AN (IN)ACTIVE PURSUIT OF HEALING

by

Sara Roik

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Sara Roik

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The following individuals read and discussed the thesis submitted by student Sara Roik, and they evaluated her presentation and response to questions during the final oral examination. They found that the student passed the final oral examination.

Ryan Mandell, M.F.A. Chair, Supervisory Committee
Stephanie Bacon, M.F.A Member, Supervisory Committee
Niharika Dinkar, Ph.D. Member, Supervisory Committee

The final reading approval of the thesis was granted by Ryan Mandell, M.F.A., Chair of the Supervisory Committee. The thesis was approved for the Graduate College by John R. Pelton, Ph.D., Dean of the Graduate College.
DEDICATION

To Joe. By allowing me insight to your struggles, you have given meaning to my own. You are the inspiration to this thesis, and I am forever grateful of your trust and willingness to let me into your life.
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ABSTRACT

This thesis seeks to raise a discussion and reflection of the current state of psychiatry in an intensely globalized world. As a result of globalization, many individuals have a lack of enculturation and a shallow connection to tradition. I take both a subjective and objective approach to understand how this has an effect on an individual’s perceptions and efficacy of treatment as many healing methods come to coexist. The subjective will be explored through my own reactions to treatment methods after becoming diagnosed with an anxiety disorder that leads to periodic states of depression. The objective will focus on two fields: cultural psychiatry, to understand the impact of social and cultural difference on mental health, and Victor Turner’s anthropological development of processual symbolic analysis, which is concerned with the interpretation and meaning of symbols within cultural performances and the need for continual reassignment of those meanings in perduring cultures.

My artwork fits into a lineage of historical and contemporary artists using the theme of mental health in their artistic practice, and the issues presented in the field of cultural psychiatry provide the conceptual basis for my video installation. Using Christine Ross’ theory of aesthetics, which links depressive tendencies to contemporary art, I discuss how my artistic practice related to mental health fits into the art world.
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PREFACE

The overlapping of two personal experiences in my life generated the foundation of this thesis: The first, being diagnosed with an anxiety disorder that leads to periodic states of depression; The second, meeting Joe.

The doctor who diagnosed me with two mental disorders strongly urged me to take medication and seek therapy. I refuse to take medication, but started going to therapy once a week. I found the experience to be unhelpful and eventually stopped going.

Shortly after that time, I met Joe. Joe is an Iraq war veteran who was struggling with Post Traumatic Stress Disorder. He also refused to take medication and found little help in therapy. We often talked about the frustration in dealing with our symptoms when we could not find any effective relief from them. Then, Joe took part in a nationwide event for war veterans who have PTSD called, “Leave it on the Mountain.” The event would have veterans do the following: find a mountain, get in their war gear, hike to the top of the mountain, write down everything they struggle with, on a separate piece of paper write down everything they hope for the future, burn the list of struggles, read aloud the list of hopes, and hike back down the mountain. He asked me to go with him, so I accompanied him on the hike. I saw the strong emotional effect it had on him, and the strong effect it produced. It was not a permanent fix, but Joe was able to sleep through the nights for a period of weeks. This was previously one of the symptoms he struggled with the most.
These two experiences raised many questions for me. Why did therapy not work for me? Why am I so against taking medication? Why did Joe’s method work for him? Why did I believe a similar process would not work for me? Why do treatment methods work for some and not others? Do I need to believe a process will work for it to be effective? How does a person’s culture affect the way they view treatment methods?

These questions made me consider the performative qualities of healing methods. I became interested in understanding the actions one undertakes, and how the perception of those actions plays a part in the results that are achieved. This led me to research and understand the issues presented in contemporary psychiatry, which largely looks at the affects of globalization on mental health. The research conducted functions as the conceptual basis for my video installation.

As an artist, I see the connection between art and mental health to be important on two different levels. First, many contemporary artists are currently concerned with the social, political, and cultural effects of globalization, creolization, and hybridization within a multitude of sub-disciplinary fields. I see myself as such an artist who seeks to understand how globalization affects the field of psychiatry. Second, my work fits into a lineage of other historical and contemporary artists who explore mental health as a theme within their artwork. My video installation adds to this progression by continuing to raise questions and provoking a discussion about the issues currently presented in the field of psychiatry.
INTRODUCTION

I have an anxiety disorder that leads to periodic states of depression. The doctor who diagnosed me strongly urged me to take medication and seek therapy. I refuse to take pharmaceutical drugs, and found the therapy sessions I carried out to be ineffective. Where then am I to turn? I feel like I have no connection to any other methods. People often tell me different things to try, but I always question them too much to actually seek them out. Why is this?

This experience and the questions it raised for me are the foundation of this thesis and body of artwork. I use my story and my experiences to provide an account of being diagnosed with a mental disorder. My story provides one perspective of many, and I do not liken my experience to what all others must be going through. It does however reflect some of the current issues and discussions presented in the field of psychiatry. My story is one that highlights a lack of enculturation and increased exposure to various social groups with different beliefs. This directly affects the way that I come to view, seek out, and experience healing treatments.

Part I of this thesis discusses contemporary issues presented in the field of psychiatry. I begin by divulging my personal perspective on the mental health system, subjective accounts of my symptoms, and childhood exposure to a variety of belief systems. These stories are linked to the theories presented in the discussion of cultural psychiatry throughout the rest of the section. Cultural psychiatry is concerned with
understanding the impact of social and cultural difference on mental illness and its treatment. I focus specifically on the concept of enculturation, which, at its basic level, is when an individual acquires appropriate values and behaviors by learning what their culture deems to be necessary. As cultures increasingly coexist due to globalization, individuals lack enculturation, which directly affects the way they perceive mental health constructions. I connect these concepts with Victor Turner's processual symbolic analysis, which is a type of investigation concerned with understanding the changing interpretations of symbols in sociocultural processes. These two modes of inquiry are brought together to better understand how present day mental health patients seeking treatment are affected by globalization. The information presented in this section comprises the conceptual basis for my video installation, which is discussed in Part II.

Part II of this thesis connects the theories and concepts within mental health to the art world. In order to understand how my artistic practice adds to this discussion, I provide a lineage of other artists, both historically and contemporarily, who address the theme of mental health. I also explain Christine Roth's theory of aesthetics as she raises critical points about depressive tendencies within contemporary art. Additionally, I discuss how the formal considerations for my video installation are influenced by the conceptual and theoretical information provided in Part I.
PART I:
A DISCUSSION ON CONTEMPORARY MENTAL HEALTH
CHAPTER ONE: THE SUBJECTIVE

