Healing Through Art

An Examination of the Intersection of the Queer and Disabled Communities

By

Tiffany-Ashton Gatsby

Figure 1: Queer and Disabled*, 2020, digital collage by Rainn - Healing Through Art Group*

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Permission to share with future University of Washington students

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Abstract

Individuals identifying as both 'queer' and 'disabled' are presented with unique challenges when interacting with support systems of family, community, institutions, and biomedicine. For queer-disabled people, the act of seeking care within these systems does not necessarily result in healing and can often lead to increased trauma, often necessitating alternative healing options. Queer-disabled people use art as one such holistic healing modality in various ways, including through art therapy, individual art practice, and as a tool for community building and social justice. The artistic expression channeled by the queer-disabled community is an effective site of resistance that promotes visibility and has the power to affect change. My research explores how interaction within support systems drives queer-disabled individuals to utilize art as a form of healing and resistance. I examined the impact of community-based art projects in comparison to art therapy and art practice, conducted ethnographic interviews and participant observation where I created a community-based art project with a cohort of my queer-disabled peers. My research shows how the experience of using art as a healing modality empowers the queer-disabled community on an individual and group level. My research results provide a strong foundation for my further study of the queer-disabled community and the challenges faced when seeking care in the biomedical system while taking a deeper look into the complexities of engagement with the arts for healing.

Keywords: Art, healing, queer, disabled, marginalization, community, biomedicine

Figure 2: Street Walkers, *2019, Tiffany-Ashton Gatsby.*
Image by author.

Prologue

One night, when I was thirty-seven, I was sitting at home on my sofa just about to enjoy some pizza and beer with my partner as we queued up a James Bond movie. Suddenly, I was overcome with an odd sensation and struck with a feeling of dread. The left side of my face went numb, and there was an intense metallic taste in my mouth. I assumed I was having a stroke and asked my partner to check if I was slurring my words or if my face was drooping when I smiled, which it was not. I was experiencing an extreme adrenaline rush combined with the feeling that I was dying. I was not scared, but I knew if I did not get to the Emergency Department (ED) of a hospital soon, that would be it for me. I was rushed through triage and given an electrocardiogram that showed irregular heart rhythm indicative of deficient potassium levels in the blood, known as hypokalemia, which the labs then verified were life-threatening. I spent a week in the Cardiac Care Unit while attempting to stabilize my potassium levels and erratic heart rhythm. The stress on my system caused an exacerbation of Multiple Sclerosis (MS)[1] that required a course of high-dose intravenous steroids. I left the hospital thirty pounds heavier and using a walker for mobility.

That next year was unbearable. I was forced to leave the workplace and give up a successful career. I was primarily homebound except for doctor visits, which were almost daily. They could not determine what caused the sudden hypokalemic episode to assess if it was likely to occur again without warning, so I had labs drawn several times per week to ensure my potassium levels were stable. I spent so much time at the clinic that I started getting an employee discount in the cafeteria. I cashed out my retirement account and borrowed money from my life insurance while waiting for Social Security Disability approval. I was experiencing a severe cognitive decline and had trouble managing my medications. I had difficulty completing even minor tasks around the home so that any time not spent attending to my health was filled with watching endless episodes of *Law & Order: Special Victims' Unit* and *Grey's Anatomy*. I started to crochet scarves and blankets and found some comfort there, and soon taught myself how to knit. It gave me a sense of accomplishment, proving I could finish a task. I experienced extreme anxiety and depression and suffered from Post Traumatic Stress Disorder (PTSD) from the hospitalization, which was exacerbated by the determination of the hypokalemic episode's origins; likely "from MS, we guess, but no way of knowing for sure." Something MS patients are familiar with as the excuse for anything a healthcare team cannot explain.

Amid the poking and prodding, I was hit with an identity crisis that left me questioning my purpose. My identity had nothing to do with who I was as a person; it revolved around my success in my career. As a child, I always planned on becoming a surgeon and hoped to one day return to school to complete that goal, but my MS diagnosis at thirty derailed that dream. I mourned for the loss of a dream I would never achieve. At the time, I did not think much of it,

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[1] "What is MS?" - National Multiple Sclerosis Society
https://www.nationalmssociety.org/What-is-MS

but I turned to photography as a way to process that loss. It gave me something new to focus my attention on and having a creative outlet lessened my anxiety levels. However, seven years later, I did not initially look to use any creative outlet to process the trauma experienced in the hospital, the fear of the unknown exacerbated by the worsening of my MS, or the grief I experienced from losing my primary source of identity - my career. I no longer knew how to explain who I was, what I "did," or why I mattered in the world. Without my career, I felt like the only tangible part of my identity was related to my disability. Instead of my life revolving around work, it now revolved around doctor visits. When people asked about me, that felt like the only tangible thing I could cling to in order to prove that I had an excuse for not working and contributing to society. Unfortunately, if I was not using a mobility aid when meeting someone new and trying to explain that I was no longer working due to my disability, I was often met with, "Well, you're doing great. You don't look disabled at all." What does disability *look* like? Not only was my identity invalidated, but because I did not match an able-bodied person's expectation of disability, I was somehow thrust into suspicion, likely thought to be malingering my illness or 'abusing the system.'

My partner and I eventually separated. They could no longer handle the unpredictability of living with a person who had to schedule trips around the proximity to a hospital with knowledge of how to treat an MS flare. By this time, I was finally able to work a few hours a week in a boring job that was intellectually dull. I realized I needed to do something that made me feel like I contributed to making the world a better place. I began hosting weekly trivia Meetup events at a pub through with Seattle Lesbian Social. I had already been volunteering for the National MS Society's peer support program taking calls from individuals with MS. I volunteered during the most recent political election cycle, but I had not done any work in the queer community. While this group was more social, it felt good to get involved in something that addressed another dimension of my self-identity. I also began frantically knitting and crocheting as many Pussy Hats as I could manage to give away at the first Womxn's March[2]. I felt like I was joining in a

Figure 3: Seattle Womxn's March, 2017. Image by author.

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[2] The Pussy Hat's concept grew from Donald Trump's Access Hollywood Tapes, where he was recorded saying "Grab 'em by the pussy." The color pink was chosen for the association with femininity. However, gender is not based on genitalia, and while the visual of womxn marching in a sea of pink hats was a stunning part of the protest, the hats became problematic as they were seen by many as exclusionary for women of color and TERF-y (Trans-Exclusionary Radical Feminism). "Pink Pussyhats: The reason feminists are ditching them" - Kristen Shamus, Detroit Free Press https://www.freep.com/story/news/2018/01/10/pink-pussyhats-feminists-hats-womens-march/1013630001/

cause and that my skill as a maker was somehow contributing to something that would affect social change.

At the time, I was receiving intensive outpatient treatment for an eating disorder exacerbated during my breakup. During group sessions, many of us were working on various knit and crochet projects. In other group sessions, we would often do art-based activities, like drawing our family dinner table or making a self-portrait from cooked pasta and instant potatoes, as a way to process our emotions centered around food. These exercises usually resulted in a significant breakthrough for one or more members of the group. After one of these moments, I realized art therapy could be a viable career option if I ever went back to school. I remembered how much photography had helped me process my MS diagnosis and how knitting and crochet even gave me a sense of purpose when I was homebound. When I finally enrolled in community college, my first course was an introduction to drawing. After over twenty years since I had been in a classroom, stepping back in to do art seemed like a good transition. Plus, drawing was a prerequisite to move on to more advanced or complex art courses.

Going back to school was a pivotal decision for me. It gave me a new sense of self-worth and a new identity - student. I spent more time in the art studio than anywhere else on campus, often working on paintings until late at night. I used the time to process everything I had been going through over the past several years and poured out my anger, sadness, joy, and happiness all over the canvases that littered my space. I also took this as an opportunity to reinvent myself. I was coming out queer and swinging for the fences, something I kept relatively quiet for so long due to disapproval from my family. Within just months, I was volunteering for multiple queer organizations, including a spot on the board of the Seattle Dyke March. On-campus, I was an editor for the school paper focusing on queer issues, health, and wellness, and I was the Vice President of the Queer Cooperative student organization. I pivoted from psychology to medical anthropology because I felt like there was a real opportunity to affect some type of systemic change concerning biomedicine. I just was not sure how or what. I was trying to find a way to bridge art and anthropology together in a meaningful way. I had so many different ideas that I was having a hard time containing them all. I felt like I had been slowly fermenting in a cold and dark cellar, and someone just shook me and pulled my cork out… where did all these bubbles come from?!?!

