many patients who have never learnt vocational skill, the feeling of competence and productivity resulting from a trade produces positive psychological reinforcement. The importance of vocational rehabilitation has been emphasized by Kissim and Begleiter (1984) (as cited in Obu 2010 p.3 "it has become evident that emotional or social rehabilitation is often ineffective without major attention to vocational rehabilitation". During rehabilitation, the disabled are treated medically and provided an agreeable craft for an idle moment while in the Centre.

Poldinger and Krambeck (1987) consider rehabilitation as re –integration and post treatment efforts. This includes all measures which serve the medical restoration, vocational requalification and the social re –integration of the ex-patients. Also art

making is a form of healing and again is a form of healing within a psychotherapeutic relationship.

Theorizing about the relationships between health and creative occupation is still at an early-stage and there is a continuing need to examine the subjective effect of meaningful occupations on well-being. From art therapy literature, we can infer that art making may benefit patients with physical illness through offering a means of self-expression particularly about feelings that are too overwhelming to describe in words. (Reynolds, 2004).

If we are to appreciate how art-making may make a difference to quality of life during long –term illness, we need to acknowledge the impact of illness not only upon physical but also psychological and social well-being looking beyond the obvious discomfort and functional limitations that illness brings about, many studies have shown that people experience with chronic health problems after experience shrinkage of social roles, withdrawal from valued occupations, loss of choice and control over lifestyle, and threats to self and identity. Illness can become a 'master status' in person's life, penetrating every aspect of personal experience as well as influencing the reactions of others (Reynolds, 2004).

Their works met the standard of the market as their works were compared with the once sold in the market and was shown to the people in the society to appreciate their work. This was proven as people wanted to buy their works.

Reynolds (2004) how may a creative occupation such as textile art challenge the 'master status' of illness? From a limited body of previous work, we may infer that textile

art can be restorative, through tactile qualities and through the quit and focused nature of the occupation. It can also provide a measure of comfort and security through linking practitioners to previous lives and relationships when diagnosed with a serious health condition, such as reconnection with long-standing social traditions may be highly supportive. Case studies suggest that some individuals use textile art to symbolize their journey through a healing process.

Art filled occupational voids, distracted thoughts way from illness, promoted the experience of flow and spontaneity, enabled the expression of grief, maintained a positive identity, and extended social networks. It value was conceptualized by one participant as a "lifestyle Coat-hanger' organizing numerous further roles and activities that gave purpose to life. (Reynolds, 2004)

Art was more than cathartic. It offered a versatile means of overcoming restrictions imposed by illness on self and lifestyle, in many cases creating a more enriched lifestyle than before. (Reynolds, 2004).

Important elements of Textile Design

It is interesting to note that some textile designs quickly attract the attention of people, especially consumers and they want to possess such fabrics. They begin to imagine how these designs will fit them; the styles the would like to sew; how others will appreciate their beauty in their beauty in these designs, and the functions that will be suitable for the use of such designs. (Adu-Akwaboa,2001).

According to Adu-Akwaboa (2001), Definitely, something in the design might have caused the sudden attraction. It may be the colour, the motif, the textures in the

design or how certain lines in the design converge or diverge. These things mentioned above and others used for the production of the design which caused the attraction are called the elements of textile design – what actually go together to from the design.

Line

The simplest unit of image formation is a dot and a connection of a series of dots results in a line, so a line is the result of projecting a dot in a given direction. A line may be short or long, straight, curved, wavy, zigzag, broken, thick or thin. Lines express feelings and emotions. The four primary directions of a line are vertical, horizontal, right oblique and left oblique. Direction of lines can express different ideas. (Adu-Akwaboa, 2001).

Shape

A series of lines of different directions go together to form a shape. The two basic shapes are geometric made up of circles, squares, triangles etc. then, natural, also known as 'free form', most of which have soft, free flowing outlines, example leaves, rivers and clouds. Shapes of objects are very important when choosing motifs for textile designs. (Adu-Akwaboa, 2001).

Size

Size is determined by the spaces between lines that to together to from shapes and these different in many respects. The size of a motif influences the aesthetic value of a

textile design and may even influence the choice and sale of a textile design. (Adu-Akwaboa, 2001).