I Feel Like I’m Going Insane

I wish I could better convey to people what it feels like. The frustration in it. The ridiculousness of it. I shouldn’t feel like this. I put pressure on myself all of the time. I should be able to handle it. I could handle it before. Before I got diagnosed. The diagnosis I didn’t even agree with at first. For fuck’s sake, I went for an art project. I didn’t even feel like I needed help. I felt like I could handle it. But my doctor never asked me if I felt like I needed help. She just told me I needed it. I went to her for a check-up. She told me to come back to talk about my stress. I thought it would be interesting. I never imagined it would have the effect on me that it did. I hate that. I really don’t think I would be like this if I didn’t get a seed planted into my head that I have a problem. That I need help. She told me I needed to take medication. I refused. She pushed it onto me harder. She listed three different medications. It all seemed absurd to me. The whole system. I was there for forty-five minutes. Some people buy into that. Just accept whatever the doctor tells you. I always thought that was a big problem. I grew up going to a doctor’s office after school. My mom worked in one. I would help organize the files. The drug reps always brought in toys for me to play with. Writing utensils, pads of paper, key chains, and other useless gadgets. I was surrounded by the advertisements my entire life. I’m not sure if that had some sort of subconscious effect. We never had to worry about medicine. It was always available to us. In limitless supplies. Maybe that had an effect on me somehow. I don’t know. I don’t know why
I’m so against taking medicine. Too much worry in it. Too many possible side effects. Too many possible long terms effects. Too much worry about something that’s supposed to help stop the worry. So my doctor told me to go to therapy. I still thought the whole thing was absurd. Then when I got into a particularly high stress period, I had a complete breakdown. It was bad. I couldn’t handle it. I didn’t know what to do with myself. That marked the beginning of my therapy sessions. Once a week. For one hour. It was bullshit. A waste of time. I don’t deny that it helps people. My friends go. They tell me to just find another therapist. I should. I know I should. They’re all in NYC. They talk about it like it’s trendy to have a therapist. Everyone has a therapist in NYC. It’s not that I feel ashamed to go to a therapist, I just feel like I’m judgmental about it. I feel like I psychoanalyze myself on a constant basis. Not that I’m a therapist. But I feel like I know the issues I deal with. I know how absurd it is. That I shouldn’t feel certain ways. I can rationalize things. But my feelings just won’t fall in line with my rational thoughts. A therapist confirming my rational side doesn’t do much to help me. I can understand the empathetic quality they provide that is beneficial to some people. That’s what my therapist was all about. “Oh, that must be really hard to deal with.” All of the time. Or, “How did that make you feel?” It just didn’t help me. I should go again. I realize that. People tell me I need to do something. I agree. But it comes and goes in waves. So I feel like it would be pointless to seek help when I’m in a calm state. But when I’m in it. Really in it. My conception of time becomes extremely altered. I feel like I have no time to do anything. And feeling like I just wasted time with a treatment method that wasn’t useful would only add to the anxiety. So I feel stuck. Constantly. But I get down on myself about it. If I feel so stuck why don’t I just try different treatments? If I’m
struggling so bad, then do something about it. But I don’t and I’m not sure why. I think people tell me about different methods because something has worked for them. But I feel like I don’t have a connection to anything. I question everything too much. Any kind of treatment. I don’t know why. I want to believe they will work. But essentially I don’t. So what are my beliefs then? I feel like I question everything too much to conform to one belief. Or any belief at all. It makes me think of my aunt. She’s a massage therapist. A big spiritual person. She had all sorts of readings done. Tarot, tea life, palm. She told me they worked. My family thought she was crazy. She took me with her. I had a couple of readings done. I still think about them sometimes. If something happens that relates to what a psychic told me. Was it coincidence? Was I just trying to make a connection in my head? Was it nothing? Was it crazy? I was baptized as a Methodist when I was younger. Went to church and Sunday school every week. I eventually fell out of line with the beliefs. I no longer conform to any religion. I think it would be easier if I had something to believe in, like God. But I don’t. I just question everything to such a degree I can’t come to even completely understand where my views lie. So I continue to feel stuck. And lost. Like this is my fault. Because it’s up to me to seek out help. It feels unbearable. Like my mind doesn’t work anymore. Like I need to get it to work. But I can’t. But I don’t know what to do anymore. I feel like I’m always failing now. I put the expectations onto myself. I know that. I know I shouldn’t. But I can’t stop. So I feel like it’s my fault. Like I need to calm down. But I can’t. I can’t sleep. I don’t feel like I need sleep when I’m in it. I never feel tired. That plays with your perceptions. When you can stay up for days. It has effects. I don’t hallucinate, but colors become exaggerated. Not everything. Just certain things. They pop out. Like neon signs. My
heart races constantly. My stomach drops. I can’t eat. I’m always tense. I grit my teeth constantly. To the point where my jaw becomes sore. My body eventually feels completely worn out. I wish I could explain it. The frustration of it. To just want to get out of it. So badly. But I can’t. And that’s frustrating. Beyond frustrating. The feeling of being stuck. Constantly. With no way out of it.

**Reflections on Feeling Insane**

The diagnosis I received is an anxiety disorder that leads to periodic states of depression. I personally feel that my anxiety and depressive state come and go in abrupt waves: They hit instantly and usually end the same way. Sometimes they are sporadic, other times they are much more frequent. “I feel like I’m going insane,” was largely written while I was “in it.” It provides my subjective account of some of the symptoms I struggle with. The objective description of the symptoms are outlined in Appendix A and B.

As stated in my personal account, I often feel insurmountable frustration. I find myself to be frustrated with the mental health system that diagnosed me, the treatment method that failed me, my symptoms, and myself for not actually seeking out other methods. From this frustration grew an intellectual interest. If I was not totally blaming the mental health system, and not totally blaming myself for my frustration, where was it coming from? As I began my theoretical research to find answers to these questions, I found cultural psychiatry.
CHAPTER TWO: CULTURAL PSYCHIATRY

An Introduction

Cultural psychiatry is concerned with understanding the impact of social and cultural difference on mental illness and its treatment. The field of "new" cultural psychiatry began in 1977 under Arthur Kleinman. Kleinman was educated as an anthropologist who studied medicine and psychiatry in different cultures. He had difficulty conducting his studies of these two fields because they were,

“…extremely disparate, fragmented among a number of disciplinary and subspecialty approaches: medical and general anthropology, medical sociology, medical history, cross-cultural psychology, several medical and public health perspectives on international and social aspects of health care, area studies, studies of the health related aspects of modernization, and other fields. The impact of reading through these varied materials…led to a predictable sense of confusion. Nothing was available to integrate the different questions and research approaches abounding in this wide, unorganized, but extremely fascinating field."¹

The field of cultural psychiatry requires a large multidisciplinary approach then. Much of the research I draw from comes from studies within cultural psychiatry, but those studies may come from any number of fields. Kleinman took a strong stance against delimiting fields and actually encouraged that they be brought together as a means to understand cultural psychiatry. He was also against the popular tendency of positivistic scientism as he saw it discouraging attempts to understand illness and care as embedded in the social and cultural world.

My research within this field comes largely from studies and research currently

¹ Arthur Kleinman, Patients and Healers in the Context of Culture (Berkeley and Los Angeles, California: University of California Press, 1980), x.
conducted and published in the *Transcultural Psychiatry* journal. Many of the articles I draw from seek to understand how globalization is affecting conceptions within contemporary cultural psychiatry.