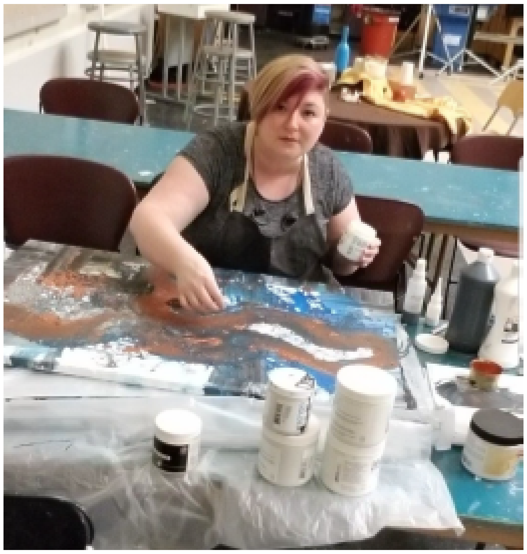

Figure 4: Me at the Seattle Central College Fine Arts Studio, 2018. Image by author.

Today I find myself firm in my self-identity. I am a proud, independent, queer-disabled, gender nonconforming parent living with Multiple Sclerosis. I am an extremely liberal, feminist, atheist womxn of Ashkenazi descent. I am an artist and activist. I am a student. Overcoming challenges fuels my drive to excel, and I expect to affect meaningful change for queer-disabled people in my lifetime. When the biomedical system failed to heal me, I looked to art as a way to cope with a body and mind that turned against me and found solace in channeling my energy into a creative force. I have experienced the power of healing through art, not a physical or medical cure, but rather a powerful emotional transformation that allowed me to change my perspective on living in a queer-disabled body. I embrace my multiple, marginalized identities and move forward into a space of recognition and celebrating them. This awakening allows me to thrive despite the obstacles in my way. It is this very reason that I was drawn to look to the experiences of other queer-disabled individuals to examine if they experienced the same type of frustrations with biomedical treatment that left them feeling invisible and raw, still not finding the kind of care they needed. I needed to know if they experienced any form of healing through art, and I needed to ask what drove them to that space and what emotional transformations they experienced when they found it. This thesis offers answers to these important questions.

Doctor, It Hurts When You Do This!

> *Every time a doctor says, "So you know that there's no cure for your illness?" That doesn't mean you can't treat me better. That doesn't mean that I can't make my life better. How dare you, how dare you say that. That's so defeatist to hear before we even enter a conversation, you know? If your doctor is making you feel like they're being an asshole is your fault, you just want to get home. We experience this all of the time.*
>
> *~ Dani (they/them)*

> *Going to the hospital used to be so much worse. They would make me feel like shit for being active in trying to seek emergency help for suicidal ideation. When they first told me about BPD [Borderline Personality Disorder], they didn't explain what that meant but just told me DBT [Dialectical Behavioral Therapy] would help. I had to research this on my own to even find out what it was. The moment doctors see it [BPD diagnosis in their chart], they just automatically stigmatize it and assume the person is going to manipulate them, so they won't believe anything the patient says.*
>
> *~ Rainn (they/them)*

> *So, I actually don't talk about my eating disorder whatsoever. This is the most I talked about it. None of my current doctors know. Only my pediatrician ever knew. But I haven't had any recent eating disorder treatments, so they don't know about it, and I don't bring it up because it's another thing I just expect to be invalidated because of it. I told them that I don't want to talk about diet or weight. The doctor will say, "Well, you know you're starting to get closer to that overweight mark; you might want to keep an eye on that." So it's not something I can talk about with them. Maybe if I had a doctor that I felt more comfortable with, but I don't.*
>
> *~ Riley (they/she)*

The experiences shared by Dani, Rainn, and Riley, are examples of what so many members of the queer-disabled community face on a continual basis when interacting within biomedical systems, myself included. All of the interlocutors that so generously shared their deep and personal experiences with me were all part of a larger narrative. When we are in the most vulnerable and fragile moments of our lives in times that we are not equipped or prepared to care for ourselves, we turn to medical professionals for care, compassion, and answers. Whether in a routine office visit or a life-threatening situation at a hospital Emergency

Department (ED), we expect to be treated with dignity and respect. Unfortunately, that is not what we routinely experience. As queer-disabled individuals, we are often met with many roadblocks when seeking medical care. We are often faced with a lack of recognition for our pain or our medical conditions, our lived experiences are questioned, our sense of agency is challenged, and we are frequently told there is no answer or no cure. Some health conditions are not taken seriously by all providers, and our intersectional identities often factor into our perceived care plan.

Diagnostic Dilemmas

Whether a person is born with a disabled body or becomes disabled due to injury, disease, or chronic illness, these individuals face similar challenges when interacting with the biomedical system. Disabled bodies are subjected to medicalization, wherein the individual's difference is deemed a deviation from the norm, prompting the biomedical system to intervene to 'fix' these individuals medically, rather than addressing the core societal issues that influence viewing difference as abnormal (Linton, 1998). While some individuals with disabilities require biomedical interventions to treat symptoms, improve quality of life, and combat potentially life-threatening outcomes, that is not the case for everyone. Individuals born with limb deficiencies may find the use of prosthetic devices more troublesome than adapting to the body they were born with (Nichols, et al., 1968). Similarly, d/Deaf individuals do not need cochlear implants to communicate successfully. They may not want them, despite the assumption made in the hearing community that d/Deaf people would all benefit from hearing (Cooper, 2019). Regardless of the necessity of medical interventions or the desire for them, most people with disabilities living in Western society will have increased contact with the biomedical system during their lifetimes. And with increased contact comes increased opportunities to experience the problems, shortcomings, and biases within the biomedical system.

Figure 5: Dani at a sleep study appointment. Image by Dani.

Dani (they/them) is a nonbinary queer person living with Ehlers-Danlos Syndrome (EDS)[3], a genetic disorder affecting connective tissue. If not for another family member with EDS, their folks may not have noticed that Dani's joints were hypermobile. Because of this, their family began suspecting EDS when they were still quite young. As a child, they were warned not to do party tricks and be extra careful playing, and it never seemed like too much of a bother. Looking back, they always had symptoms of EDS, but it

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[3] "What are the Ehlers-Danlos Syndromes?" - The Ehlers-Danlos Society ?https://www.ehlers-danlos.com/what-is-eds/

was manageable until college when they started vomiting every day, sometimes for hours. They would wake up, vomit, and head to class as if this was just part of the daily routine. “I don’t really remember most of my senior year, because I was just so sick. I don’t know how I even graduated.”

Dani started having other symptoms confusing to their doctors. They were in and out of hospitals, seeing specialists, and geneticists, running test after test, sometimes not knowing what the results implicated, and even telling them everything was fine. The doctors all gave Dani different sets of diagnoses, usually asking, “Why do you think you have EDS?” Dani started questioning if they were even sick, not understanding what was wrong with them (Mattingly, 2014). One primary care doctor accused Dani of not admitting they were bulimic, refusing to believe their weight loss was involuntary. When they finally found a specialist they hoped could help eliminate their constant vomiting, the doctor told them not to worry since it was no longer getting worse. This completely invalidated Dani’s experience, which included sleep deprivation and constant pain and nausea. Dani was looking for validation, sympathy, and for the physician to provide a treatment that would alleviate their suffering. Instead of healing, they were told to get accustomed to the way things were.

When Dani moved to Seattle, they started seeing specialists at the University of Washington Medicine (UW Medicine), and the care team concurred that it was indeed a complex form of EDS. Unfortunately, that’s when things started to spiral. Despite finally getting better care, Dani’s hip issues worsened and required surgery that was only marginally helpful. Their weight loss was out of control and they became dangerously thin. Eventually, Dani was bed-bound for three months, relying on their mother for round-the-clock care. Dani’s care team discovered that they also had dysautonomia, a dysfunction of the autonomic nervous system that controls heart rhythm, digestion, my brain, my endocrine system, and various other bodily functions. These conditions are incurable, so the best hope is that the symptoms are manageable.