Colour

The element of a textile design that first appeals to the consumer is colour according to Adu – Akwaboa. Perhaps, it is the most important element of a textile design. It is actually the colour of a textile design that normally invites us to approach it before we identify the other elements in the design. It is a powerful element that influences the choice and even the sale of textiles. A textile designer must be very familiar with colour. (Adu-Akwaboa, 2001).

The location of a colour around the colour wheel or an identifiable colour name is referred to as hue, example; yellow, red, blue, are hues. Hue is one of the three measurable colour properties or one of the three essential characteristics of colour, the others being value and Chroma or intensity. Value is the degree of lightness or darkness of a colour, the range from light to dark or the amount of light or dark existing in a colour example, light-green, dark-green. The degree of saturation of a colour, that is, the brightness or brilliance of a colour is known as Chroma; example. Bright –red or dull – red. (Adu-Akwaboa, 2001).

Colour is a very important element in a textile design and its impact on the consumer cannot be over-emphasized. The impact of colour is well demonstrated if one considers the fact that poor designs have sold well and fast because of the very rich

colours applied. A good knowledge of colour and its symbolism is, therefore, not only a necessity but also an asset to the textile designer.(Adu-Akwaboa, 2001).

Light is the source of colour and so colour is seen where there is either natural or artificial light. Sir Isaac Newton's experiment showed that a beam of sunlight is composed of different waves, which are interpreted to be colours. This fact, is demonstrated and proved by passing a beam of sunlight through a prism – a triangular shaped glass. The beam of sunlight, in its passage through the prism, is bent (refracted) and split up or dispersed into different colours, which forma band called spectrum. The main colours in the spectrum are Red, Orange, Yellow, Green, Blue, Indigo, Violet (ROYGBIV). Formed in between them, as they blend together, are several intermediate colours, the grading of which is imperceptible, that is, red gradually changes through orange-yellows to yellow and in like manner through all the other colours to violet. (Adu-Akwaboa, 2001).

Colours are seen because coloured objects have some physical properties called pigmentation or colour quality, which enables them to absorb or reflect colour waves. A red book appears red to the eye because all other colours in the ray of light are absorbed while the red waves are reflected. (Adu-Akwaboa, 2001).

Warm and Cool Colours

Colours can give the impression of warmth, coldness, brightness, nearness or distance. A colour is said to be warm when it contains a greater proportion of red or yellow while it is regarded as cool when it contains a greater proportion of blue. Red which is brilliant, cheerful and a very powerful colour seems to advance slightly towards

the observer while yellow which is not as warm as red but luminous and vivid strikes the eye more distinctly. Blue which is cool colour seems to recede from the eye. (Adu-Akwaboa, 2001).

While warm colours tend to increase the size of an object, cool colours usually tend to decrease it. While dark values tend to decrease the size of an object light values tend to increase it. While warm colours advance, cool colours recede. While bright colours increase the size of an object, dull colours reduce it. (Adu-Akwaboa, 2001).

While light values usually advance, dark values tend to recede. While bright colours advance, dull colours recede. While warm colours tend to stimulate, cool colours tend to relax. (Adu-Akwaboa, 2001).

Colour Harmony

A textile designer should be very conversant with colour combinations and their effects on a textile design since not all colours combine well to create beautiful designs it is therefore necessary for textile designer to learn more about colour harmony to be able to produce rich designs. (Adu-Akwaboa, 2001).

Since colour sense varies in different people, it is not easy to determine colour harmony because what appears harmonious to one observer may appear inharmonious to another and this may also depend on the degree of development of colour sense in the individual persons. Colour harmony may be any colour combination that is very pleasing and gives the observer full satisfaction. (Adu-Akwaboa, 2001).