**Key Terms**

First, it is important to define and explain key terms. The term “globalization” emerged in the 1990's as the preferred term for encompassing the multiplicity of supranational forces that have imprinted themselves on the contemporary world.² The initial time period that globalization began though is contested and widely depends on the definition applied to the term. Non-western contexts had dimensions of globalization as religious wanderers sought traces of God, kings searched for wealth in other lands, and consumers prized exotic precious goods. In western concepts of globalization, modern immigration and industrialization played an important role in international expansion. The shift between colonial and post-colonial concepts around the 1950's provide yet another dimension to the discussion. Defining globalization with a focus on any of the previous contexts takes on different political, social, and cultural discussions. But virtually all accounts of globalization recognize its quantitative significance and multi-dimensional character. It is widely agreed to be a process that transforms economic, political, social, and cultural relationships across countries, regions, and continents by spreading them more broadly, making them more intense and increasing their velocity.³ For the purposes of this thesis, I am concerned with the secondary effects to come out of globalization in the process by which the traditional

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³ Ibid., 16.
boundaries that separate individuals, societies, and cultures start to dissipate. This process of dissipation has become intensely accelerated with technological advancements in media in the last few decades, strongly affecting more recent generations. This changes perceptions and views of the way individuals conceive of the world they live in and will undoubtedly have a large effect on the field of psychiatry.

The term “enculturation” is a concept developed within anthropology. It suggests that an individual learns values, behaviors, and processes inherent to a culture through learning without specific teaching. There is no deliberate intention to teach individuals particular facets of a culture; a network of parents, peers, and other adults influence a developing individual. This becomes important to the discussion of globalization and plays a large role in conceptions of mental health.

Lastly, what is meant by “culture?” Defining and understanding this term becomes difficult. The "old" cultural psychiatry operated under the pretense that culture was conceived of as a homogenous field in which each individual internalized collective representations. Within this conception, mere samples of beliefs and practices of individuals would be enough to characterize a cultural system. The "new" cultural psychiatry, as referred to in this thesis, does not see culture as limited to the beliefs, knowledge, and attitudes of just individuals, but also within larger social institutions that develop rules, relationships, and practices. Psychological anthropology has largely made it a goal to understand how culture is something both external to an individual by the social context he or she resides in while also understanding the ways in which individuals

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internalize that culture. "If individuals vary in their beliefs and understanding and if social systems are comprised of many actors with diverse perspectives vying for their version of reality to dominate or take hold, then we need to study not the cultural topography but the specific dynamics of each actor's story. Culture is not simply a matter of the spatial or temporal distribution of representations, but a dynamic system in which stories have power; stories reshape our perception of the world, drive us to action, and imbue every action (and inaction) with meaning."6

**The Subjective Within Cultural Psychiatry**

My personal story has connections to three issues cultural psychiatry is recognizing as problematic for the contemporary mental health patient. The first is in a lack of enculturation. The second is various treatment methods coming to coexist. The third is in symbolic actions of treatment methods that affect efficacy.

"In the contemporary world, migration, telecommunications and mass media have made such cultural variations not simply a matter of intellectual curiosity, or a source of scientific hypotheses about the nature of healing, but a practical concern for clinicians seeking to provide effective care to an increasingly diverse population. Indeed, this is not only an issue for newcomers but a feature of the general population."7 Within cultural psychiatry, there is an emphasis on understanding how those who migrate can be fairly and effectively assessed in new cultural systems without ethnocentric biases. But my story is not one of migration. Globalization does not just present issues for those who

migrate, but also for those who have never left home. "We need new models to understand the potential effectiveness of culturally based healing in a world in which cultures are in constant flux, transformation, and hybridization. This new level and intensity of change means that individuals do not have the same degree of enculturation through childhood building up intense and effective associations and also that social groups do not have the same degree of cohesion." Cultural psychiatry is beginning to take notice that as cultural associations are weakened due to a lack of enculturation, an invariably large effect on conceptions and treatments of mental illnesses also results.

"In multicultural urban settings, we face situations in which many people have only a shallow connection to a tradition and healing practices themselves undergo creative change and hybridization." If the effectiveness of a healing method is dependent upon shared cultural background or acts, it may be reduced as many individuals now move between and are affected by different cultural worlds. The coherence of traditional systems of healing and their links to an underlying culture are becoming challenged and strained in the contemporary world. As globalization continues to accelerate with more technological advancements, there is a continued importance to understand how individual cultural associations are affected. This is especially important to the field of psychiatry as conceptions of mental health are culturally constructed and can be largely affected by a lack of enculturation and shallow connection to tradition.

I can identify with this lack of enculturation, lack of cohesion in social groups, 

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8 Ibid., 45.
9 Ibid., 44.
10 Ibid., 45.
and shallow connection to tradition. As a child, I was surrounded by the medical field, my religious group, and my aunt's belief in extrasensory perception. Additionally, I have Ukrainian heritage; my paternal family is full Ukrainian, with my grandmother and grandfather's generation emigrating here from Ukraine. As a child I was dressed up in traditional clothing, my family cooks Ukrainian food for the holidays, and my grandmother has many *pysanka* (Ukrainian Easter eggs with traditional symbols, patterns, and motifs) around her house. I know very little about the traditions of my heritage. My childhood provided myriad perspectives of various belief systems, yet my connection to each is shallow. This has an effect on the way I have come to perceive of mental health, and is a key factor in how I seek out treatment.

So, how do patients decide on what method to seek out within multicultural societies? As healing systems come to coexist, patients become self-guided by playing active rather than passive roles during healing processes and by choosing what is relevant to their needs. Some choose a method because its tradition; the specific method is part of a larger system of values or a way of life they are invested in. It is assumed that if a treatment exists for a long period of time within a system, it must be effective, even if it is harmful or maladaptive in some respects.\(^\text{11}\) Some come to view alternative or traditional methods in a romanticized way; it becomes a novelty for them and they come to idealize the exotic.\(^\text{12}\) Or, patients seek out methods as a last resort when biomedicine has failed to help them.\(^\text{13}\)

Presently, I do not fit into any of these categories. The conventional treatment

\(^{11}\text{Ibid., 44.}\)

\(^{12}\text{Ibid, 45.}\)

method within North America for mental illness is medication and/or therapeutic options. I do not deny that pharmaceutical drugs are effective for many people, but when I was told to take them I had to be warned about the possibility of suicidal thoughts. Upon my own research into the medications prescribed to me, I read many accounts of people who were negatively affected by them, or had loved ones that actually did commit suicide. People talk numbers, about how more people are positively affected than negatively affected, but there is no denying this treatment method can have serious side effects that I do not want to deal with. I do not hold any sort of romanticized idealization of alternative or traditional methods, and even after therapy failed me I still could not get myself to seek out another method. Why was this?

In an article entitled “Globalization, Cultural Psychiatry and Mental Distress,” feelings of disappointment, despair, disillusionment, and alienation are discussed. Disappointment and despair are said to come from expectations and a failure on the part of the individual and society to achieve such aspirations. Disillusionment and alienation are said to come from the knowledge of newer therapies, which may not be accessible, or a disparity of services. In relation to my own experiences, I can identify with a sense of alienation from a disparity of services. When others see various treatments as something new and exciting to try, I feel a sense of detachment in something I feel no strong connection to. My own feelings of despair do not necessarily come from aspirations or expectations that were unmet. I particularly felt more critical and judgmental going to my therapy sessions, but feelings of disappointment still resulted when there was a failure to receive anything valuable from it.