Many people, when diagnosed with an incurable and unpredictable disease, might feel anger, sadness, or fear. Dani felt relief with just a touch of happiness, something I felt when I received my MS diagnosis. Finally having the answer to a question Dani and I were both searching out our entire lives, “What’s wrong with me?.” Having an answer is empowering. I stopped thinking I was crazy for spending so much time with so many different doctors. Dani stopped worrying that they would be perceived as a hypochondriac. Knowing that another doctor could not send us away saying nothing was wrong was a relief. The only problem with having a diagnosis is that medical teams then move on to the next and more exhausting task - trying to fix everything (Linton, 1998).

Dani has many medical issues that their care team is constantly trying to fix, often unsuccessfully. Their blood vessels and organs are fragile and may rupture, their shoulders sometimes dislocate in their sleep. They often have unpredictable adrenaline responses that mimic panic attacks but happen due to physical triggers causing pain and shaking, so they sent Dani to a neurologist. Then Dani was told to see an ophthalmologist annually and rush to the Emergency Department (ED) if they have any vision issues because corneal detachment is common in EDS and they could permanently lose their vision. The more they reach out to their medical team for care, the more medications they put Dani on. Dani was having trouble raising their arm above their shoulder, and their doctor said to just stop raising their arm, which Dani did for a few years without an option for treatment.

Dani felt lost, with no one managing their care. They had to find their own doctors and specialists and get all of the information about their conditions on their own through the internet or EDS support groups since there are so few EDS specialists because of its rarity. And because EDS presentations are wildly unique, there is no standard of care. At one point, Dani was having so much difficulty walking, they purchased an arm crutch from Goodwill. At their next doctor's visit, the provider said, "This is great you decided to get the arm crutch instead of a standard cane. You really need the extra support." Dani was furious as no one said they needed a mobility aid in the first place, let alone a specific type. The provider then decided to fit Dani for ankle braces, since they kept rolling their ankles, which would not have come up if they walked into the office without a cane that day.

More recently, Dani is having difficulty swallowing from fractured peristalsis, meaning the involuntary muscle movements that move food down to the stomach are not working properly. Sometimes they cannot even swallow their pills. Their digestive system is slowing down causing gastroparesis, where food does not pass through the stomach for an extended period of time. Their doctor informed them that it was "a software problem, not a hardware problem. Your brain is wrong and we can't fix that." So Dani is forced to go to the infusion center twice a week for intravenous fluids. Their veins are getting so scarred, the doctor is considering putting in a port, and Dani is a bit apprehensive. They know it is necessary, but it makes Dani feel things are becoming more permanent.

Becoming accustomed to the reality of the uncertainty of their daily life became difficult. Dani was realizing there were no set goals for treatment or healing, other than trying to keep the symptoms at bay enough to live decently. They understand there will always be problems, even on their best days, but it took a long time to come to accept that. Dani felt that some of her doctors stopped seeing her as a person but as a problem that was unsolvable. Dani constantly hears, "There's not much we can do for you right now" from so many of their providers, it often makes them feel invisible. One doctor said that while they could not offer them any treatment options now, they heard of an ongoing drug trial that might be able to manage some of their symptoms, and were sure that some better options would be coming down the pipeline in the next three to five years. It was not a guarantee or false hope, but a sliver of hope without a lie. Getting honest feedback from a doctor was so refreshing. Knowing that a doctor was thinking about Dani's future was such a relief since some providers refuse to talk about possible interventions as if they are trying to shield Dani from some truth the doctor thinks they are too weak to handle.

Queer-Disabled Community

While the stories Dani and I have are different, we share some underlying commonalities. The first being that we are queer-disabled individuals. Referring to a queer-disabled person or the queer-disabled community describes persons impacted by the multiple identities of queerness and disability. They may inhabit one identity at a time, independently or together (Crenshaw, 1991; Garland-Thompson, 2001; Vernon, 1999). Being constantly challenged or subjected to othering while simply living life causes great harm. However, millions of queer-disabled people thrive in the world despite the obstacles they face and often do so because of those obstacles

Currently, the term ‘queer’ is a reclaimed term, primarily used as an identity marker for those that do not conform with heteronormative practices, allowing for more inclusivity than the standard LGBTQIA+ (lesbian, gay, bisexual, trans, queer/questioning, intersex, asexual, etc.) acronym, which does not explicitly include individuals that engage in other unnamed practices or lifestyles that are beyond socially accepted normative behaviors (Shelly, 2004; Brontsema, 2004). Like many individuals, Riley, one of my interlocutors, does not embrace queer as a personal identity marker and prefers to identify as a nonbinary dyke, but they view themselves as a member of the larger queer community. Within the greater LGBTQIA+ community, the term ‘queer’ is not only flexible in its inclusivity of varying identities on the spectrum of gender and sexuality, but it is also inclusive of those who support political ideologies of activism and inclusion (Birch-Bayley, 2019; Brontsema 2004). My queer identity encapsulates my identity as a gender-nonconforming person, a dyke, and an activist and volunteer in the community.

Figure 6: Three queer-disabled folx at an adventure healing event in Montana for people with Multiple Sclerosis, 2018. Image by author.

Similarly, the term ‘disabled’ is also defined as an identity marker so that those that say they are disabled are therefore categorized as such (Linton, 1998). However, disability in and of itself is a more nuanced subject considering that having a disability and being ‘disabled’ has social and legal implications, including the rights to services and government benefits (Wendell, 1996). I claim ‘disabled’ as an identity marker, primarily because my disability impacts who I am and how I navigate through spaces in the world. But I also claim ‘disability’ as an indicator of my place within society as I am officially labeled as such by the state, as a recipient of disability benefits. In addition to those that claim their disability as an identity, ‘disabled’ also includes those that are marginalized, stigmatized, and categorized by others as ‘disabled’ due to any identifiable or invisible medical impairment, including chronic illness, disease, mental illness, and neurodiversity (Shelly, 2004; Wendell, 1996). Some of the interlocutors did not feel they had a right to claim ‘disabled’ as an identity marker because they do not feel their impairments disable them, but acknowledge that they are othered by society due to their recognizable limitations.

The marginalization of persons in the sphere of the queer-disabled population is rooted in the subordination of both queer and disabled individuals, stemming from compulsory normativity of both cis-gendered heterosexuality and able-bodiedness (McRuer, 2016). We all come into existence in a previously established world where those before us are performing and modeling established norms, passed down generationally, where we are infrequently exposed to cultural “others” (Janika, 2015). Individually, queerness and disability are inherently considered to be an “other” by the mainstream. As both homosexuality and disability have been historically defined as the opposite of normal, either behaviorally or in the physical state of being, queer and disabled bodies are often culturally defined as living in a state of abnormality, at which point, performative normalcy may be attempted but never attained. Living in a queer-disabled body automatically disadvantages and devalues the individual as belonging outside of the realms of normality, noncompliance with fulfilling the compulsory norms, and defying consolidated hegemonic identities (Linton, 1998; McRuer, 2016). People living with multiple identities and oppressions are outside of the dominant normative world, not fitting in fully with any singular predominant group, yet understanding and fitting in with others living in similar margins (Anzaldúa, 2001).

The lived experiences of my respondents and myself prove that not having the ability to be our authentic selves can have detrimental effects on our emotional state and can even negatively affect the type of biomedical care we receive. Hiding our true identity can lead to depression and anxiety and may cause harmful health outcomes. Rainn, a non-binary queer respondent, suffered from extreme depression by hiding his queerness from his family and employers. But since they began living truthfully, embracing their intersectional identity allowed them to emotionally and spiritually thrive and eliminated the stressful burden of code-switching. Unfortunately, it is not always feasible for queer-disabled individuals to live their whole truth at all times. This may mean hiding parts of their queer or disabled identities from various people within interpersonal, professional, or care-based networks. Individuals may feel uncomfortable disclosing their queer status just as much as they may feel uncomfortable disclosing their status as a person living with a disability. This may be especially true for those living with invisible disabilities, conditions not readily noticed by others. If individuals do not feel safe coming out to friends and family, how are they supposed to feel safe coming out to medical providers? The biomedical system has historically pathologized queerness, demonized disability, and vilified mental illness, often institutionalizing people simply for existing (Baker, Beagan, 2014; Eckhert, 2016). It is no surprise that in this curing but not caring medical field that queer disabled people will hide parts of themselves from medical providers, especially when they know they have to advocate for themselves and get providers to recognize their multiple identities and experiences when the system may hurt them more often than it heals them.