Even though there are no fixed principles governing colour harmony, some harmony of colour has been achieving through the personal experiences of old masters

and these have been recorded for the experience and use by posterity. You may also like to have a personal experience of colour harmony by seriously going through colour mixing exercise. There are many ways through which colour harmony can be obtained; the following is just to guide you in your colour mixing exercises. Colour harmony may be achieved through the following;

i. Showing contrast in values by the use of monochromes or many different values of one colour;

ii. By the use of related colours (that is analogy) – colours which have a common factor, example red, red-orange, red-violet, the common factor being red;

iii. By the use of complementaries, that is, opposite colours on the colour wheel especially when they are modified by black or white,

Example yellow- violet

Blue-orange

Red-orange –blue green

iv. By the use of colours in succession on the colour wheel which may be three to six colours on any side of the colour wheel, example; yellow-yellow – green, green, blue-green;

By the use of split complementaries – the use of a colour and two colours located on each side of its complement; example blue-green and blue –violet against orange, Blue, which is a complement of orange, is a common factor to blue- green and blue – violet. (Adu-Akwaboa, 2001).

Colour Symbolism

In many parts of the world, colour symbolism has played a very important role in the art, religion, politics and socio-cultural activities of people. Colour has been used to send messages and its interpretation has helped a great deal in many human activities, example; wars, games and sports. Colour has even influenced the language of some people. Typical examples are English expressions like "once in a blue moon", (very rarely or never), "catch somebody red-handed" (to catch or discover somebody in the act of doing something wrong or committing a crime), "in black and white" (in writing or in print), "green light" (permission to start or continue with a project). Many of these cannot be translated literally; they are figurative. (Adu-Akwaboa, 2001).

Even though white has generally been used to depict victory, success or happiness, symbolism or colour differs from country to country. In Ghana, generally, red indicate danger, alarm, unrest, agitation and mourning while blacks depict sadness or melancholy and mourning. Textile designs for sad events, therefore, carry reds and blacks. White sands for victory, success, happiness, purity and festivities. People in white colour for happy social, cultural and religious activities are a common sight in Ghana. Green depicts freshness, love, sincerity, female and vitality in life while blue portrays peace, love, sincerity, female tenderness and serenity. Wealth, royalty, pageantry, power and kingship are portrayed with yellow and golden-yellow. Many ceremonies which portrays wealth and culture of the Ghanaian, therefore, have yellow and golden yellow backgrounds, example; cloth for chiefs, their umbrellas, though some ethnic groups may have their special colours that symbolize their beliefs and depict their culture. The textile

designer should be familiar with colour symbolism to be able to satisfy his clients.(Adu-Akwaboa, 2001).

***When illness Inspires Great Art by Jana* Hauschild**

Hauschild (2013),states that at the start of the 20th Century, doctors thought they could use patient's paintings to diagnose their psychiatric conditions. This turned out to be largely untrue, but, even so painting remains an important part of psychiatric treatment to this day. The act of painting allows patients to come to terms with traumatic experiences, fears and sometimes the result are remarkable pieces of art.

'Art allows patients to release their inner tension, "says psychotherapist and art historian Georg Franzen, director of the institute for Art Psychology in Celle. A hundred years' after Hans Prinzhorn began his collection, Art has become an integral part of psychiatric care: Today, almost all clinics offer art therapy in addition to Psychotherapy and medication. (Hauschild, 2013).

A Growing Phenomenon

"Patients are able to express inner pictures with a brush and a pencil in a way they wouldn't be able to with words "Franzen continues. The works serve as a starting point for conversations between therapists and patients, as the feelings and thoughts they have put to paper. Franzen explains' concentration, emotional competence and feeling of self-worth. (Hauschild, 2013).

Canvas of Emotion

It's not unusual for former psychiatric patient to establish a living for themselves as artists. So –called "outsider art" is a now a permanent fixture on the art market, and even if illness is the driving force behind the artists" work, it can then take a backseat to their creativity. (Hauschild, 2013).

These days, open workshops used by artists with mental health issues are attracting ever more notice. "Art colleges visit them regularly to experience their unique, creative atmosphere, "says psychologist and art historian Thomas Roske, director of the Prinzhorn collection since 2002. Since 1980, a further 12,000 works by patients past and present have been brought into the collection, which continues to grow. (Hauschild, 2013).

How textiles can change lives

According to Ami James (2016)she lives in Derbyshire, England, and she is fairly new to textile arts. She started sewing just over two years ago after she was diagnosed with bipolar disorder. The thirty – four 34 years old mother reached out to us with her inspiring story. Ami found that textile and crafts had significantly aided her recovery by opening her own haberdashery in swadlincote. In this interview, Ami James discusses the sudden onset of type 1 bipolar disorder, how her newly discovered passion for embroidery helped her to cope, and what eventually led her to open her own haberdashery.