14 Mastrogianni and Bhugra, “Globalization, Cultural Psychiatry and Mental Distress,” 164.
In review, there is a range of services available to me in biomedicine, therapeutic options, and alternative methods. Yet, my exposure to different social groups with different beliefs, and my shallow connection to tradition have made this disparity generate feelings of despair and alienation. When I don't feel like I conform to any one set of beliefs, it directly affects the way I view and seek out treatment. But so far, all of these largely have to do with my own personal *expectations* as a result of living in an urban, multicultural society. How then, can this be said to affect the actual process of healing treatments? How do some people gain meaning and efficacy out of specific treatments and others do not? As cultural psychiatry is concerned with the social and cultural implications of mental health, there is a gravitation towards using a symbolic healing model to understand the sociocultural symbols within treatments and how those gain meaning for patients. This leads into the next chapter, which focuses specifically on Victor Turner's explanation of symbols in his processual symbolic analysis.
CHAPTER THREE: PROCESSUAL SYMBOLIC ANALYSIS

An Introduction

Victor Turner was a cultural anthropologist who focused on symbols, rituals, and rites of passage. He started his symbolic studies specifically within rituals, but eventually came to study symbols within all social actions in general. This shift led him to develop a type of investigation called processual symbolic analysis. “Processual symbolic analysis is concerned with the interpretation of the meaning of symbols considered as dynamic system of signifiers, signifieds, and changing modes of signification in temporal sociocultural processes.”15 Turner's system was more than just a symbolic study of social actions and rituals because it understood that processes within cultures were bound to change in time. Turner emphasized that social meanings could not be taken for granted any longer and a continual assignment and reassignment of meaning was needed.

Key Terms

"Ritual" and "performance" are central to this discussion. The descriptions of each are in accordance with the way Turner came to understand them and apply them to his writings. He used Erving Goffman's accounts of performance, believing that all social interaction is staged whether consciously or subconsciously based on a cultural tradition of social interactions. Goffman himself defines performance as "all the activity of a given participant on a given occasion which serves to influence in any way any of

the other participants. Taking a particular participant and his performance as a basic point of reference, we may refer to those who contribute the other performances as the audience, observers, or co-participants. In relation to this discussion, a therapy session would then be seen as a performance. There are two roles being played, the patient and the therapist, which act as co-participants within the performance. Both enact a sociocultural interaction and affect one another. The roles are constructions that have been created to reinforce one another’s position within the performance. The therapist influences the patient by trying to help her, asking her personal questions, and listening to her. The patient reinforces the therapist’s role by talking to him, answering his questions, and being receptive of his advice. When both act out their roles accordingly, the process becomes a culturally constructed treatment method.

Turner drew from Ronald Grimes, a scholar focused on studies of ritual, in understanding "ritual" as a "transformative performance revealing major classifications, categories, and contradictions of cultural processes." Turner saw ritual as the performance of a complex sequence of symbolic acts. The performance of complex symbolic acts makes many alternative and traditional healing methods determined as “rituals.” They develop a succession of actions that hold symbolic meaning, transforming someone from an ill patient to a healed person.

The “efficacy” of treatment questions if a healing method is successful. What determines “success” is difficult to ascertain. Healing methods have a common concern

17 The therapist is described as male, and the patient as female in relation to my video installation. A distinction between genders became important for formal considerations in my artwork and is described in Part II.
to alleviate suffering, but the effectiveness of healing is judged against its ability to achieve goals that vary widely across different settings. Epistemological questions about our certainty that something works are also raised. Efficacy is judged on ethical and aesthetic values about what constitutes a positive change, improvement, health, or well-being. This means individuals will invariably perceive the effectiveness of a treatment based on personal value judgments.

Cultural Psychiatry in Processual Symbolic Analysis

I refer back to Kleinman for a moment with his outline of the three basic stages of healing rituals. Stage one is labeling illness with an appropriate cultural category. Stage two is manipulating that label through a cultural transformation. Stage three is applying a new label (well) as a meaningful symbolic form. Stage two, the treatment stage, is seen as a metaphor. It is the vehicle by which a person transforms from stage one, feeling ill, to stage two, feeling healed. All treatment methods can be seen as metaphors that reflect social behavior, conduct, and action. But how do some gain meaning from specific processes and others do not?

Turner recognized the critical importance of meaning and symbolization. He referred to symbols as units of rituals. These include objects, activity, relationship, word, gesture, or spatial arrangement. Meaning comes from and is stored within these symbols, both verbally through speech and nonverbally through ritual. They are posited by the framing culture between signifier (symbol-vehicle) and signified(s). This leaves

20 Ibid, 42.
21 Kleinman, Patients and Healers in the Context of Culture, 372.
symbols open for interpretation wherein the meaning is not absolutely fixed. Signifiers then may not always produce symbolic meaning for everyone. In addition, subjective responses become important. "Individuals may add personal meaning to a symbol's public meaning, either by utilizing one of its standardized modes of association to bring new concepts within its semantic orbit (metaphorical reconstruction) or by including it within a complex of initial private fantasies."\(^{23}\)

Thus, the performative or ritualistic activities presented in healing methods are sociocultural processes that gain meaning through symbols. If an individual feels a shallow connection to tradition and has been influenced by many different social groups with various beliefs, how then is she to view symbols within treatment methods? If the signifiers presented within various healing methods never gain significance for the patient, they therefore cannot be seen as symbols and lack any relevant meaning in the process for the patient. It becomes a process in which one merely goes through appropriate actions, yet never attains an effective treatment.

Turner's investigation within processual symbolic analysis becomes important within this dissuasion. Because cultures are bound to go through changes as they exist in the world, there is a need for continual assignment and reassignment of meaning. He saw this to be important for various reasons including reinterpretation or redefinition of rules and relationships or, to change the character and structure of common sense. The latter of these is central to this discussion. While it seems obvious that many people in our contemporary world will be affected by a variety of different perspectives as a result of increased globalization, the effect it has within psychiatry does not seem to be largely

\(^{23}\) Ibid., 77.
understood or focused on.

**In Conclusion**

To summarize the information presented in Part I, a lack of enculturation, shallow connections to tradition, and an exposure to various social groups have profound affects on mental health patients. When a disparity of treatment methods is presented to them, they feel alienated in the variety because they do not have an intense connection to any of them. This lack of connection directly affects the way they view symbols inherent to various methods, and leads to a lack of significance within them. When signifiers fail to operate as symbols, meaning is then lost within the process, making the treatment method ineffective.

These are some of the concerns relevant in the discussion of contemporary psychiatry. My subjective accounts function to convey just one perspective of a person with a mental disorder in our present time. There are many other factors that would influence other patients’ experiences and affect their views. The information provided under Part I will be translated into the contemporary art world and my personal art practice in Part II.
PART II:

AN ARTISTIC PRACTICE ON MENTAL HEALTH
INTRODUCTION TO PART II

Why do I make my work? How do I see it fitting into the contemporary art world? Many contemporary artists deal with social, cultural, and political effects of globalization, post-colonialism, or creolization. Many artists do so in a number of ways relating to a number of different fields. I see myself as such an artist with a focus on the sociocultural aspects of mental health. The field of cultural psychiatry is just coming to understand and pay attention to the effects of globalization on mental health. As more people are diagnosed with mental disorders, this is an important and relevant discussion to bring into the art world. I use the information provided in Part I of this thesis as the basis for my conceptual ideas in my video installation. Through my artwork, I intend to provoke a discussion on the current issues presented in the field of psychiatry.
CHAPTER FOUR: ARTISTIC INFLUENCE

Many artists have focused on the theme of mental illness in their artistic practice. I am interested in how other artists use personal stories to reflect larger cultural concerns. The context from which their artworks emerge involves conceptions of mental health throughout history. Art, therefore, can be seen to play a critical role in reflecting cultural constructions of mental health. I provide a brief history of artists who have contributed to this lineage in order to understand how my work adds to that progression.