Mental Health Madness

Rainn (they/them) is a nonbinary person living with multiple mental health diagnoses, diabetes, hypertension, and other various chronic illnesses. Rainn was diagnosed with multiple mental health disorders including Complex Post Traumatic Stress Disorder (CPTSD), Borderline Personality Disorder (BPD), Generalized Anxiety Disorder (GAD), Attention Deficit Hyperactivity Disorder (ADHD), Type II Bipolar Disorder (Bipolar II), and Type II Diabetes. However, there have been disagreements about the diagnosis among different providers, indicative of a systemic issue within psychiatry (Kirschner, 2013). Rainn still feels that there is stigmatization around their mental health issues and their queerness. Rainn is not alone in this assumption, as the history of clinician bias interfering with the diagnostic process is well documented (Fitzgerald, Hurst, 2017; Snowden, 2003; Wellbery, 2011). It takes them about a year to officially come out about their mental health issues at work because they know it will impact promotions and standing in the company. Rainn also has constant battles with their doctors every time they need blood work or a refill to keep them on PrEP, a prophylaxis medication for high-risk individuals to prevent infection with HIV. They are often the ones educating their healthcare providers on why they need to take the medication, and why it personally makes sense for them to use it. The conversation is so awkward for Rainn, they had to work to become desensitized around the issue. Unfortunately, the medication can increase hypertension and can cause kidney issues. When that started happening, the only option they were given was to discontinue PrEP. Rainn had to ask to find a new hypertension medication. They finally found a queer doctor that understood Rainn’s issues and the importance for them to stay on this medication (Baker, Beagan, 2014). They were able to work together to try different medications to find a combination that worked with their body.

Figure 7: Digital collage by Rainn - Healing Through Art Group

Rainn's first hospitalization resulted from a bad reaction to the combination of Zoloft and Wellbutrin, two common antidepressants, which were prescribed simultaneously. The result was an exacerbation of mental health symptoms. During this hospitalization, Rainn's was changed to Schizoaffective Disorder and they were put on anti-psychotics. It was rapidly determined that it was a misdiagnosis, based on the reaction to the medication regime. Rainn became even more suicidal. Subsequently, Rainn learned they had to handle the system differently. When they were living in and out of shelters, they were constantly treated with disrespect. Now, upon admission to a hospital, they tell the staff that they are working towards their degree in social work and that they are a certified peer counselor trained in handling crisis situations. They are more often treated with respect and given information on any benefits available. Rainn did not understand how important it was to advocate for themselves, and how counterintuitive that is to the process of accessing treatment.

They then tell the care team that they do not want to be alive or exist, but they do not have a plan to die nor do they have a plan to hurt themselves or others. Rainn has spent up to three weeks at inpatient psychiatric units. Rainn began going to the same unit so they would get the same treatment team and noticed that each admission was a shorter and shorter time. Rainn found that when their care team realized they were self-aware, their treatment greatly improved. The team would involve Rainn in treatment decisions and keep them informed about their diagnoses.

Rainn often had trouble with medications not effectively controlling their depression. The doctors would suggest titrating on or off of medications, and the change would often help for a short period of time. But then their body would get used to it and it would lose efficacy. Rainn had another hospitalization for a bad reaction to another common antidepressant medication. And somehow the conversation comes back to PrEP, making Rainn feel that his care team does not have an adequate understanding of how these medications interact in people with complex mental health diagnoses. It is as if his existence as a queer-disabled individual is incommensurable with his treatment plan.

Pregnancy Problems

I have experienced this incommensurability on multiple occasions, usually when interacting with care teams in the ED. Because of my complex medical history, I find myself in the ED quite frequently. Similar to Dani, my journey from diagnosis to diagnosis was long and frustrating. My arrival into this world was nothing less than dramatic, born six weeks late and a medical mystery from the start. My mother was given a cesarean section without even local anesthesia. Doctors found what they referred to as a toxic fluid circulating in my body and determined that the only safe course of action was amputation of both my legs. My mother would not accept a medical decision that she found less than favorable, so she refused to allow that course of treatment. After nearly a month in the hospital, the medical team eventually settled on attempting to drain the fluid from my legs, leaving me with a cute, dimple-like scar on my upper right thigh, which I referred to as my 'chicken-bone-hole' through the majority of my childhood, for reasons I cannot fully explain.

As an infant, I was at the pediatrician's office several times per week with a string of strange allergies and oddities that were never fully sorted. As I got older, I missed school often for one medical reason or another - losing my balance and walking into walls, concussions from my head hitting those walls, recurrent infections and fevers, fatigue, allergies, muscle weakness, and so on. I was always getting scans and blood tests, doctors never finding a root cause to my issues. Some of the problems began to subside in my early teenage years, and I started living a life that no longer revolved around running to the doctor's office several times a week. Unfortunately, my mother suffered from a Traumatic Brain Injury (TBI) and became abusive. I ran away from home at fifteen and lived on the streets for close to a year. When I finally returned home, I married my middle school sweetheart and got pregnant a week later. After my daughter's birth, I began having neurological problems, often falling or feeling a heaviness from the waist down. The doctors at the time dismissed the issues due to my age, stating they thought it was likely a sensitivity to the epidural that would resolve without intervention.

Figure 8: A rare maskless moment, smiling through the stress, during a hospitalization from an MS flare in August of 2020. Image by author.

In my twenties, I started getting migraines and experiencing some cognitive difficulties. My doctor ordered an MRI (magnetic resonance imaging) of my brain to "make sure it's not a tumor," almost laughing it off. When the results came back, she referred me to a neurologist for follow-up. When I called to schedule the appointment, the scheduler asked if I was calling for an initial consultation for my MS. I indicated that I was referred by my primary care physician (PCP) after an inconclusive MRI, and I was promptly informed that the neurologist I was scheduled with was an MS specialist who only saw patients with MS. I dropped the phone. The only reference I had for MS was a family friend that recently died from MS-related complications and the knowledge that Dr. Kevorkian (aka Dr. Death) had assisted MS patients in ending their life.[4] I made a panicked phone call to my PCP and she told me that she wanted to rule out MS, and sending me to a specialist made the most sense. Over the next two years, I was often at the doctor or hospital several times per week. I endured several MRI's, a lumbar

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[4] "Kevorkian Helps a Suffering Woman With MS Commit Suicide" - John Hilkevich, Seattle Times 1995 https://archive.seattletimes.com/archive/?date=19950822&slug=2137672

puncture, evoked potential nerve testing, urodynamics testing, and lab panels while experiencing intermittent bladder problems and sensory deficiencies before I finally got an official diagnosis. My doctors also recommended that any future plans of having more children be postponed indefinitely, and I had a tubal ligation[5] months later.

One continual point of contention in my treatment plan revolves around pregnancy testing. I am often in need of emergency imaging, such as a computerized tomography, or CT scan, that uses rotating X-ray machines and computers to construct a detailed set of cross-section images of the body. These scans are often done with and without an iodine contrast solution in order to provide a clearer image for the diagnostic team. While there is a small amount of radiation exposure from a CT scan, it is unlikely to do any serious damage to a fetus, should the patient be pregnant.[6] In my case, I have informed many ED care teams that I had a tubal ligation, that I am in medically induced menopause due to severe endometriosis, that I am a lesbian/queer not engaging in any sexual activity that could result in pregnancy, that the possibility of me becoming pregnant is scientifically impossible, and that if the laws of science and nature were somehow broken and an embryo was growing in my uterus it would need to be promplty removed because of my health, age, and for my sanity. And yet, they still make me wait, often for hours, for the negative pregnancy test before proceeding with CT scans or other various imaging. To add insult to injury, they charge me for the test I said I did not want or need.

There are several issues surrounding emergency medical treatment and the need to determine a patient's pregnancy status, and no easy solutions. One of the first questions AFAB (assigned female at birth) or femme-presenting patients are asked upon admission to the ED is if there is any chance they may be pregnant and the date of their last menstrual period (Koksal, et al., 2013; Olshaker, 1996). This question, seemingly benign on the surface, can be problematic depending on the patient's gender identity and sexual orientation, especially if they are not out to their healthcare providers or to any friends or family that may be in the room during their visit. If they indicate to the treatment provider that they are queer, that does not disqualify the possibility of pregnancy. However, if the patient indicates that they are not engaging in sexual activities that would result in pregnancy, the care provider should be able to utilize this information to proceed with imaging without waiting on a pregnancy screening. Rather than take the patient's word, the provider usually processes a pregnancy screening without asking for consent. Providers may assume that patients do not always disclose the full truth, possibly because of personal repercussions, in the case of a partner violating terms of a relationship, a child not wanting to disclose sexual activity in front of a parent, or a sexual assault the patient does not want to discuss. The list is endless. Medical facilities justify a pregnancy screening is simply erring on the side of caution.