Textile Artist.org: Tell us a bit about your background and life before textiles.

Ami James: five years ago, my life was completely, different. I was happily married to my hubby David with one child, Ben who was 6 years old at the time. I had completed a few small cross stitch kits that you can get free in a magazine but that was about my limit. I had no interest in sewing or any other crafts.

In June 2011, the nightmare, my mood, plunged dramatically out of the blue, within a couple of weeks I had gone from being happy to depressed and suicidal. The change came with such speed that my world had been turned upside down. I can remember David taking me to see my GP where I explained everything and he prescribed me antidepressants …well, that didn't work. Two weeks and lots of appointments later I was considered high risk and was taken to hospital to be evaluated. Bipolar, that's what I have. My official diagnosis was bipolar type I with psychosis. That's when the hard work started.

How and when did you stumble upon textiles as a medium

After being discharged from the hospital, my mum took me out for a coffee every week. We could talk about everything and nothing. It was great distraction. One day, I took a brochure that had come through the letter box about courses being held at already been planning on learning something new that would become hobby. But at the time we were looking for something like flower arranging for upholstery we noticed there was a beginner sewing classes that ran over a number of weeks that was it – we both signed up. It was great for me because not only was I learning something new and having sometime with mum but I was also socializing. So l learnt how to use a machine and basic

patchwork, and we made cushions, bags and doorstops. I looked forward to every Tuesday afternoon. (James, 2016).

What inspired you to explore textiles yourself?

According to James (2016), three weeks into the sewing class, my dad treated me to a sewing machine. I was so chuffed. It was a basic machine but that was fine as I didn't need a fancy one. It lived on the dining room table and was quickly surrounded fabric and threads. I wanted to try so many techniques but I really wanted to start quilting.

Now, for some unknown reason, I found that I could not follow patterns –and I mean not any pattern or instructions. Dress patterns, sewing patterns, quilt patterns, knitting and crochet patterns. No, I could not follow any of them. I gave up trying and went on my merry way, making it up as I went along. I find that way there's it up pressure for it to be perfect and it's more unique. (James, 2016)

Tell us a bit about the condition you have and how it has affected your life in general

Bipolar is classed as a mood disorder but to many it's much more. In fact, people that don't know about bipolar automatically think that we are "just moody". High and low moods are just a part of it. The other symptoms that make up bipolar are normally the worst parts. Restlessness, irritability, racing thoughts, anxiety, panic attacks, easily distracted, aggression, and struggling to focus is classed as high mood-so not a good mood as you might think. (James, 2016)

Depression, lack of energy, negativity, hopelessness memory problems no concentration, tired, emotional, intrusive thoughts of self-harm, hallucinations, paranoia, guilty, emptiness, feelings of no worth, and loss of interest are all symptoms of a depressive episode.(James, 2016)

After being discharged from hospital / spent the next two years trying different medications, some of which had harsh side effects I tried different therapies and coping strategies as well as weekly appointments with y psychiatrist. The biggest part of my recovery after and how to come to terms with it. This wasn't easy for a long time as felt and weak.(James, 2016)

The biggest part of my condition is anxiety. Anxiety for me was a living nightmare. It triggered panic attacks, hallucinations and Paranoia. My husband was living the nightmare with me. He is so supportive and caring and it has been a learning curve for him too.

I have now found a happy level with my medication. I do have to have blood tests every three months to make sure my blood has not turned toxic with the levels of lithium in my body. I still have good days, really good days, bad days and really bad days but I am getting there. (James, 2016)

What role have textiles played in coping with your bipolar disorder?

A huge part… from the sewing class I became more confident. But the biggest change was definitely my awful anxiety. Instead racing thought about negative and dark things, I had a mind full of fabrics, quilts, new equipment, and things I wanted to try.