Franz Xavier Messerschmidt was an 18th century artist who created a body of sculptural busts called *Character Heads*. Little is known about the artist and his intentions for this body of work. Many have speculated about what the overly exaggerated facial expressions were intended to convey, but no one knows of Messerschmidt’s intended purpose. The year 1770 marked a definite observable turn in the artist’s personality. Colleagues described a change in his demeanor as, “confusion in his head,” leading many to believe he suffered from a mental illness. This marked the beginning of Messerschmidt’s production of *Character Heads*.

Many 18th century artists were influenced by Charles Le Brun’s theory on facial arrangement. Under this theory, the physical arrangement of the face is derived from the activity of the soul. “Because of its proximity to the pineal gland - located in the brain and the reputed-resting place of the soul - the face displayed subtle shifts in the soul’s
status and there held a privileged relationship to it in comparison to the body.”

Many 18th century artists had an interest in creating readable language of the passions by manipulating facial expressions. Messerschmidt exaggerated his *Character Heads* to such an extreme that the facial expression became difficult to read. The unconventional character of Messerschmidt's busts, in relation to the other artists in his time, must have equally reflected his unconventional character, leading people to believe he was insane. Friedrich Nicolai, a German philosopher, wrote texts claiming Messerschmidt reported visits from the “Spirit of Proportion” that tormented him with pain, and so thought his busts were a recording of that pain. Messerschmidt's *Character Heads* then reveal personal expressions of his mental distress as well as cultural constructions of the time period of what it meant to be mentally ill.

Around 1900 in Vienna, Sigmund Freud had a profound effect on artists as he pioneered new ideas about the self and psychiatry. Visual arts were linked to practices and spaces of psychiatry and to mental illness as filtered through both psychiatry and popular culture. The range in which artists engaged with mental illness during this time, from cure and control to celebration and imitation, was linked to Viennese society’s fascination with, and deep ambivalence towards, mental illness and its treatment. Psychological portraits, art for teaching tools of mental health issues, and artists that provided subjective accounts of mental disorders provide a range of artistic practice to reflect the growing interest in the emerging field of psychiatry.

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In 1911, Max Oppenheimer depicted the novelist Heinrich Mann in a state of nervous enervation with flickering eyelids and rigid limbs. Jean-Martin Charcot, a psychiatrist, developed a collection of photographic journals on the study of mental illness from 1888 to 1918. The artist Josef Karl Radler spent most of his life as a patient in psychiatric institutions near Vienna working on double-sided watercolor paintings reflecting his life in asylums.

This group of artists reflected the growing cultural interest in psychiatry as the field was just starting out. At the time, therapy was still in its infancy and there was an ambiguity of analyzing and observing mental illness.26 This can be seen in the range of artwork that emerged from Vienna in 1900 to explore the new conceptions of psychiatry in a variety of ways.

In contemporary artistic practice, the term autopathography has been applied to artists using ideas of personal illness within their artwork. Although there is no exact definition of autopathography, it is generally employed with reference to biographical accounts of illness or suffering that take a literary form.27 The visual arts are now applying this term to performances, art objects, photographs, and other media to convey their personal stories. The resulting art works do not just function on a therapeutic level for the artist, but beyond that by articulating political, aesthetic, and metaphysical positions in relation to lived experience.28

Bobby Baker is a contemporary artist who makes autopathographical artwork. I focus specifically on her *Diary Drawings*, which are drawings that were made during the

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26 Ibid., 167.
course of her treatment for mental illness from 1997 to 2008. She emphasizes her reactions to the various treatments she received and documents them through her art in the midst of mental crisis. The drawings show the progression of her thoughts as she starts her therapeutic endeavor and eventually overcomes her illness to return to health. Baker’s artwork is largely centered on her personal story and struggles with mental illness. Her work does however reflect cultural implications that are important to Britain, where she resides. The incidence of mental illness is rising and is speculated to rise further in societies like Britain, which are facing numerous social changes. There is presently an importance in the training and response of health workers. The Diary Drawings reveal how the interactions between the members of the group in therapy, whether doctor or patient are critical in the healing process. By giving accounts of her personal stories in treatment, Baker highlights the delicate relationship between patient and doctor that becomes a crucial dimension of mental health treatment.

By relating my conceptual ideas within my artistic practice to contemporary concerns within cultural psychiatry, I see my artwork adding to this progression of artists. Art clearly reflects constructions of mental health in the way it is perceived in different contexts. The field of psychiatry will always continue to progress and decipher constructions of mental illness and treatment in different ways. Due to the field’s current interest in understanding the effects of globalization on mental health patients, and the perception and generation of meaning through treatment methods, my artistic practice achieves relevance by reflecting these continued considerations.

CHAPTER FIVE: THE AESTHETICS OF DISSOCIATION

Christine Roth, a professor of art history, has recently developed her theory on *The Aesthetics of Disengagement*. Ross draws from studies, which declare more than half of the world’s population will have a depressive disorder at some point in their lifetimes. She states that art, a highly subjective field, must be affected by these high rates of depression.

She sets out to understand a trajectory of contemporary art that highlights depressive enactments. These are particularly geared toward performance and media arts where both the subjects (characters, individuals, performers) and the formal structure of the work showcase the patterns of depression. Such qualities may include slowing down, near immobility, opacity, looped repetition of the image, withdrawal or communicational rupture. She explains that these traits are both attached to the subjects within the artwork and also devitalize the relationship between the viewer and the artwork. For Ross, the disengagement that is inherent to depressive disorders is where contemporary art and depression meet. She states, “The disengaging symptoms of the depressed [are]…the withdrawal into the self, the radical movement of protection of the self from the other, the subject’s signaling to “keep my distance,” the…sense of isolation, the rupture of communicational intersubjectivity, perceptual insufficiency. The artistic reiteration of depressed disengagement, I contend, transforms disengagement into an aesthetic strategy of disclosure of the ways in which individuality and depression intertwine today; more
important, it uses disengagement to reach the depressed viewer.”

Ross raises the question, can an artistic practice rooted in depressive enactments be critical? And should it be? She explains how sufferers draw on discourses to give meaning to pain and then explains how mental disorders are human constructions. They exist in culture, yet cannot be reduced to culture. With this understanding, artists can then help add to the discursive debate on depression and do so in significant ways as artists produce their own subjective employments.