The issue is further complicated for trans patients in the ED, especially when visiting medical facilities that do not have their full health history. Trans women may need to disclose their status to avoid delays and unnecessary testing, while trans men may need to inform a

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[5] "Tubal Ligation" - The Mayo Clinic https://www.mayoclinic.org/tests-procedures/tubal-ligation/about/pac-20388360

[6] "CT (Computed Tomography) Scan" - Healthline https://www.healthline.com/health/ct-scan#risks

provider that they are in need of a pregnancy test, even if they were not asked about it due to transmasc presentation. Not only could the situation be personally uncomfortable for the patient, but there is also a possibility that the information could put the patient at risk. Dani worries that disclosing their gender identity may result in a physician refusing to treat them (Crenshaw, 2016). While they do not necessarily worry about that happening in a Seattle hospital, they have heard horror stories from friends living in less progressive parts of the country.

Trips to the ED are also complicated for Dani. One trip, in particular, stood out, as they suspected it would be a simple visit. Their Intra-Uterine Device (IUD) fell out for the second time in three months. Finally, something that had nothing to do with EDS. Dani was a little irked when they realized the attending physician was a man, simply due to the conversation they knew was coming up. He was taking his time trying to dislodge the device and said to Dani, "Let's talk about your birth control options." They explained to the doctor that they only have the IUD because of their illness. The doctor kept pushing the issue, trying to go over all of the available birth control methods they could use. Dani explained that he did not have any information they needed and became increasingly uncomfortable as they did not want to have to explain that they are gay and do not need to worry about contraception. What should have been a simple visit ended up causing emotional distress. During ED visits, Dani is always asked about the possibility of pregnancy, and when they finally explain the impossibility of the situation, the rest of the visit sometimes devolves into questions about their sexuality and gender (Crenshaw, 2016). Dani wishes that patient intake forms could include these types of questions so they could avoid all of the extra emotional labor involved in explaining themselves while in the middle of a medical emergency.

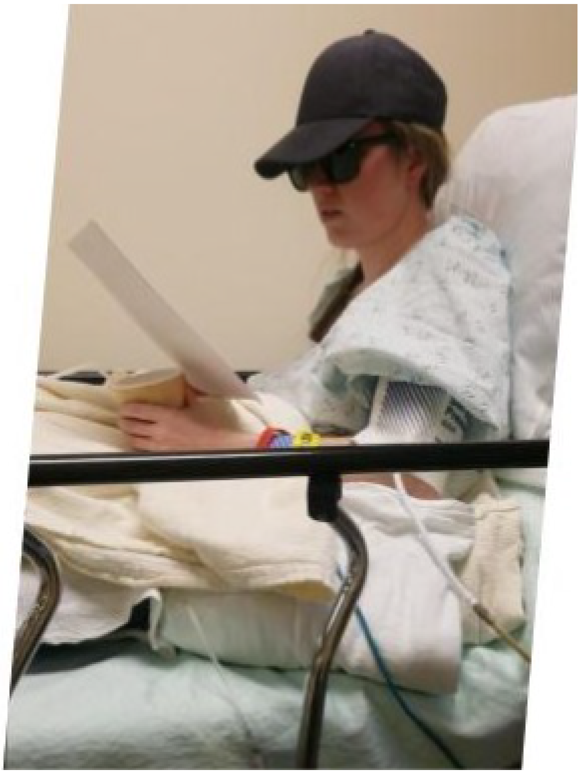

Figure 9: Dani in the hospital for a routine visit. Image provided by Dani.

Outside of an ED, Dani has other concerns regarding pregnancy. While some specialists have told Dani that it's safe for them to have children, once their cardiologist learned of their sexual orientation, they retracted their stance on safety and excitedly encouraged Dani to find a partner willing to carry a child instead. Dani felt as if their care team was simply appeasing them based on the assumption that individuals that present as women must all want to carry children. Dani argued that they were not too delicate or fragile to need to pretend the potential for fatal complications was not an issue. Dani questioned why medical advice would drastically change based solely on their sexuality and gender identity (Kirschner, 2013; Peacock, Patel, 2008). This fed into Dani's existing worries that the standard of care for cishet individuals was different than for queer individuals, possibly due to implicit or unconscious biases which could affect treatment outcomes (Crenshaw, 2016; Fitzgerald, Hurst, 2017).

Riley (they/she) is a nonbinary dyke living with chronic intractable migraines[7], allodynia[8], and an eating disorder. Riley feels stigmatized in the medical community. Trying to explain sexual situations to medical providers is often uncomfortable. They acknowledge that they have to be asked about pregnancy because they could be in a lesbian relationship where they could become pregnant through insemination or if their partner was a woman with a penis. But when medical providers ask those questions, they are often confused. Outside of specific queer health clinics, most providers do not think of trans inclusive lesbian relationships and how that can affect health outcomes. Riley often gets upset because sometimes people make mistakes, but she often feels the need to appease the provider while getting into an internal debate on gender politics. They question the validity of stating, "Oh, I'm a lesbian" when asked about birth control and thinks they should rephrase their answer to "I'm not having penetrative sex" or "I am not currently having penis-vagina sex" or even "I have no contact with semen at the moment with my current partner." Riley feels that the different parts of sexual contact should be part of a normalized medical discussion and that the word "sex" should not default to the assumption of "penis-vagina sex."

Biomedical Bungles

Riley admits to not wanting to engage in pessimism, but they never think there will be a point where everyone is ambiguous and when no one cares about gender, genitals, or genetics of people and their partners. They hope one day people will just go about living their lives, but until then, Riley finds comfort in the fact that they are not alone. Despite how awful it is that so many people are suffering because of queer issues, disabilities, or both. They have difficulty reconciling where they fall in the disabled community and if they belong or if they are actually an imposter. They struggle with their diagnosis identity, even after being diagnosed with chronic migraines and nerve pain, and later diagnosed with absence seizures. They were dealing with these issues for almost a decade and still did not feel they knew where they belonged.

Riley was having mood swings and ups and downs and random pains that were hard to describe. This was going on for about five years when they started having more extreme black outs, walking around and losing complete consciousness and falling over. Prior to Riley's migraine diagnosis, during one hospitalization, the medical team prepped Riley for neurosurgery before quickly changing the treatment plan. Riley kept thinking it was so extreme that it must be

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[7] "Intractable Headache" - The American Migraine Foundation https://americanmigrainefoundation.org/resource-library/intractable-headache/

[8] "Everything You Should Know About Allodynia" - Healthline https://www.healthline.com/health/allodynia

something more serious than a migraine, which they felt was not a “big deal.” Otherwise, why did their care team keep looking for surgical interventions?

The biomedical interventions made them feel like an imposter, constantly having to fight for their doctors to take them seriously (Mattingly, 2014). They would have so many visits where the doctors could not find anything wrong with them, yet they were in agonizing pain. They were often told that everything was fine and the team would discharge them from the ED even when their pain level was a seven. They thought that it was possible they were overreacting to their own pain. They did not feel like they were exaggerating, but they felt that maybe they did not know how to interpret and explain their pain. The fact that Riley is young and active is one of the reasons they were often sent away without resolution by their care team, as they made the judgment that their pain must be overexaggerated based on perceived age, gender, and socioeconomic status (Peacock, Patel, 2008). Logically, they knew that they were experiencing excruciating levels of pain on a regular basis, but they doubted this reality because their care team did not seem to take their situation seriously (Eaves, 2015; Boujaoude, 2020).

Riley has struggled to find a provider that will appropriately manage their pain as they have a history of misuse of painkillers in their medical record. The misuse noted in their file was an intentional overdose of narcotics during a time when Riley’s pain and other personal issues were becoming too much to bear. Because of this history, physicians turn to alternative forms of treatment such as suggesting biofeedback training, meditation, and mindfulness to cope with often debilitating pain. They feel like the doctors expect them to somehow fix themselves, and they try, with mixed results. Riley has learned to try and calm their whole body to try and fight off inflammatory attacks that lead to seizures. They found that controlling their diet has been somewhat effective, but is a dangerous path for Riley to go down.