Okay, so my mind was still racing, but full of positively instead. But then that stopped the hallucinations, Paranoia and low moods, sewing became some sort of a therapy for me. I would try and do something crafty, as I soon realized it was the learning of new skills and techniques that was also keeping me grounded and focused. (James, 2016)

Tell us the business you set up and how that came about

In September 2014, I had an idea. I wanted to set up a haberdashery in my local town of swadlincote. My family thought I was absolutely barking. I had seen an empty shop which my family talked me out of as it was too far out of town and I am glad they did. My dad suggested having a market stall to see how it went. That's how simply Needle craft started six months of getting up at 5am twice a week come rain or shine. My dad was my partner in crime. It was bloody hard work but we enjoyed. We had such a good reception and the stock was growing fast. We started to gain loyal customers. It was so much fun. (James, 2016).

However, a trip to the local post office was where the real journey started when I spotted an empty shop in the town centre. Looking through the window, it appeared perfect and I just knew I wanted it. I made a call to the estate agent and booked a viewing for the following week. We loved it. (James, 2016).

We picked the keys up on February 13, 2014 and decided we would open the doors to the public the 1st of March. Two weeks of painting, decorating, cleaning, sourcing furniture, more cleaning, ordering, unpacking, and being excited, and we were ready in time. The local councillor came to cut, the ribbon along with local newspapers

and radio stations. It was a lovely day and the shop was packed all of crafters. (James, 2016).

Fast forward fifteen months and simply Needle Craft Haberdashery is doing great. I became a dealership for Singer Sewing Machines.

In 2015, we have already expanded and now there is a fabric snug, upstairs is being worked on as we speak, and it is turning into a lovely comfy, bright and inspiring sewing studio where people can hire out Singer machines and come in for classes. It is a dream job for me. I am surrounded by beautiful fabrics, yarns and all things crafty. I love seeing what my customers have been making, and I can fit course work around the shop. It is without doubt the best decision I have made. I will never be free from bipolar and I cannot say if I will have another breakdown but I have found my coping strategy in sewing. I cannot imagine life without it now.(James, 2016).

Jessica Kingsley (2012); Using Textile Arts and Handcrafts in therapy with women an interview with Ann Futterman Collier.

Women all over the world make objects with fibres and textiles. Historically, textile – making has served a Central and functional role for women. With the beginning of the Industrial Revolution, textile-making moved out of the home and into factories; eventually individual textile-making declined. This further exacerbated as women in the 60's and 70's questioned and rejected stereotypic famine constructs that the perceived as domestic and oppressive. Fibre arts were seen as uncreative, old – fashioned and ugly. Despite this denigration there has been a renaissance in textile handcrafts since the early

part of the 21st Century. Labelled everything from the "Craft revolution" to the "new generation of do-it-yourselves," the pendulum has swung back and they are now seen as more acceptable, creative, and worthwhile pursuits. (Kingsley, 2012).

Textile words, metaphors, and idioms are deeply engrained in the English language ("spinning a tale," "a thread of discourse," hanging by a thread, on pins and needles," "wear and tear," and "at loose ends,"). As such, they naturally avail themselves symbolically describe our inner psychological and outer social lives and can be used to explore key issues. And, in the every-day making of textiles, women cope with their lives, they keep their spirit uplifted. This book provides the Clinician with framework for how to use the metaphors and idioms already entrenched in textile arts, therapeutically it also provides Clinician with a framework for how to explore textile-making in therapy. (Kingsley, 2012).

Finally, in my experience, multiple psychological issues can and do arise while taking fibre-related workshops-which many women (and men) take. Most artists (other than art therapists) are not trained in how to deal with these issues. (Kingsley, 2012).

They are an effective starting point because many women already know how to use multiple kinds of textile techniques (e.g. knitting, crocheting, weaving, spinning, sewing, embroidery, beading, rug hooking, felting) and because many women already use them this way. (Kingsley, 2012).

However, I agree that art-making using one's preferred medium has therapeutic value regardless of gender and regardless of the medium. Yes, I believe that the benefits

of textile making are applicable to men as well. Especially if that man was already a textile hand crafter. (Kingsley, 2012).