Ross does not wish to make a generalized statement about all of contemporary art and does not wish to merely provide an analysis on artworks that take depression as their theme. Rather, she “wants to show that contemporary art cannot be isolated from the depressive paradigm, [and] attempt[s] to historicize the subject contemporary art represents, performs, assumes, and addresses”

Ross specifically relates her theory to depression, as it is a widespread disorder affecting many people. I do not rely solely on depression in the discussion within my work, but I do believe that in the number of people who struggle with it, there is an importance in bringing my discussion on treatment methods to that population. My work reflects some of the disengaged qualities Ross points out. The patients within my videos are isolated and have communicational disruption, which sets up a spatial distance between the patient and the viewer.

My work is intended to function in a way similar to Ross’ summation. She believes that art has a subjective quality that adds to the discussion of mental health that

\[31\] Ibid., xviv.
affects so many people presently. This subjective quality does not necessarily need to be one that focuses on the artist and her experiences specifically, making that the main intention of the work. Rather, she saw that the formal qualities presented within work could evoke an important conversation in the present about the nature of mental health. This is how I intend my art to function. There are subjective qualities inherent to the work, but they lead to larger discussions of contemporary cultural psychiatry.
CHAPTER SIX: THE VIDEO INSTALLATION

Upon walking into the gallery the viewers will see the first video, entitled *Treatment Method #1*, projected onto the wall in a trapezoidal shape. Directly across from the projection sits a light blue couch. Within this video, there is a red couch, an end table, a glass of water, and myself all placed within a dark, black, space. Throughout the video, I go through the motions of a therapy session. I appear to be expressing a dialogue that causes me distress, but my words cannot be heard. It is only when I can visually be seen to stop talking that an audio component can be heard of a man's voice saying one of the following: "that must be really hard to deal with," or, "how did that make you feel?" I appear to give responses to the audio, but these responses are always muted. At times, I will reach over to take a sip of water from the glass on the end table. The video is looped to make this process go on indefinitely. The entire scene is shot from one perspective that is directly in front of the couch.

When the viewers leave the first room to continue through the gallery, they will walk through a small "L" shaped hallway. When coming out of the hallway into a larger room, the second video, *Treatment Method #2*, is seen projected onto the wall in a trapezoidal shape. A grey couch is placed in front of the projection next to an end table that has a glass of water and egg on top of it. The scene in the video is set up in the exact same way as *Treatment Method #1*. There is a red couch, an end table, a glass of water, and myself all set up within a black space. Within this video another person is seen rubbing an egg all over my body. After the process of rubbing the egg along my body, he cracks it open into the glass of water on the end table and watches to see how the yolk
will react in the water. He then gets another egg to rub it along my body again. This
series of actions is again shot from a single perspective, and looped to make it an
indefinite process.

On the wall perpendicular to the second video is the third and final video entitled,
*Undetermined*. In this video I am sitting at a table, again within a black space, and have a
glass of water in front of me. This video is also projected onto the wall in a trapezoidal
shape with a table butted up against that wall to make it appear as though the figure is
sitting at the end of the table. At the other end of the table sits an empty seat for viewers
to sit directly across from the projection. Within this video I reach outside of the frame to
the left or right to pick up either an egg or a pill. With the egg, I sometimes crack it into
the glass to watch how the yolk reacts in the water, similar to the process in *Treatment
Method #2*. With the pill, I sometimes swallow it with a sip of water. These are the
intended ways to use the egg and pill for the purpose of a healing treatment. Throughout
the video, I begin to mix the appropriate procedure for both of them. When I crack the
egg into the water, instead of watching for the reaction of the yolk, I drink it. When I
reach for the pill, I open the capsule and release the contents within the glass to see how
they will react in the water. At times I use the objects central to healing in their intended
ways and other times hybridize it with that of the other healing treatment. This process is
again put on a loop.
CHAPTER SEVEN: EXPLAINING THE VIDEO INSTALLATION

The Subjective

The subjective is presented within these videos based on my past experiences and heritage. Healing Method #2 is the traditional egg healing ritual of my Ukrainian heritage. It is a traditional folk ritual that is still practiced today in Ukraine by healers who are taught through tradition. The egg is moved in clockwise circles along the patient’s body and plays two important roles within the process, it extracts the malady and acts as a diagnostic tool. As it comes into contact with the afflicted part of the body, the egg becomes heavier at which point the healer will crack it open into a glass of water. The location and color of the egg white filaments give insight to the healer as to what is wrong with the patient. They also tell the healer any additional course of healing to take such as dietary modifications, massage, or changes in behavior, but some have reported feeling better for both physical and mental ailments directly after the ritual.

Although I do not have strong connections to my traditional heritage, and no connection at all to this ritual, I have been surrounded by the pysanka (Ukrainian easter egg) my entire life. Even though I do not fully understand the symbols within the psyanka, I have a connection to the egg in a way that most people in my culture do not. To me, it symbolizes my heritage and holds significant meaning in thinking about the traditions of my close-knit family. However, the Ukrainian tradition of this ritual is largely seen as a spiritual one, believing that the egg has the ability to draw illness out of a body and give knowledge to a healer on the sickness within the body. There is not
enough significance for me to believe an egg has the power to do that through a healer. Due to my exposure to various social groups there is a desire to believe so, but that desire becomes clouded by the scientific medical beliefs I have been exposed to.

These videos also draw upon my experience with going to therapy. Through continued sessions, I began to sense my therapist had little interest in my stories as she always gave me the same responses. "That must be hard to deal with," or "tell me how that made you feel." I felt like my stories were irrelevant and she didn't much care to have a sincere interaction with me. I felt as though anyone could be sitting in my place and she would react the same way, making me feel extremely insignificant in my problems.

These formal considerations play a large role in the connection to my own personal perspective. As stated earlier, personal stories gain significance, and the viewers who come to my work will inevitably have much different ones than mine. So, how are they to react to my work?

The Viewer’s Experience

These three videos comprise the installation and are intended to be seen as a whole. My artwork takes on popular characteristics of installation works, as viewers build up information from all three videos as they walk through the gallery space. Installation artworks are participatory sculptural environments in which the viewer’s spatial and temporal experience with the exhibition space and the various objects within it forms part of the work itself. These pieces are meant to be experienced as activated spaces rather than as discrete objects; they are designed to “unfold” during the spectator’s
experience in time rather than to be known visually all at once.\(^{32}\)

Walking into the first room, viewers will encounter *Treatment Method #1*, which mimics a therapy session. The couch presented in the room encourages viewers to sit down directly across from the projected video. This immediately encompasses them into the therapeutic atmosphere. They are no longer in the position of just being an outside viewer to the artwork, but become activated in his position within the space. They are at once both a viewer and co-participant within the performance. As I convey unheard information, they are seated in the position of the therapist, as though I am talking to them. Even if they have not experienced a therapeutic session before, they are still culturally conditioned to understand how the process works in general. They may have absolutely no connection to the process, but still understand it and its intention due to this culture’s convention of it.

Upon walking through the gallery viewers are then confronted with *Treatment Method #2*. This method has the same exact set up. There is a couch that sits across from the video projected onto the wall. In the viewers actual space, they appear to have the same process available as they sit on the couch, next to a glass of water and egg. Yet, the viewers are largely ignored in this method. They are an outsider to it, and ignored by the patient and healer in the video. With the similar formal compositions and spatial set up as *Treatment Method #1*, the viewers conclude they are observing another healing method even though they may be largely unaware of how it functions or what its significant meaning is. Their associations with the egg, which is central to the process,

\(^{32}\) Kate Mondloch, *Screens: Viewing Media Installation Art* (Minneapolis: University of Minnesota Press, 2010), xiii.
are most likely very different, giving them little to connect with in the ritual. There is a strong contrast here in the familiarity of the first video with an understanding of the process and the feeling of alienation within the second.