Riley’s childhood experience with eating disorder treatment facilities led them to feel that all the treatment for eating disorders is inherently fatphobic and elitist. And because they do not have faith in the system to find a validating treatment option, they try to manage their disordered eating behaviors without medical or therapeutic intervention. This puts Riley at high risk for relapse of both the eating disorder and further suicide attempts. But even with their record of an intentional overdose, they still give Riley prescriptions in small quantities that have the potential for misuse. They are very careful about dispensing the medications, to the point where Riley feels their pain experience is invalidated, which is worse than not treating the pain at all. Riley feels like their care team is not actually protecting them, and it has led to feeling like they no longer need or deserve treatment for their pain, leaving them more likely to turn to other substances for relief. Everything relating to pain is anecdotal and subjective. Unfortunately for Riley and others like them, individuals with migraines and nerve pain are often undertreated and the pain is never appropriately managed. And Riley’s body adapts to new medications quickly, so that even with increased dosages, every treatment eventually fails. They have found no ‘magic bullet’ that will work for Riley in the long term.

With the legalization of both medical and recreational marijuana in Washington state, medical providers will now recommend using cannabis to patients when nothing else seems to be working. Occasionally, Riley will use cannabis to treat their pain. Unfortunately, they never found that it was helpful to actually stop the pain and found that rather than taking the pain away, it provides an escape, but does not fix the problem. Unfortunately, some cannabis strains induce Riley's migraines, completely invalidating the purpose of turning to the substance in the first place. Then Riley is high and in pain, not a combination of feelings they enjoy experiencing. So they start the same cycle over again and again, trying new medications to manage their conditions until they ultimately fail and the cycle continues. Riley feels the biomedical system has failed them.

Methods Mayhem

______Riley is not alone. In fact, all of my respondents felt let down by the biomedical system in some way. Despite the multiple intersections of identities represented in my group of interlocutors, the prevailing commonalities remained that they felt the biomedical system failed them and that they found a space where, through art, they could heal. These findings were made possible by making genuine connections with a group of queer-disabled peers, taking the time to get to know them and hear their stories, listening with respect, and sharing stories of my own. Only through this intense form of peer-observation and ethnographic research was this information gathering possible.

I formally embarked upon this research project late in 2019, when putting together a statement of intent for undergraduate honors research, initially looking at the accessibility of art therapy in the Seattle area for queer-disabled individuals. I wanted to know how other queer-disabled people, like myself, came to experience healing through art but had not quite determined where to begin the research. Living in the Pacific Northwest, I was not concerned with finding respondents. Seattle especially is considered by many to be one of the most accepting areas in the country for LGBTQ+ individuals[9] and boasts the largest chamber of commerce for LGBTQ, and allied businesses, corporations, and nonprofits in North America[10]. Unfortunately, the COVID-19 pandemic shut down the world just as I was preparing my research proposal. The intent was to move forward with traditional in-person interviews when the restrictions were lifted. But by summer of 2020 when I was ready to move forward, we were all still isolating at home.

The COVID-19 pandemic presented many challenges, as I not only planned to conduct ethnographic interviews, but I intended on doing participant-observation work with a cohort of queer-disabled individuals where we would have the opportunity to share our lived experiences while concurrently working on a collective artpiece designed for public installation. The idea

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[9] "The ten best cities for same sex couples in the US" - Insider, F. Olito (2020) https://www.insider.com/best-cities-for-same-sex-couples-2020-6#seattle-washington-is-the-best-city-for-same-sex-couples-in-the-us-according-to-the-study-1

[10] "About Us" - GSBA https://www.thegsba.org/about-us

was to process together, make art together, and heal together and then have something tangible to show for it. It became more clear that doing this within a physical space together was an impossibility, so to achieve this goal, it was necessary to shift to an online environment. Over the past few years, I had been a somewhat active event organizer within the Meetup community, mostly within the Seattle Lesbian Social network, a group with over three thousand members. Meetup is an online platform designed to connect people with common interests for social gatherings[11]. All Meetup groups were directed to discontinue in-person meetings and encouraged members to move meetings to online spaces. With the knowledge that all people participating in the Meetup community were used to browsing for spaces of belonging that spoke to them, and that they were now accustomed to an exclusively online environment, it made sense that it would be an effective recruitment tool.

I formed a Meetup group, entitled "Healing Through Art: For the Queer-Disabled Community." The page publication announced the details of the group, clearly stating that this was for research purposes approved by UW's Institutional Review Board (IRB) and that I was not a mental health professional. All interested members filled out a request to join the group, indicating they were at least eighteen years of age, and identified themselves as LGBTQ+ and were disabled or living with a chronic health condition or mental illness that significantly impacted their quality of life. The initial response was quite significant with over fifty people signing up for the group. Due to scheduling and the nature of these groups, significantly less people attend actual events.

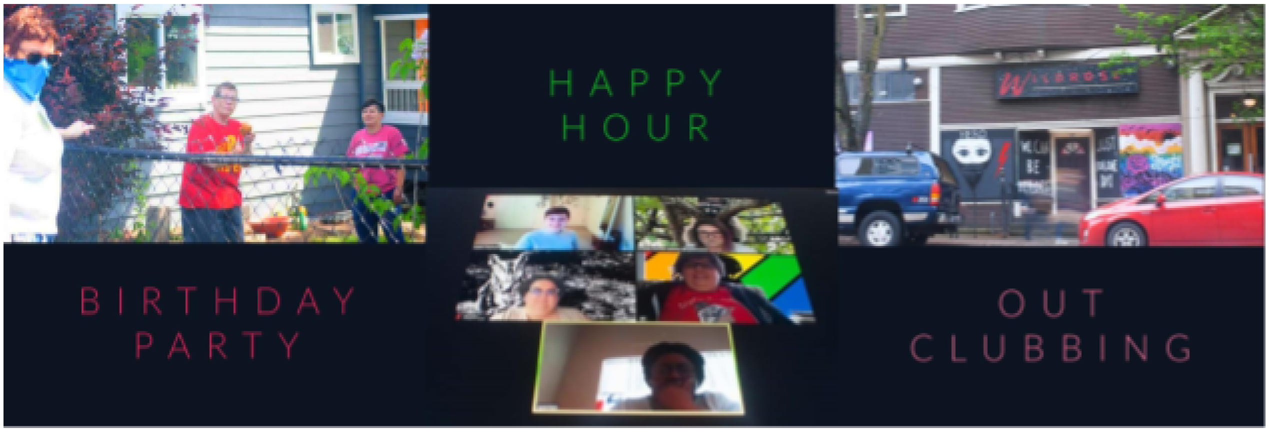

Figure 10: Love in the Time of COVID-19, *Tiffany-Ashton Gatsby, 2020. Image by author.*

I was still unsure of how to create art organically in an online space. In addition to interviewing three licensed art therapists, I spent seventeen hours of online coursework on guided art practice for self-help groups and for life-coaches. The entire point of my participant-observation space was to form a collective, rather than have a group lead by one individual driving the conversations and instructing them on what type of art to make. It wanted

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[11] "About" - Meetup https://www.meetup.com/about/

the group meetings to flow naturally. So I decided to start the meetings and hope that we could collectively decide on the best path forward as a group, rather than by my direction.

The group met for an hour to an hour and a half weekly for about twenty-two weeks, skipping some sessions for holidays. In total, there were eleven different respondents at the sessions. The majority of meetings had four participants, including myself. All but one participant attended more than one meeting. Some attended regularly, and some sporadically. All of the participants consented to audio recording and agreed to have any art they created used in a collective project. After the first meeting, I scheduled individual orientations for all future participants, consisting of approximately a half-hour discussion with each individual prior to them joining the group meetings.

Our initial discussions centered on what brought the individuals to the group. This started a dialogue on why these queer-disabled individuals were looking for a healing space, and why they felt that art was their way to find that healing. Held over Zoom, the initial meetings were somewhat awkward. While an online meeting space may provide less human interaction than an in-person meeting, the direct focus on everyone's faces on the screen was more intimate and more vulnerable. All participants kept their cameras on by their own choosing. While I am comfortable discussing personal information with people, I had no idea how this space would feel. I wanted to share many of my stories, but I did not know if they would be well received or accepted. However, I knew that if I was not able to open up and be completely comfortable, I could not expect that from any of the participants.