About five years ago, I began to wonder about this from a research perspective. Although I know that textiles helped me to cope, my theory was that any leisure activity that was energizing, absorbing, and engaging should head to rejuvenation and hence positive mood repair. My preliminary research has suggested that there are indeed multiple mood changing activities available for us to use, such as listening to music, exercising and talking to friends. The more engaging and energizing those activities are, the more they can positively change mood and result in rejuvenation. Going back to my textile research, the more arousing the fibre-making activity was (weaving and quilting were rated as the highest), the more effective it was at mood repair and rejuvenation. Thus exciting about fibres, mentally challenging and engaging textile projects, and even the movement associated with making textiles, all appear to be good for your mental health. (Kingsley, 2012).

Art therapy classically emphasizes psychodynamic and psychoanalytic approach. This typically encourages the person to express and vent negative feelings through their artwork. My approach uses art-making somewhat differently. It is seen as a way to bring about positive mood, pleasure and rejuvenation. I believe that this, in turn, reinforces the continuation of textile-making, which subsequently promotes more positive mood and coping. This book shows how textile art- making can be taken to an entirely new level. Building and constructing metaphorical objects in order to explore issues in more depth. (Kingsley, 2012).

First, results confirmed that self-identified textile handcrafters create a lot: they have tried almost dozen techniques, reported overall mastery with approximately five techniques, and have used only three textile techniques during the previous three years. Women in this sample had tried many more techniques than reported by Johnson and Wilson (2005); however, their sample size also was considerably smaller (n = 39). Women engaged in fewer textile techniques than they had mastered during the past 3 years. This suggests that women have resources and skills they may not be using at any given time. If an art therapist were to consider using textiles in therapy with women, it would be worthwhile to explore their history of textile making, even if they were not obviously engaged in making textiles. (Kingsley, 2012).

Knitting was the main technique that women in this study had tried, felt mastery over, and used frequently. Knitting is both popular and very portable; with some persistence it can easily mastered. Sewing, weaving, quilting, and spinning were all common activities that participants had tried, felt mastery over, and had used I the past 3 years. Although crocheting has made somewhat of a comeback in "old fashioned." Textile design and multi-media techniques all were used, but participants did not self-rate themselves as being skilled in these techniques. (Kingsley, 2012).

The result confirmed the hypothesis that textile handcrafters engage in fibre arts predominantly for enjoyment and not for financial reasons. In fact, making handcrafts for income was the least likely reason that women reported for creating with fibres. The majority of handcrafters in this study preferred to give away or keep their products. Most of the women did not consider themselves to be professionals. (Kingsley, 2012).

Why, then do women make handcrafts? For most of the respondents in this study, it was because of their aesthetic love of textiles: the beauty of it, the feeling that it was part of their identity, and the sense that it was vital means of expression. For other women, motivation was related to the grounding quality of textile making. Women truly enjoyed the sensations of fibre making, the repetition, and the rhythm involved. Textiles provides a sense of continuity in their lives. Psychological fulfilment, the desire to do things for other, and social fulfilment, were also the reason that women reported for working with textiles. Although not as statistically sound as the five factors identified earlier, women also made textile handcrafts for financial reasons (example, to save money, to make money) and because it gave them tangible outcomes. (Kingsley, 2012).

Other reasons given for making textile handcrafts included coping with illness, cognitive coping, and not wanting to have "idle hands." It is ironic that despite being derogated as "craft" and "women's work," textile making provides an important source of cognitive coping or intellectual stimulation for many women. Geda (2009) at Mayo Clinic in Minnesota suggested that people who engage in cognitively challenging activities, such as working with computers or crafting (specifically knitting and quilt making), in middle age or later life had a decreased risk of mild cognitive impairment that protected against memory loss. Textile handcraft guild participation also has been correlated with better emotional and cognitive adjustment in older women (Schofield – Tomschin & Littrell, 2001). The comment "idle hands are the devil's playground," an old saying datein at least as far back as Chaucer in the 4th century (MacDonald, 1988), appeared in multiple places in the survey responses. Many women have strong work ethic

and use their textile handcrafts to feel productive and to provide a cognitive release. (Kingsley, 2012).

The hypothesis that textile handcrafters were functioning within healthy norms on every indicator of well-being was confirmed. The respondents were not, however, superior in well-being to the average population. The textile-copers reported that fibre making successfully changed their negative mood, rejuvenated them, and allowed them to be absorbed in an activity. The most common techniques textile-copers used when in a terrible mood is were knitting, weaving, and spinning; activities related to textile planning; sewing or quilting; and needlework. These techniques would therefore be best to try as frontline therapeutic interventions. (Kingsley, 2012).