The third video, *Undetermined*, encourages the viewers to sit across the table from the projection. The glass of water that was present in the previous two videos at this point becomes familiar to the viewers. They also see the egg come into the process, which they can draw a connection to from the second video. Even though they may not know the direct intentions of what the egg meant within the healing method, they can acknowledge the importance of it to that particular ritual. The pills also become recognizable. Although they are not informed as to what kind they are, their previous viewings leave them to deduce that it is intended to get well in some way. They are also culturally conditioned to understand how they function. They are now seated across from a person who is performing absurd actions as the functionality that is intended for each of the objects become mixed with one another. In all of these videos, viewers are urged to consider their relationship to each of the methods. By placing them in the spatial layout of the installation, inherent beliefs will generate viewers’ own relationship and response the distinct methods.

**Douglas Aitken**

I was largely influenced by Douglas Aitken’s *Electric Earth* for the spatial layout of the three videos. This is a fictional narrative of a young man as he journeys through a deserted Los Angeles landscape at night. The installation is comprised of eight different screens that are spread out across three or four conjoining rooms. This was one of the first video installations I had experienced and is largely what got me interested in video
installation. One of the many things that intrigued me about his work was the way in which I experienced it and came to build connections within the storyline. This is one of Aitken's main intentions. He is interested in going against the structured quality of linearity that is inherent to video. He questions how he can collapse or expand time so that it is no longer confined to one narrow form. This had a strong impact on me. I was first presented with the option of entering the space from either side. Upon entering, I quickly started to question if I had entered the appropriate side. Within one room there were two to three videos that played off of each other at times, and other times seem to have an unrelated part of the story intermixed. There was a considerable amount of confusion, yet the way in which the videos would play off of one another at intermediated times kept me interested. I wanted to build the story. I wanted to go back through the rooms after having gained information from my first time through. The man within the videos was clearly journeying to some unknown place, and seemed to be completely caught up in himself. It became interesting to me as a viewer then, to be journeying through my own actual space in relation to his projected journey.

My videos function differently from Aitken's in that they do intend to follow a linear sequence. In fact, the spatial arrangement of my videos within the space forces the viewers to see them in the sequence I have laid out. The viewers are guided along the gallery, removing their choice of what to see first, middle, and last. However, like my experience with Electric Earth, there is a considerable amount of fractured information that the viewers must come to understand as they progress through the space. When the viewers walk into the gallery, they develop a certain kind of relationship to the first video

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33 Ibid., 49.
that falls in line with an understanding and acknowledgement that this is a conventional treatment method. As they walk out of the gallery, they will have new connections to the composition of the video. No longer is it just a therapeutic process, but one that connects the process of *Healing Method #2*, and the function of the water glass from *Undetermined*. Although separate, the viewers draw relationships between the two processes. They now see the video in a new way through the connections to the other videos, no matter how shallow those connections were.

**Space**

The actor within the videos is in a black void, which represents a psychological space. She feels stuck in it. In her head. The minimal objects within the space represent symbols central to the healing methods she is carrying out. The most important factors, aside from atmosphere, are provided yet the patient resides in the black space, never to finish the process. Therapy sessions rely on talking and presenting the patient with a place they feel comfortable in. Although the atmosphere is removed from the video, the key elements in a couch, and an end table for a glass of water are representative of the comfort therapists seek to give their patients.

The differences in couch colors hold significance in the virtual and actual space. In the virtual space presented of the projections, the couches are a brightly saturated red color. As this represents the psychological space in the patient’s mind there is an intensity that is brought to the space through the stark color. This intensity is in strong contrast to the calm blue and neutral grey colors of the couches in the gallery. The actual couches operate in accordance to how therapists use color symbolism in their offices. They often use neutral colors to produce a calming atmosphere to put the patient at ease.
The trapezoidal shapes of the projections operate in a similar manner to the color symbolism. Healing methods have the intent to alter an “ill” mind to a “healed” mind. What one views as sick and healthy in mental health is in direct relation to the culture a patient resides in. As viewers in the gallery space look at the trapezoidal shape of the projection they have an immediate sense the frame created by the edges of the projection are skewed. There is an expectancy to watch the video in a rectangular format because this is how conventional formats of video and film are viewed in. As the viewers then sit on the couches and chair within the gallery space, there is the sense that something is off in viewing the videos that needs correcting.

The voice that is heard in Healing Method #1 is recognizable as a male. Since the dialogue the female patient is expressing is muted and the black atmospheric space represents a psychological state of mind, there is a need to show a recognizable distinction between patient and therapist. Put more clearly, it is important that the viewers understand the performative quality that emerges through patient-doctor dialogue in a therapy session, and that the video is not viewed as a completely psychological state where the patient could simply be stuck in her mind having an internal dialogue.

As expressed earlier, psychologists are interested in understanding how individuals internalize the external social world they live in. The black space is a method to show this. It is the way I perceive of my multicultural society, and come to feel lost in it, going through the actions without getting results.

Screen-Reliant Installation

The psychological space in the videos and the actual space of the gallery become both separated and unified through the screen. Kate Mondloch has developed what she
calls screen-reliant installation. Artistic screens have long been talked about before media art. Leon Battista Alberti's formulation of the canvas/screen as a window that opens into a space "beyond the frame" dates to the fifteenth century. Camera obscura images also positioned their observer in front of "screens" of various kinds. The conversation on screens in media generated art is not a new one, but rather a continuation of the discussion. Mondloch discusses the viewer-screen interface as that which connects the viewer and the mechanisms for screening, which could include film, camera, projector, and screen.

Media screens made initial forays into art galleries as early as the late 1950's. However, the incorporation of mass media screens into art environments or installations in the mid-1960's marked a distinct shift of emphasis. With screen-reliant installations, artists were newly concerned with the viewer screen interface itself: the multifarious physical and conceptual points at which the observing subject meets the media object. This means that media installations have the dimensions to generate a tension between illusionist/virtual and material/actual spaces. The viewer is urged to consider and acknowledge both their physical space in the gallery as well as their relationship to the illusionistic space in the screen. "In a curious amalgamation of gallery-based spatial experimentation and political aesthetics, this model of spectatorship proposes that the viewers be both “here” (embodied subjects in the material exhibition space) and “there” (observers looking onto screen spaces) in the here and now."35

34 Ibid., 2.
35 Ibid., 62.
VALIE EXPORT

VALIE EXPORT’s film installation, *Ping Pong*, created in 1968, is an example of the “here” and “there” spectatorship. This consisted of one half of a ping pong table abutted against a wall, a paddle and a ping pong ball. On the wall, a video was projected of large black dots that would slowly appear and disappear. *Ping Pong* invites viewers to play the game against the moving targets.

The game the viewer plays is both imaginary and actual. The viewer’s opponent is imagined “inside” the illusionary screen space and yet the game actually takes place in real space. The immaterial dots of projected light emerge from inside or beyond the screen. The actual ball’s automatic return from bouncing off of the screen situates the spectator back into the actual gallery space and confirms the screen’s material flatness.