When I began sharing bits of my journey as a queer-disabled person and how I found solace in art, I was met with resounding echoes of "Yes! Me, too. I understand. Same here." While those reactions were somewhat expected due to the many commonalities we all shared, there was an immense sense of relief that washed over me as if a weight had been lifted from my soul. I was surrounded by people that were not just empathizing with my experiences because they were compassionate, they understood my experiences because we shared them. The group began to flow more naturally from there.

In addition to these participant-observation sessions, I completed in-depth interviews with three interlocutors, two that were participants in the group, and another individual who expressed interest in the research. Each interview was approximately two hours in length, however, significantly more time was spent with the interlocutors that were part of the participant-observation group when they would log in early or stay after our meetings. I also spoke more informally with over a dozen individuals that identified themselves as part of or adjacent to the queer-disabled community, including artists and researchers. I attended multiple online seminars and conferences throughout the past year relating to disability visibility, disability justice, public art, and community art activism. I reviewed relevant literature pertaining to the queer-disabled community, healing through art, biomedical interventions, and applicable theoretical frameworks.

Additionally, I conducted hour-long interviews with three art therapists, two of whom identified as LGBTQ+ to gain insight into the difference between community-based art compared to more formal and therapeutic art therapy practices. I met with one of the founders of the NAMES Project AIDS Memorial Quilt, and a curator from Tangled Arts Gallery in Toronto. The majority of these interviews would not have taken place prior to the COVID-19 pandemic. However, the rapid familiarity everyone gained with using Zoom removed the barriers created by distance. I was no longer tied to the Seattle locations accessible by public transportation. I was able to speak to someone in San Francisco, in Canada, in Anacortes, in Bellingham. When this research began, I thought that the COVID-19 pandemic would be a barrier to successful research, but it manifested into quite the opposite experience. It enhanced the process, allowed for audio transcription and recordings that were an asset to the written work, but proved a far greater asset to the final artwork created during our meetings. Without the shutdown, most of this would have been beyond reach.

Art Heals Better Than You Sometimes, Doc.

I’m very present when I’m taking pictures, it’s like really zoomed into the detail and it’s like I’m there, I’m right there. And when I was suicidal and I couldn’t be present, photography brought me back to the joy of being present and the beauty in life. Time moves in a different way.

~ Sandy

I know when I was in the psychiatric unit, like art therapy, that's what really helped the most for me. Like, I think I said it before, too. It gives you control over something. You can make it however you want to.

~ Rainn

I wanted this creative outlet and dance wasn't working, so I tried photography. It was a way to do something creative without, you know, passing out from physical pain or without the body image issues from dance. So it was something that I could put that creative outlet into with a lot of strain. I go out to the arboretum and take photos and I find things that I enjoy. That's really, really calming and really, really helpful for me to feel like I'm doing something and creating something, but it's, you know, no pressure.

~ Riley

Figure 11: This was my first attempt at photography borrowing a friend’s camera. The trip to the Washington coast in July of 2007 was meant to process my recent MS Diagnosis. Once I started taking pictures that weekend, it was the best I’d felt, emotionally, in years. Images by author.

When I asked each one of my respondents why they were interested in joining a research group to explore healing through art, they all shared very similar answers. They had all, at one time or another, sought a creative outlet to process trauma or to distract from it. Rather than focusing energy on pain, the energy was focused on creating. Each of us described moments when we were not the ones in control of our lives, our emotions, or our bodies. Making the choice to turn to art allowed us to take control over our emotions and bodies, even if only for several moments at a time. We choose to expend energy on creative activities in which we have the ultimate final say as a way of recapturing our agency, which is often usurped by our care teams, our family, and our own bodies.

Why Art?

In many ways, each interlocutor's story illustrates how using art in the process of healing is about finding a sense of comfort with the self through addressing broader social and political issues. Fighting back in any way against systems of oppression that are detrimental to the health and welfare of the queer-disabled community combats collective negative health outcomes within the broader community (Mishori, 2019). Using art to heal has provided us all with the opportunity to restore a sense of self by pushing back against the decades of injustices and mistreatment faced by our queer-disabled communities while forced to abide by compulsory heteronormative and ableist standards (MacRuer, 2016; Stuckey, Nobel, 2010). The long genealogy of reclamation of identity through art brings both visibility and healing to various communities, as observed through the reclamation of Camp[12] as an artform and activist strategy in the queer community (Meyer, 1999). Another community activist strategy that is often employed through the arts is Disability Justice, a framework or movement that embodies the principles of intersectionality, leadership of those most impacted, anticapitalism, cross-movement organizing, wholeness, sustainability, cross-disability solidarity, interdependence, collective access, and collective liberation (Berne, 2015). I attempted to keep the principles of reclamation, community health, solidarity, wholeness, protest, activism, and intersectionality in mind during the research process and in the forefront when creating artworks for facilitating healing.

At two years of age, Riley started dancing, professionally trained in a dance studio and with the Pacific Northwest Ballet. Their only friends were through the dance studio, in an intensive competitive environment, where everyone was simultaneously a best friend and worst enemy. Riley was pre-professional, meaning they trained to pass annual exams in order to qualify to the next level. Those levels eventually led up to an interim contract with a dance company. This meant they had the option of going to college for dance or apprentice at a company to be a full-time professional dancer. Unfortunately, Riley fell down a flight of stairs, fracturing her spine and causing a concussion and mild TBI (Traumatic Brain Injury) causing them to take a

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[12] "What Does It Mean To Be Camp" - BBC. https://www.bbc.com/culture/article/20190503-what-does-it-mean-to-be-camp

nine month break. At the pre-professional level, there was no way to keep up the intense training regimen.

During the healing process, they lost their pre-professional spot and had to audition to get it back. While they were able to get back at a lower level, their body was not ready. This happened when Riley was fifteen, right when they were in the middle of puberty. This is considered the worst time to stop dancing. Dancing at all became too taxing because of the new limitations on their body because of the injuries, but also lost some basic functionality. At fifteen, Riley felt their whole life was falling apart and completely stopped dancing.

Riley realized they had not acknowledged how important having a creative outlet was to their overall mental health and wellbeing, recognizing that dance is an art, although never identifying as an artist. During college, they took an interest in photography, partially because they felt they had a calling towards the arts. Their interest took off because they needed a creative outlet when dance was no longer working. Riley began going with their friend to various photoshoots and started experimenting. Once, Riley was helping their friend second-shoot a dance performance. It inadvertently got Riley back into dance, but at a recreational level, where they could find their body's limits. They felt like photography was the thing that made them come full circle. Doing something creative without passing out or without dealing with body image issues was something Riley could channel creative energy into without a lot of strain. Riley eventually realized that the lack of a creative outlet caused by their chronic health issues damaged their ability to do their originally chosen art form, giving them a new and different appreciation for it.

Despite Riley's love of creativity and expression, their perfectionist tendencies and insecurities often caused them stress when turning to art. So while Riley loves hanging out with their camera taking photos, their photographer friends pushed them to commoditize their photography. Riley could not shake the idea that the photos would not be good enough to charge someone for and decided it may not be beneficial to charge for their work. They enjoy going to the arboretum and taking photos and find that immensely calming when there is no expectation of perfection, no exchange of goods for payment. Creating without pressure is key. Riley found that in those moments, the outside noise faded away and they were no longer focusing on their pain, something that rarely happened when solely relying on biomedical intervention (Stuckey, Nobel, 2010). In these moments, the art was a conduit towards the reclamation of their whole self.

Figure 12: Photograph by Sandy, Healing Through Art Group. Image by Sandy.

Sandy has not worked in over two years due to PTSD and other mental health issues, as well as a digestive disorder and underlying lung condition. They spent the majority of their life, as they described it, ‘art-phobic.’ The only exception to this was photography. Their obsession with the camera on their iPhone exposed them to find an accessible and creative outlet later in their life. Finding something that brought joy to their life made them more able to focus on the present, but also helped bring them out of a major depression when they were dealing with serious suicidal ideation. For Sandy, the act of documenting some of their more negative experiences is extremely powerful. Why they acknowledge that those photos may not be their favorites to look at, they can look back and remember what they were going through, while being thankful at the progress they made that brought them to where they are today.

