I. Introduction

When I was born I had a “normal” corporeal body and at twenty-two years old I was clinically diagnosed with multiple sclerosis. The disease rapidly ravaged my central nervous system; I became greatly impaired cognitively, physically, and mentally. A few days after my twenty-ninth birthday I willingly entered a clinical trial for a stem cell transplant to treat multiple sclerosis. Amazingly I regained the ability to walk, think, see and function. From this reclaimed functioning I returned to college, and created art about an awareness to the social injustice of disability identity and the traumatic institutionalized biomedical experiences related to this cultural model.

My goal is to challenge dominant oppressive characterizations, remodel a globally recognized unprejudicial understanding, remove the social stigma related to “disablism,” and develop a righteous critique of power from the perspective of the injured. I will facilitate the gallery space to channel inequity into a social movement of change and explore different mediums of art as a way to respond to prejudicial misconceptions surrounding “ableism.”

Some have suggested that because I create art about disability (and I am disabled) thereby it’s “therapy” based art. Is this because the minority group I am a part of has been marginalized, stigmatized and shunned? The art I create may be inspired by the experiences I have endured, but it’s been conceptualized, aesthetized, and broadened to relate with a larger audience and not created so, “I feel better.” “Moreover, the work of many talented writers, artists, photographers and so on who
were disabled have had their work minimized or suppressed in the same way that people of color or women have experienced. The recovery of this work is only now beginning (Davis 4). First person accounts surrounding disability theory actively takes into theory the socio-cultural personal accounts of the injured, yet “lack the complex social, historical, cultural and political conditions under which the lived experiences they recount take shape” (McRuer and Mollow 55). In turn, this identity theory renders it impossible to separate it from narrative lived experiences. It is important that my art creates a social platform which actively promotes a discursiveness surrounding social injustices and prejudices surrounding “ableism” in turn generating an awareness about the objectivity to the human body occurring from bio-medicine’s biopower.

I will begin my argument by discussing what is disability identity, since it is not commonly known or misunderstood.

II. Disability Identity

In the past thirty years “disability studies” has become a cultural studies model for a developing new field of study. The largest minority group in America are “disabled,” and yet remain as the most underrepresented, oppressed, repressed in terms of social justice, freedoms and platforms. According to Darling, “the US Bureau of the Census, in 2010 18.7 percent of the non-institutionalized US population had a disability, and the numbers increase with age” (1). I would argue most of society is disabled; whether it’s glasses, an eating disorder, depression, medication, pain, etc.
When one has abnormal vision, wouldn’t they require a prescription and a device in order to obtain perfect eyesight? How is a wheelchair any different and why would it be treated differently? Disability is always present, despite its seeming absence in society. What appears to be differences among people becomes the target of power (Tremain 93).

The American Disability Act (ADA) of 1990 which constitutes a disability as “a physical or mental impairment that substantially limits one or more major life activity. This includes people who have a record of such an impairment, even if they do not currently have a disability.” Arguably the Webster’s Dictionary definition of “disablism” is “a condition (such as an illness or an injury) that damages or limits a person’s physical or mental abilities.” Most people would fit under said categorization. Why is it then society refuses to admit to their impairments? The claims about disability depend on, “discourses of ableism for their very legitimization” (Tremain 109). Most people live in fear of being discovered or viewed as “disabled” because the social stigma behind this identity is viewed negatively. “Coming out” about disability discrimination enacts power and positive images of disability (Tremain 116).

Race, gender, sexuality, and religion have been accepted by academia, print, and discourse; yet disability studies has up until recently been written, studied, and noticed. Davis exemplifies this monumental prejudicial situation, “when exceptional or disabled people do appear in literature and other artistic works, they are usually rendered as stereotypes, appearing to be more or less human” (78). Laws, scholastics, and humanity have yet to release the prejudicial hold over the “disabled” community
and accept this group as part of the human condition and existence. According to Davis “is it not time for the disability studies to emerge as an aspect of cultural studies, studies in discrimination and oppression, postmodern analyses of the body and bio-power?” (2). Darling agrees that identity politics is a process by which identities are deployed strategically to bring forth sociological change (7). While Michael Oliver argues disability is a personal tragedy, disability cannot be spoken as anything other than an anathema because it’s unfortunate event occurring at random to individuals (Tremain 109). Most of society would agree with Michael Oliver’s theory and I at one point agreed with these misconceptions about the “disabled.”