I was intrigued to discover that the textile-copers also reported greater depression and anxiety symptoms, lower health QOL, and greater mastery than non-textile –copers. However, even when controlling for small baseline differences in these variables, textile-copers still reported greater changes in their mood than non-textile-copers. It is important to recognize that the negative indicators with respect to well-being are still within the norms of healthy functioning, they are not clinically pathological. One could say that textile-copers have come up with constructive, practical way to deal with difficult moods. If slightly elevated depression and anxiety and lower health QOL draw these women to make textiles, it is fair to say that fibre making is certainly good for their mental well-being.

In recent art therapy study, Dalebroux, Goldstein, and Winner (2008) reported that the greatest mood valence changes in participants occurred after creating a drawing that depicted a positive emotion, compared to venting or a neutral control. This finding is

contrary to a long-standing art therapy approach that encourages clients to express negative feelings through art making. These authors suggested that art making can be most beneficial by orienting people away from distressed feelings and towards more positive feelings to create short-term mood repair. Approximately half of the textile handcrafters in the current study have discovered this same benefit for themselves. The aesthetics and grounding quality of textile making helps them cope with negative moods. By focusing on creating something beautiful with their art, textile-copers experienced more success and rejuvenation than non-textile –copers. (Kingsley, 2012).

Several investigators have discussed the concept of skill and "flow" in artistic endeavours (example, Nakamura & Csikszentmihalyi, 2005; Rheinberg, 2008). Flow is mental state in which a person is fully engaged in an activity, has mastery yet feels challenged by the activity, becomes completely absorbed, feels an energized focus, and finds the activity to be intrinsically rewarding (Csikszentmihalyi, 1990). Blood (1990) examined flow theory applied to textiles, specifically with non-industrial clothing and textile making. She found that participants experienced greater occurrences of the flow state the longer they engaged in the textile activity. They also experienced a highly focused state, a sense of control, and creativity. My results are consistent with the flow theory in that the textile –copers, who reported more success and rejuvenation with mood change, were also significantly more skilled and engaged in their handcraft making than non-textile copers. Skill and flow, combined with the desire to create an aesthetic object and to feel grounded, are all motivations that can be accessed by art therapists when working with clients who may be attracted to textile handcraft when faced with turbulent life events and illnesses. (Kingsley, 2012).

It would be reasonable to question whether any activity, hobby, or leisure activity that involves flow would have similar results. In the current study, textile-copers were far more engaged and effective at changing their mood states than non-textile-copers, who used other leisure activity or hobbies to cope. This study suggests that textile media may be therapeutically beneficial for women who already knew how to apply textile making to cope with their lives; the other half may fare even better by using their skills. (Collier,2011).

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Overview

This chapter presents the summary of the study, conclusions drawn on the key findings and recommendation projected on the premise of the study outcome. Recommendation for research has also been made.

5.2 Summary of Findings

The researcher reveals the following findings. As the researcher visited them in their various communities and societies and homes, there was massive improvement in the way they carried themselves and welcomed the researcher. There was improvement in their mental status as shown in their dressing and the way they communicated. There was massive improvement in their construction of sentence and clear meaning of what they wanted to say. They responded well in questions and answers in their form of communication.

The rehabilitation centres trained inmates in various vocations as shoemaking, textiles, dressmaking and tailoring. This was to equip them with vocational training and as a form of rehabilitation to the inmates.

The textile art was an effective vocation because those who practiced the tie and dye, it occupied them and kept them busy. They interacted with people as they did the tie and fabric and this improved their interactions and prevented them from being lonely and depressed which would end them up in the psychiatric hospital or rehabilitation centre.

The work also gave them skills that they are using it as a vocation and also as a source of employment, so that when they are not employed in private and government offices they can do this business for income and financial benefit for themselves.

Their work met the standard in the market because they had good colour combination, good designs and was aesthetically good. It was able to withstand sunlight when dried and the colours did not come out when washed.