My video installation functions in a similar way. In all three video arrangements, the viewers are situated in the physical space of the gallery in a way that makes them consider their relationship to the individual in the illusionistic space of the videos. They are “here” in the gallery space, sitting on the couches or chair developing connections between all three videos. They are “there” in the continuation of illusionistic space of the videos to place them in an atmosphere that makes them consider their relationship to each healing method.

Time

By putting the videos on a never-ending loop, the results that are strived for are never reached. The patient continually feels stuck within the psychological space of her mind. This shows that there is a desire to heal by the continual repeated processes that are central to healing methods, without ever fulfilling those desires to be healed. Efficacy
is never reached in her psychological mind, leaving her to continue to feel lost and disconnected from the process she seeks help from.

**Performance Within Video**

The healing methods within these videos are not seen as actual points in time when a healing method was conducted for efficacy, but rather a reenactment of the processes. By doing this, and setting it up within the black space, the viewers are forced to focus on the symbolic objects and processes. *Treatment Method #1* and *Treatment Method #2* show these objects and processes, as they are intended to function within each healing method. They never come to hold significance for the patient though, as she continues the process never to stop. Although they are intended to act as symbols, they merely become signifiers, never producing any sort of meaning for her.

The patient shows certain knowledge in both the intended function of the pill and egg as relative to their cultural positioning. As stated earlier, the patient now plays an active role rather than a passive one. It is up to her to seek out treatment, as the patient becomes largely self-guided in multicultural societies. She swallows the pill and cracks the egg into the water, as the original function would have her set out to do. The two processes begin to merge though as she reverses these functions. At times, she will release the pill capsule into the water only to view the contents and never ingest them. At other times after she cracks the yolk, she swallows it as she would the pill. Her understanding of each becomes convoluted as both of these come to coexist for her. As she interacts with one of the symbols, she cannot separate and distinguish it from her connection to the other, making each one lose meaning and efficacy.
CONCLUSION

This thesis reflects current concerns within cultural psychiatry that affect the contemporary mental health patient. I have given both a subjective and objective account of reactions to an intensely globalized world and showcased the importance given to efficacy in treatment methods.

I follow up with one more artwork to be discussed. It is obvious that the process of carrying out a thesis may cause significantly more stress to some people. I have become affected by this high stress period, regressing into my symptoms in a way that has been extremely difficult to deal with given the issues discussed in this thesis. This high stress period will reach its peak during my oral defense, and is the setting for my final artwork.

_I Want to be Better_ is a performance piece in which I defend my thesis body of work. I will be in the role of a graduate art student who is expected to effectively and coherently communicate my body of work. The setting of the performance places me in front of an audience comprised of twenty-five graduate art faculty. As outlined by Goffman, both the role of the performer and the audience member will be influencing one another in how they contribute equally to the dialogue at hand.

I assume a dual role in this performance. Along with my role as a graduate art student, I also will be in the role of a person diagnosed with a mental disorder for which I can find no effective help. The symptoms of my anxiety disorder and depression will be
further exaggerated when placed under a high stress situation. Nonetheless, I will continually attempt to hold my composure in the role of a graduate student defending her thesis.

Laurie Anderson conducted a similar process in her performance entitled, *For Instants*. Within this performance, Anderson’s work included a description of its own making. She described the hopes and failures of the work she intended to present. For Anderson, this provided not one past, but two in what actually happened and what she said happened.36

My intention with this performance is not so much one of past considerations, but of the future. As I have become even more affected by my diagnosis through this process, I have become increasingly interested in different ways I can use my own experiences to raise larger cultural discussions on mental health. Instead of reenacting performances, I am interested in using my self and real experiences for future artistic endeavors. I find it important to do more than simply focus on my personal struggles with mental illness and treatment, and rather continue to find effective ways to use these experiences as catalysts to evoke a discussion on important psychiatric issues in our contemporary time.

BIBLIOGRAPHY


APPENDIX A

Diagnostics and Statistics Manual IV:

Major Depressive Disorder

The essential feature of a Major Depressive Episode is a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. To count toward a Major Depressive Episode, a symptom must either be newly present or must have clearly worsened compared with the person's pre-episode status. The symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

For some individuals with milder episodes, functioning may appear to be normal but requires markedly increased effort.

The mood in a Major Depressive Episode is often described by the person as depressed, sad, hopeless, discouraged, or "down in the dumps" In some cases, sadness may be denied at first, but may subsequently be elicited by interview (e.g. by pointing out that the individual looks as if he or she is about to cry). In some individuals who complain of feeling "blah," having no feelings, or feeling anxious, the presence of a
depressed mood can be inferred from the person's facial expression and demeanor. Some individuals emphasize somatic complaints (e.g., bodily aches and pains) rather than reporting feelings of sadness. Family members often notice social withdrawal or neglect of pleasurable avocations.

Appetite is usually reduced, and many individuals feel that they have to force themselves to eat. When appetite changes are severe there may be a significant loss or gain in weight.

The most common sleep disturbance associated with a Major Depressive Episode is insomnia.

Psychomotor changes include agitation (e.g., the inability to sit still, pacing, hand wringing; or pulling or rubbing of the skin, clothing, or other objects) or retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering; speech that is decreased in volume, inflection, amount, or variety of content, or muteness.) The psychomotor agitation or retardation must be severe enough to be observable by others and not represent merely subjective feelings.

The sense of worthlessness or guilt associated with a Major Depressive Episode may include unrealistic negative evaluations of one's worth or guilty preoccupations or ruminations over minor past failings. Such individuals often misinterpret neutral or trivial day-to-day events as evidence of personal defects and have an exaggerated sense of responsibility for untoward events. Blaming oneself for being sick and for failing to meet occupational or interpersonal responsibilities as a result of the depression is very common and, unless delusional, is not considered sufficient to meet this criterion.
Many individuals report impaired ability to think, concentrate, or make decisions. They may appear easily distracted or complain of memory difficulties. Those in intellectually demanding academic or occupational pursuits are often unable to function adequately even when they have mild concentration problems (e.g., a computer programmer who can no longer perform complicated but previously manageable tasks.) When the Major Depressive Episode is successfully treated, the memory problems often fully abate.
APPENDIX B

Diagnostics and Statistics Manual IV:

Generalized Anxiety Disorder

The essential feature of Generalized Anxiety Disorder is excessive anxiety and worry, occurring more days than not for a period of at least six months, about a number of events or activities. The individual finds it difficult to control the worry. The anxiety and worry are accompanied by at least three additional symptoms from a list that includes restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and disturbed sleep. Although individuals with Generalized Anxiety Disorder may not always identify the worries as "excessive," they report subjective distress due to constant worry, have difficulty controlling the worry, or experience related impairment in social, occupational, or other important areas of functioning.

The intensity, duration, or frequency of the anxiety and worry is far out of proportion to the actual likelihood or impact of the feared event. The person finds it difficult to keep worrisome thoughts from interfering with attention to tasks at hand and has difficulty stopping the worry.
APPENDIX C

Artwork Described in Thesis
http://www.wellcomecollection.org/