Disability identity can compound multiple forms of oppression. Since two-thirds of the disabled population are unemployed; wouldn’t this mean that they are on government based assistance? And of the one-third whom are employed wouldn’t they possibly be working a lower ranking position with a lower pay grade? A study by Johnson and Lambrinos in 1985, found more than one-third of a wage difference between the visibly impaired and the non visually impaired, could only be attributed to discrimination (Davis 173). In considering that most people who are “disabled” and working are receiving low-income due to societal environments that prohibit accessibility and acceptance of the abnormal, would they not be oppressed? And what if this disabled person was a woman or was black? The multiple forms of oppression could become insurmountable. Women with disabilities have faced “double oppression” which may magnify the salience of disability identity (Darling 5). When I became disabled I lost my house, business, money and stature. I was a highly
successful business women, with two children, married, with a home, as well as a full-time student. The government offered no assistance until I lost everything and the assistance I had finally received rendered me into a welfare state.

The basic thrust of the “minority-group” model of disability asserts that disabled men and women have been subjected to the same forms of prejudice, discrimination, and segregation imposed upon other oppressed groups which are differentiated from the remainder of the population on the basis of characteristics such as race or ethnicity, gender, and aging. Disabled persons not only have exhibited one of the highest rates of unemployment, welfare dependency, and poverty in the United States; but they have also experienced a more pervasive form of segregation in education, housing, transportation, and public accommodations than the most rigid policies of apartheid enacted by the racist governments. (Davis 174)

III. Historical Significance

The social stigma surrounding disability identity derived from “ableist” misconceptions began thousands of years ago and has remained unchanged. Throughout historical writings, the disabled minority group has been exiled, prostituted, sold into slavery, used for amusement, sterilized or killed. Infanticide was the earliest practice by the Greeks and Romans to handle those who “could not contribute”. Even Aristotle remarked in Politics, “let there be a law that no deformed child should live” (Davis 82). Infanticide was implemented out of fear from the echoing of Dr. Frankenstein’s monster might mate and produce a race of monsters emphasizes the terror with which the “normal” beholds the differences in body (Davis 15). It wasn’t until almost the fourth century that parents lost all rights over murdering their child. By the mid-eleventh century church and state law regarded the disabled, deprived of rights of inheritance, forbidden to testify in court, and forbidden to make a contract, deed, note
or will (Davis 90). By the thirteenth century, medieval Europe appeared to grant some aid to the “unwanted” by the church’s hospice care. Throughout Medieval times the “retarded, blind, deformed” were deemed as witches, insane, or the “devil” and were either caged, placed in lunatic hospitals, put on display, beaten, tortured, or burned (Davis 91-99).

Society’s model of categorization began in 1835 (during the Industrialization period) when the government first employed staticians to measure humans in hopes of improving and removing deviations and or abnormalities. The government’s goal was to create a population that was “normal” in terms of the corporeal impairments. This in turn created outliers or genetic anomalies from the bell curve model of the general population. “The rather amazing fact is that almost all the early staticians had one thing in common: they were eugenicists” (Davis 14). The goal was to create a statistical ideal to the normal curve of distribution and to create as Davis put it, “human perfectibility, and the elimination of deviance, to create a dominating, hegemonic vision of what the human body should be.” Human variations and disabilities, such as: deaf-mutism, pauperism, insanity, mental deficiency, cleft palate, hermaphroditism were merged into the same grouping because they were contributing to the disease of the nation (Davis 18). By the late eighteen hundreds, confinement, institutionalization, and dependency was the reality of the disabled. They were seen as not being able to do for themselves, a burden, and a group in need of acute constant surveillance (Tremain 83).

Disabled children are often abandoned. Female amputees are less desirable wives because they cannot work. Many employers will not hire amputees no matter how skilled they are. In some cases, male amputees have not been allowed to become Buddhist monks because they are no longer “whole. (Strauss, Between the Eyes 60)
The disabled community is still treated much like it was during the 1800's; some of the impaired being institutionalized and treated like a burden to society. Wexler agrees, “Institutional life continues to haunt us today, but with particular voracity for the poor, people of color, and the disabled. Whether we speak of prisons—which are operated closely like mental hospitals—nursing homes, or “special” schools, the majority of the population within these institutions are comprised of some combination of the categories above” (258). Mental hospitals, rehabilitation centers, respite care, nursing homes, assisted living centers, independent living centers and hospitals are the socially accepted forms of institutionalized “care” for the disabled community. Yet there is nothing independent about these facilities. People situated in residential care accommodations, as mentioned above, are forced to eat, sleep, perform hygienic care, evacuate and socially engage when expected to by the “care” institutions schedule. When someone does not desire or “refuses” to perform when instructed, they are deemed as “bad” and will receive punishments or sanctions. Staff members have the power to impose: medication, banishment to beds, withdrawal of care, reprimands and the denial of visitors (Tremain 73). I agree with Tremain as I have encountered all of the above forms of punishment during the times I was hospitalized.