5.3 Conclusions

When mental patients are accepted by their family and they are taken care of, shown love and people have good perception towards them, it improves their health condition and helps them in early recovery. For instance, since the family cared for them, took care of their needs for example, their dressing, hygiene, food, clothing and continued their medication, there was massive improvement in the health of these discharged mental patients the researcher visited. The families have been educated on how to care and relate with these discharged mental patients before they are discharged from the rehabilitation centre, so that they will be able to help them in fast recovery. Furthermore, through communicating with these discharged mental patients, it improved their communication skills, it prevented them from being lonely, idle and depressed which could have led them back to the rehabilitation centre.

The nature of vocations studied as inmates was geared towards equipping them with vocational skills so that, when they are discharged from the rehabilitation centre, they can continue this vocation as a source of self-employment and for financial support,

because of the stigma attached to discharged mental patients most private and government institution do not employ them and they end up being a burden to the society and family or relapse back to psychiatric hospitals.

Textile art produced by discharged mental patients are effective vocations that prevent them from returning to the psychiatric hospitals, because the textile art prevents them from being idle in the house. It serves as a source of self-employment to the discharged mental patients because as they do these fabrics and sell them it serves as a source of income and financial support to them. It prevents them from being a burden to their families.

Again, as these discharged mental patients do these works, they communicate with the people they are working with, some asks questions and interactions goes on, thereby it prevents them from being lonely, and depressed which could end them back to the psychiatric hospital or rehabilitation centre. It also improves their communication skills and enlightens them.

When discharged mental patients are given the right instructions and processes to follow in learning of a vocation, they are able to produce good works which meet the standard in the market or the already sold goods in the market.

5.4 Recommendations

From the findings and conclusions made from the study, it is recommended that

- When stigma towards discharged mental patients is removed and there is good perception towards them, it will improve their mental state. Therefore, there must be more public education in the media and seminars organize to educate more

people on discharged mental patients within our family, communities and society to erase the negative perception of people towards discharged mental patients.

- There should be more rehabilitation centres and professionals in the field of art to train these discharged mental patients in vocational skills, to equip them in their rehabilitation process and acquiring job skills in trade, for instance, dressmaking, shoe making, basketry, ceramics, textiles, jewelry, sculpture, leatherwork, and painting professions.
- There should be a follow- up in these rehabilitation centres when these discharged mental patients are taught these vocational skills and released to their various communities and societies. The government should support these staff at the rehabilitation centres financially so that they can go on follow –up to these discharged mental patients at their various homes to know their health conditions and economic status in their various societies. Also, money should be allocated to these individuals as capital so that they can continue these vocations learnt at the rehabilitation centres as source of employment.
- There should be more training of vocational skills in the rehabilitation centre as their work met the standard in the market. This means that when discharged mental patients are taught the right vocational skills and given the right financial support, they can produce good works and sell their product to support them financially and serve as a source of self-employment for them.

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APPENDIX A: INTERVIEW GUIDE THAT WAS USED TO INTERVIEW

STAFF

PYSCHIATRIC NURSE /ADMINISTRATOR

1. Have there been any follow up to these discharged mental patients discharged from the Home?
2. How is their health?
3. How is the family and community relating to them?
4. Have there been any supports from their family members towards the vocation they have learnt?
5. Are they continuing the vocation they learnt?
6. Have the rehabilitation centre been supporting them on financial basis to continue the vocation they learnt?

APPENDIX B: INTERVIEW GUIDE THAT WAS USED TO INTERVIEW

PARENTS OF THE DISCHARGED MENTAL PATIENTS

1. How is your son / daughter relationship with you?
2. How is their relationship towards the community?
3. How does the community relate to them?
4. Do she / he continue with his / her medication?
5. Do you see any changes in your ward behaviour?
6. Will you be willing to support you ward with the tie and dye he /she is doing?
7. Are you impressed about the works you ward are producing?

APPENDIX C: INTERVIEW GUIDE USED TO INTERVIEW DISCHARGED MENTAL PATIENTS

1. How are you doing?
2. How is the family treatment towards you?
3. How is the relationship of the community towards you?
4. Will you like to continue this textile art tie and dye that you are doing?
5. Are you satisfied with the work you have produced?
6. If you would want to sell it how much will you sell it in the market?