IV. Normalcy

Due to social media’s influence of perfectibility and hegemony, being labeled with a clinical diagnosis makes the individual an outlier. Was diagnostic labelling
invented to create power over the individual? Tremain would argue that diagnostic labeling has created a pathology to be an embodied part of individual identity and create individuals as subjects of professional intervention. This is to allow a role of maintenance of professional power over the individual (Tremain 66). Bodily differences are fabricated from norm and valorize a regime which impairments offend biological laws of nature. Oddly enough social stigma that surrounds impairments has risen simultaneously with clinical distinctions (Tremain 82). The disabled prognosis generates a pre-determined set of expected outcomes, long-term and short-term, to determine future course of treatment.

Examinations, testing, electrocution, medication, institutionalized care, surgery, prosthetics, transplants, devices, implantations, and injections are different forms of biomedical treatments for the purification process in which a body returns to normalcy standards. If impairments remain after treatment(s) you are seen in terms of a functioning scale to rate the level of impairment and abnormalcy by the medical institution. The more outwardly your body is visually disabled the more “monstrous” and repulsed is the viewer's gaze (Tremain 176).

Those who have an “invisible” disability remain being viewed as imaginary, less impactful and more desirable since there are less visual abnormalities and the body appears as whole. In terms of functioning, the less noticeable impairments can be the same, worse or better than say an amputee. Is this due to lower “monstrous” aesthetics and that the body is seen as whole? Sontag would argue that it’s the language that is used that determines the “ill-omened, abominable, repugnant to the
senses. Cardiac disease implies a weakness, trouble, failure that is mechanical; there is no disgrace, nothing of the taboo that once surrounded people afflicted with TB and still surrounds those who have cancer” (Sontag, Illness as Metaphor 9). Darling would argue, “a person with an impairment such as asthma or diabetes may experience some limitations in life activities but probably will not encounter the stigma and social exclusion experienced by an individual with cerebral palsy who uses a wheelchair and a speech synthesizer” (1). I would argue with Darling, from my experience I have incurred more social exclusion when my impairments are not outwardly noticeable. Random strangers have told me to remove my car from handicap parking, to not use electric carts, and to think positively and work harder because they can not visibly see my impairments. When I have used a walker, crutches or wheelchair I do not receive such comments.

V. Abnormality

In today’s world, deviances from the norm are those who are not only disabled, but also those who chose not to follow protocol treatment to purify the abnormality. Tremain defines normativity as “the power of social and legal norms that are imposed upon people. Normative norms orient people to external rules that they must follow or to which they must conform. Controlling mechanisms ensure conformity with social norms; deviation and disobedience are subject to penalties and sanctions” (193).
Medical power is asserted over those who are acutely impaired. In turn, they lose possession of their bodies and any say over their course of treatment (Tremain 31-33). “It felt as though I was in a prison, rather than being nursed back to health” (Tremain 33). Those who refuse prescribed treatment are deemed disobedient, hostile, insane, abnormal, grotesque and therefore should not be covered under insurance, are mistreated and or abused and cannot receive governmental assistance. One must assume corporeal ownership by asserting authority over one’s care by deciding course of medical treatment (if any). When I entered a clinical trial my physicians supported this decision while my friends and family did not. The biomedical community saw it as a chance for normalcy when friends and family were frightened by possible: side effects, more illness(es), death and disease(s). Also the notion of my body becoming a hybrid of machine and man, from the transplant and chemotherapy. My options were to welcome death or take the chance to function once again.

VI. The Grey Area

Since there are numerous types of diseases, ailments or impairments, on any level of the corporeal body, and each body reacts uniquely, this creates innumerable variabilities of disability and or impairment. Similarities may exist between labeled diagnosis, but the prognosis, and effects vary greatly; this in turn creates a grey area in disability identity. This grey area includes diseases that are “invisible” and not seen on the outside. Some of these diseases cause disabling amounts of pain. Pain is classified
by the medical community as disabling, but disability identity refers to pain as trauma and thereby psychoanalytical. Why wouldn’t pain be considered as another grey area surrounding disability identity? Is there not the mentally impaired disability identity (such as Post Traumatic Stress Syndrome)? Furthermore, is there not trauma induced by the biopower biomedicine treatment? Trauma induced by the medical community is accepted under disability identity, but trauma caused by pain is not? Paintings (such as *Broken Column*) by Frida Kahlo, depicts the pain she suffered from an accident and the trauma induced to repair the abnormalcy. Vincent Van Gogh painted *Vestibule of the Asylum* while staying in-patient in a hospital.

Being born with a disability is different than acquiring an impairment later in life. Most people that are born disabled typically have “disability pride” and have learned how to function since birth with their condition. Becoming disabled later in life is less acceptable and is rejected, or time is required to accept one’s new identity. It can also be argued the person with a newly acquired disability has to let go of their previous identity before accepting their new status.

Some people with conditions, such as multiple sclerosis, have a disability that progressively worsens and new impairments continue to incur until death. Although disability pride is a positive identification, how can one be with “pride” knowing their disability will continually progress into death? How can one ever accept this state?

**VII. Visual Imagery Exploration**
The paintings and sculptures I was first creating in my undergraduate years recreated memoirs through symbolic imagery of torturous events. The sculptures I was creating didn’t animate the story because they were a still frame of an event. I would begin my sculptures by videotaping and photographing an ideal from a memory which was symbolic imagery of the torturous act. I would sift through the video frame by frame searching for the pose to sculpt from. Over time I came to realize the performative act was unequivocal to any other form of medium because it narrated reality. Phelan argues the real tangible act of performance is lost once transferred to a photograph or video because it becomes two dimensional. For example, *Lou*, by Robert Mapplethorp is a photograph of a pinky finger being inserted inside the male urethra. The photograph captures the pinnacle point of the performance, but what does the audience allude to when viewing it? Is the photograph viewed as a non three dimensional object and thereby not captivating the pain, realness, force and trauma of the act? On the the other hand, if Lou was to actually stick his finger in his penis in front of the viewer (as a performance), we would have an extreme corporeal reaction. Phelan explains it best, “The desire to preserve and represent the performance event is a desire we should resist. For what one otherwise preserves is an illustrated corpse, a pop-up anatomical drawing that stands in for the thing that one most wants to save, the embodied performance (3).”

A problem I have discovered is when the audience only views photographs or video of my performance, a fundamental element is lost. This is because the visceral corporeal grotesqueness of reality disappears and a false sense of reality is generated
through the use of technological devices to replay or capture the performance. The photograph, *A Death of a Thousand Cuts*, by Anonymous, 1905, creates a moment where one may gasp at the image. The actual atrocity which took place cannot be felt by the viewer. Is this because the viewer is anesthetized by the bombardment of imagery from the media and feels nothing? And if it’s not nothing we feel, are we in disbelief from conjured false reports and manipulated photographs? Even photographs of the Civil War were staged by the photographers, such as *The Valley of the Shadow of Death*, by Roger Fenton. “The crisis of belief we are experiencing is much larger than a simple mistrust of photographs. It involves the wholesale, active relinquishing of our public right to know” (Strauss, *Words Not Spent Today Buy Smaller Images Tomorrow* 78).

During my second and third semester in graduate school, my work began trying to empathetically connect the viewer through pain. My work began to go into the direction of biomedical treatment. For example, the piece *Weight* was created to portray legs as heavy weights, simulating the difficulty and pain to walk or move when experiencing polyradiculoneuropathy. I used one inch thick steel at the base, causing the boots to weigh over 20 pounds. Inspired by orthopedic braces for feet, work boots, and Frankenstein’s boots, I fashioned a pair of steel boots to depict polyradiculoneuropathy. This type of pain one feels from this condition is invisible and worn on the inside. The steel fabricated boots are lined with brown suede to depict poverty one may face being on disability based income from the condition. *Weight* is made from several pieces of steel, as I have felt that my body has been put back
together from all of the medical surgeries and procedures I have undergone. The straps and buckles provide the flexibility of putting them on and being fastened securely to be worn for a performance. Rivets were used to fasten the leather into place and to depict a tortuous device. “Pity can entail a moral judgement if, as Aristotle maintains, pity is considered to be the emotion that we owe only to those enduring undeserved misfortune.” (Sontag, Regarding the Pain of Others 75)

Time progressed and I began to realize that I was expressing social injustices from a disability identity perspective. I personally am not afraid to label and identify myself as a part of this movement and census, though society deems it the most grotesquely unwanted abnormality to relate to. “What a society makes of this biomedical abnormality (often called the “disability” proper) is a social construction superimposed on a given biological reality” (Tremain 94).

In turn, during my last semester I began to focus more on biomedical treatment, institutions, torturous medical apparatus, pain, stigma, and social injustice. The piece piece regarding the grotesque daily rituals of self catheterization is titled *Grotesque Biomedical Treatment*. This video performance explicitly exposes a hidden impairment I encountered daily. Creating this piece was to shed light on the perspective of the injured. I didn’t want the face of the performer involved because it is not public knowledge as to who performs medical practices such as this. In addition, the anonymous portrayal creates objectivity; in the eyes of the medical community I am only a diagnosis. The vagina was the only thing of importance since it was the area of impairment that had to be prodded, exploited and examined. I placed sheets of
brushed polish metal together on the floor to simulate a medicalized area where I
would sit. I hung a light below my face to hide identity and to create a bright light effect
on the area of importance to simulate a doctor's office lighting up the area they are
examining. I sat down on the steel, legs were then spread widely to permit an area I
could plunge the catheter into and collect the urine from my bladder. When the bladder
was done evacuating its contents, I pulled the catheter out of the urethra and left the
tortuous medical apparatus on the steel and walked away.

In each instance, the gruesome invites us to be either spectators or cowards, unable
to look. Those with the stomach to look are playing a role authorized by many
glorious depictions of suffering. Torment, a canonical subject in art, is often
represented in painting as a spectacle, something being watched (or ignored) by
other people (Sontag, Regarding the Pain of Others 34)

The piece titled Cranial V Nerve, is a diagnosis named after the set of three
nerves which branch off the trigeminal nerve. These nerves can be affected from
lesions on the brain or spinal cord, and trigeminal neuralgia, and cause extreme
“suicidal” pain (Trigeminal Neuralgia Fact Sheet). These specific nerves are located
within the jaw, cheekbone, nose and forehead. This type of pain caused by some form
of nervous system damage typically affects the face asymmetrically. The interactive
sculpture, which can be worn, is made from steel round stock and anatomically forms
the shape of my face. Steel was chosen to depict a tortuous type of pain generated by
this of nerve damage.

Pain is a repeated theme in my work; some find an aestheticism in something
gruesome. When we drive past a car accident, do we not slow down to look at the
grievous calamity? Is it the aesthetic horror which we desire to see or is it a voyeuristic
lure? Some would argue that pain would want to be avoided and not experienced. Why then would we want to look at the photographs, films and imagery of pain? Edmund Burke observed, “I am convinced we have a degree of delight, and that no small one, in the real misfortunes and pains of others” (Sontag 97). Stella Young would agree, as there is much “inspirational porn” on social media sites.

VIII. Thesis Work

The main art piece to my thesis titled, *Rise of the Cyborg*, originates from undergoing an autologous stem cell transplant: where medical infrastructure and biomedical engineering would be creating life where there was almost death. When I underwent an autologous stem cell transplant my body was frequently incurring acute relapses from multiple sclerosis. I underwent this transplant in hopes I would be able to run, play and care for my children. This treatment began with high doses of chemotherapy, which destroyed red and white blood cells bringing the corporeal body near death. The afflicted would actively focus on memento mori while in this incapacitated drug induced state. Simultaneously doctors, nurses and hospital personnel frequented my patient room, which transformed the room and body into a frankenstein-like, biotechnological, biomedical, grotesquely macabre spectacle. “The gaze (a technology of power) produces information and knowledge” (Tremain 81). The patient was forced to remain passive, submissive, “good” and quiet, while under their controlling regime; willingly submitting their body as an object. A disabled person
would desire to undergo treatment to become “normal” through biomedicine. In this process they are exposed, examined, purified from abnormality and treated tortuously.

The title originates from Donna Haraway’s *Cyborg Manifesto*, “A cyborg is a cybernetic organism, a hybrid of machine and organism, a creature of social reality as well as a creature of fiction” (147). The Monster from Frankenstein became the first cyborg when he came to life with electricity. I in turn was given life (metaphorically represented through functioning again); and life was generated through chemotherapy and my blood purified through being put through a machine and washed before re-transplantation (Burt and Kozak).

I used performance to create a reality consisting of grotesque powerful imagery relating to and about disability identity. The aforementioned scene is inspired by the comparison of the “monster” from *Frankenstein* coming to life and undergoing a stem cell transplant. The Frankenstein reference is signified by creating a comparatively similar table to that of the film. The table is composed of fabricated steel tubing to simulate a torturous appearing medical apparatus. The material used for the bedding is from acrylic glass to signify biotechnology. The performer wore a in-patient hospital gown from Health Alliance Hospital located in Kingston, New York. These items signify a patient status as well as a sterile environment. The performer shaved their head to represent the undergoing of chemotherapy. The performance artist walked into the gallery amongst the audience (to signify the disabled among them), and climbed onto to the 45 degree laden table and stood on two small pieces steel implanted within the acrylic. The table will be at this angle to permit interpretations of either coming to life, macabre and the spectacle; furthermore the film and book *Frankenstein* was
was referenced, as well as surgical beds and emergency stretchers.

The performer stood on the small steel platform for two hours to withstand and depict the physical and mental pain involved in hospitalization, the spectacle of monstrosity and analysis of abnormalcy. The museum became the hospital or institution and the audience the spectators or guests entering my hospital room. The hair I shaved off was placed on the floor, around the performer and onto the bed. This is to represent the grotesque spectacle of hair loss during chemotherapy. The action the performer did was minimal and silent to appear “quiet and good.” The movements were the head moving, to slightly sitting up. This was to depict the biopower and control over the body from within an institution.

A projector was housed within the steel framework; it projected through the clear acrylic, illuminating the performer's body and instilling the final image onto the ceiling of the museum. The video consisted of recordings from fire burning, rain falling and bright light. The three elements are similar to the memento mori the patient experiences, the spectacle from being viewed, the hell one might project into the experience, the sadness, grief, loss and hope. I interwove the three elements in a psychologically twisted perception of what I experienced as a patient, when I underwent a stem cell transplant. I created the psychological elements by speeding up, slowing down clips, flashing different images quickly and at times complete blackness projected to show fear and foreshadow death.
A second piece in my thesis exhibition titled *Waking* was a video of a performance encompassing how disability affects not only the afflicted, but the caregiver as well. This piece inspired by previous memoirs when helped with alleviating spasticity, by being carried and or moved. At the time I felt incarcerated by my corporeal body and biomedical treatments. I derived the movements from times of caregiving, in which I re-created an endless loop of contemporary dance between the role of the caretaker and the impaired. The performers wore black while performing in a white space to reflect timelessness and unconditionality of the roles portrayed.

Another video performance piece titled *Alive* was also included in the thesis exhibition. It was a site specific outdoor performance filmed on the boardwalk of Rondout Creek located in Kingston, New York. In this piece I recreated the day I regained the ability to walk from high dose chemotherapy while inpatient at Chicago Northwestern Memorial Hospital. I awoke after three days of high dose methotrexate, to find I could move my limbs again. I got up from my bed, grabbed the IV pole I was attached to and skipped along the stem cell transplant floor. I rejoiced at being able to move again, although I was still disabled and under biopower biomedical infrastructure and regime. In this piece I skipped along the boardwalk, in a hospital patient gown, with an IV pole. I created a hospital bracelet to simulate being an inpatient at a hospital. The bracelet had not only my name but “Dr. Robert Burt’s” as well because I was under his care while in Chicago. The outdoor venue was chosen to reference my nostalgia while I was skipping in the hospital.
The final piece of my thesis exhibition, *Gamma Knife* is a steel, riveted crown which can be worn. It was created to be one and a half inches larger than my own head. The four screws were fashioned to twist in the crown and then into the skull of the person who wears it. In the future I have plans of performing with this piece to depict how it functions. This piece references one of the brain surgeries I underwent in Syracuse, New York. The surgery called “gamma knife” is when high energy gamma radiation, penetrates deep within the brain to destroy nerve(s) or tumors. This brutal biotechnological surgery incurred to stop the trigeminal pain, which was secondary to the multiple sclerosis. I depicted the metal apparatus similar to the head piece I wore for the surgery.

**IX. Conclusion**

The pieces created for my thesis only touch upon the current crisis that surrounds “disability” identity. Until changes occur, objectification purification and perfectibility of the human body will continue to endure. When will society look upon deviances with admiration and beauty and realize their inclusion? Will the biopower of the medical infrastructure continue to permeate and label anomalies as something needing to be perfected? I look forward to the future, when history is re-written to include oppressed minority disability artists, writers, and curators, and “disability” art practice is not observed with stigmatization and is accepted to empower the inflicted.
X. Works Cited


http://www.performance-art-research.de/texts/french_chapter_pain_as_an_image.pdf.


XI. Artist Statement

The historical social injustice of disability identity creates traumatic experiences from institutionalized biomedical infrastructure. Art on this subject has been long overdue to empower the disabled minority group and to respond through a visual language to these prejudicial misconceptions. Objectification, purification, and perfectibility of the human body will continue to prevail, until art explores the dominant oppressive characterizations associated with sociopolitical cultural discourse on disability identity.

A disabled person would want to undergo treatment to become “normal” through biomedicine. In this process they are exposed, examined, purified from grotesque genetic abnormality and treated tortuously. I have chosen to re-create an autologous stem cell process; where medical infrastructure and biomedical engineering would be giving birth to the cyborg.

Biography

Rosary Solimanto is best known for her mixed media conceptual based work which explores the the objectification she has faced battling multiple sclerosis. She encourages discourse on disability identity to unfold to empower the inflicted. Solimanto is an emerging artist who has exhibited in the United States and Spain. Awards include Parnassus Award in Fine Arts at Adirondack, New York; Kulakoff Award at Albany, New York; and the Sojourner Truth Fellowship at New Paltz, New York. Born in New York, Solimanto has received her Associate in Arts from State University of New York at Adirondack in 1999, then received her Bachelor of Arts in English Literature and Fine Arts with a minor in Psychology from the State University of New York at Albany in 2013, and has recently receiver her Masters of Fine Arts in May 2015 from the State University of New York at New Paltz. She currently lives and works in New York’s Hudson Valley.
XII. Images

*Weight.* 15” x 14” x 17” Steel, Suede. Leather. 2014

*Weight (Profile View).* 15” x 14” x 17” Steel, Suede, Leather. 2014
Weight (Installation). 15” x 14” x 17” Steel, Suede, Leather. 2014
Grotesque Biomedical Treatment. Still from Video. Female French Catheter. 2014

Grotesque Biomedical Treatment. Still from Video. Female French Catheter. 2014
Rise of the Cyborg (Installation). 56” x 40” x 72” Steel, Iron, Acrylic Glass, Mirror, Video, Hospital Gown, Hair. 2015
Rise of the Cyborg (Photo of Performance). 56” x 40” x 72” Steel, Iron, Acrylic Glass, Mirror, Video, Hospital Gown, Hair. 2015
Rise of the Cyborg (Photo of Performance). 56” x 40” x 72” Steel, Iron, Acrylic Glass, Mirror, Video, Hospital Gown, Hair. 2015
Rise of the Cyborg (Performance Still). 56” x 40” x 72” Steel, Iron, Acrylic Glass, Mirror, Video, Hospital Gown, Hair. 2015
Waking (Performance Still). 2014
Alive (Performance Still). Hospital Gown, IV Pole, IV Bag, Hospital Bracelet. 2015
Alive (Performance Still). Hospital Gown, IV Pole, IV Bag, Hospital Bracelet. 2015
Alive (Performance Still). Hospital Gown, IV Pole, IV Bag, Hospital Bracelet. 2015
Gamma Knife (Installation). 15.5" x 15.5" x 8" Steel, Rivets, Screws. 2015
Gamma Knife (Installation Detail). 15.5" x Steel, Rivets, Screws. 2015
XIII. Show Card

RISE OF THE CYBORG
Rosary Solimanto

Exhibition Dates: May 8-12, 2015
Opening Reception: Friday May 8, 2015
Live Performance: 5:00pm - 7:00pm

Gallery Hours:
Friday - Tuesday, 11am to 5pm

Location: Samuel Dorsky Museum of Art
State University of New York at New Paltz
Alice and Horace Chandler & North Galleries,
1 Hawk Drive, New Paltz, New York 12561

rosarysolimanto.com