Rainn says they like to explain an association they have with feeling suicidal as feeling like they are watching themselves from the outside. There are potential paths or timelines that can happen. They think of science fiction shows and play out the multiple timelines in their head. When they were in high school, Rainn experimented with photography finding peaceful moments when alone in a darkroom developing their prints. More recently, Rainn began channeling all of their energy into plants when the early signs of depression or suicidal ideation surface. Now, whenever they are feeling depressed or suicidal, they start researching plants; how to care for and propagate them, and how to design pots that are appropriate for each type of plant. Rainn feels like the intersection between art and horticulture resonates with them. Not only does it give them something to create, but it also gives them something to care for.

Rainn noticed that when conversations with their mother devolved into overstepping boundaries and became more aggravating and triggering, they usually started spiraling. Recently, after an emotionally intense conversation with their mother, Rainn ended up down a rabbit hole searching for memes that would passive-aggressively irritate their mother. They found a relatively funny meme they thought would be good for plants. They found a pot and started painting it, and realized that it bounced them out of their usual pattern of negativity and anger. As soon as they were focused on decorating a pot for one of their plants, it helped de-escalate their emotions.

Figure 13: Selfie-Collage by Rainn, Healing Through Art Group, 2020

Rainn has been hospitalized for mental health issues multiple times. They always gravitate towards art activities in order to focus and self-soothe. Whether it was nature walks for inspiration or sitting in one of the rec rooms drawing, Rainn found they were able to focus their attention on something within their power to control when their world felt like it was falling apart. When the COVID-19 pandemic sent everyone into isolation, Rainn began having extreme anxiety and depression. They were browsing Pinterest and saw an air-dry pot project for small plants, so they ordered some clay and started experimenting. They had never worked with it before, but they started making small air-dry pots for their plants, and it made them happy. Rainn looks back at that as the project that helped get them through the early part of quarantine.

Dani graduated from college with a degree in music, so they were accustomed to turning to art to process their emotions. Dani tried photography, and really enjoys it but recognizes that they have any actual skill. When they were performing music, there were high-pressure steaks, which is why they love photography. They do not feel the pressure to create something that anyone thinks is nice. They are not seeking outside validation, and they can create for the sake of creating. The same applies to the work Dani has done painting. They do not have any work they think is objectively good, but when they had a severe concussion and could not turn to music to heal, they turned to painting to get them through. Without a creative process, they felt their recovery time would drastically increase. More recently, Dani focuses on documenting their visits to the hospital and usually snaps selfies whenever they visit, sometimes multiple trips weekly. That documentation provides some tangible evidence of their constant interaction with the biomedical system and gives them something to look back on to note the changes they have undergone, positive or negative.

Figure 14: Selfie-Collage by Dani, Healing Through Art Group, 2020

JC (they/them), who identifies as trans, has dealt with major depression since they were young. These issues were compounded after getting kicked out of their conservative midwestern home, and they became suicidal as the stresses of living in their car was too much to handle. When JC was hospitalized, they found that using art as a way to deal with unexpressed emotions significantly helped them cope. The treatment facility referred JC to a nonprofit organization that brings professional artists in to teach art to people experiencing homelessness, domestic violence, and mental health issues. The intent is to restore individuals and communities from trauma through engagement in the arts and community, which is quite a different approach than art therapy, but no less effective. Rather than using art as a therapeutic tool, JC was making art for the purpose of channeling their creative energy into something productive, which gave them purpose. After some time in transitional housing, JC was finally able to secure a permanent home through the Seattle Housing Voucher program and continued to attend the art classes as they transitioned to Zoom. JC felt that without that touchstone keeping them engaged in creating, they would sink into a deeper depression. Like JC, some individuals experience post-traumatic growth, wherein the individual's psychological wellbeing is perhaps better than it was prior to being faced with adversity (Murtagh, Lobban, 2018). After years of mistreatment by their family and society, JC was able to reclaim their queer identity and is fairing better now than when living at home.

Keesha (she/her), a lesbian with depression and anxiety, lives in a small trailer in rural Washington with her wife. Keesha has been unable to work for several years and receives Social Security Disability Income (SSDI) due to her disabilities. Despite spending over two years trying to qualify for SSDI, when her claim was finally accepted, she did not feel relieved but felt defeated and depressed. Keesha felt she was not officially labeled by the government and society as 'disabled' and it meant the end of working or the possibility of a career. There is no lesbian community where Keesha and her wife live, which makes it difficult for her to want to make social connections. When her wife is at work, Keesha spends her days in a small trailer. The boredom and isolation were becoming intolerable and making her mental health worse, so Keesha began crafting. She started weaving baskets out of old magazines and making wreaths from newspapers. Keesha felt that being creative kept her busy and gave her a sense of purpose. She also found a local artist that offered

Figure 15: Cellphone art by JC, Healing Through Art Group, 2020.

biannual nature retreats, the idea being to disconnect from your daily life, commune with nature and use found items to create pieces of art. Keesha found that looking forward to these artist retreats kept her excited about the future, something she had not experienced in a long time. The act of breaking free from her daily routine and creating art in nature, actually allowed her to feel more like herself than she did when she was spending days on end at home in solitude.

As a kid growing up in LA, it was normal to do some performance-based art. I was involved in tap and ballet, did some modeling, some stage acting, and directing. I was never interested in visual arts outside of filmmaking, but as a teen, my mother put a stop to that creative outlet and pulled me out of drama. Not only was a creative outlet taken away, I lost a good portion of my friend group, and I was bitter. When I ran away from home at fifteen, one of the ways I attempted to support myself living on the street was through doing hair wraps, covering small braids of hair with embroidery floss and beads, at county fairs, art shows, concerts, and festivals. But once I came back home and settled into a career and being a mom, other than knitting and crochet, I turned my back on any form of creative expression until I was thirty. I was coping with the new MS diagnosis and worried about my career and my future. I went on a camping trip to the Washington coast with my kiddo, my spouse, and one of my in-laws and spent countless hours running around taking photos, mostly of trees and ripples in the sand. My mom used to joke that I would waste all of the film taking pictures of trees whenever we went on vacation, so I was happy to use a digital camera so I could waste as much space as I wanted on trees with no consequence. I was drawn into this world where nothing exists except for what I saw through the lens. It was peaceful. And for some reason, it felt like I was doing something important.

I had absolutely no idea what I was doing, but I got a fancy digital camera with a few giant lenses and started dragging it with me everywhere; restaurants, casual walks, hiking, to the mall, and the library. This went on for a few years. However, when I was hospitalized in 2014 with a major MS relapse, it took years before I turned back to art. My vision difficulties and lack of fine motor skills made photography a depressing option, as it brought more attention to my

Figure 16: Challenging Heteronormativity, *Tiffany-Ashton Gatsby, 2019*

deficiencies rather than providing a distraction. I started painting in 2017 and was immediately transported to a different mental and emotional space. I was fortunate enough to have unlimited studio access while attending SCC in a large space where I could stretch out and take over without needing to interact with others. Some days, I would spend ten hours in the studio, completely losing track of time, absolutely absorbed by the process. I immediately began experimenting with new materials, combining beach sand and ground glass in my paint. While my professor was extremely supportive, they were relatively conservative and I worried about my identity as a queer individual as well as creating queer-themed art. They never came out against it, but rather would look curiously, or really question the work like there was a lack of understanding.

The intersection of queerness and disability has often made me feel uncomfortable, even during the creative process of making art. The critique process is often lengthy and challenging for disabled persons to endure, but able-bodiedness continues to be compulsory, so I have chosen to create works that push back against these expectations. Compulsory heteronormativity surfaces when categorizing queer art pieces as a niche; as such, I have attempted to create pieces that actively challenge the ideas of heteronormative sex acts (Buckner, Morrissey, 2016). Trying to push boundaries by challenging heteronormativity and calling out the inaccessibility to the arts has often been met with less than positive reactions, which is the very reason it is so important to do so (Cyrus, 2020).

Outside of the physical act of making, and the emotional energy focused on creating, the act of displaying work on subject matter that was once considered, and still considered by some, as taboo, brings another level of healing through art. Neither myself nor any of my respondents would challenge that the therapeutic benefits of the art-making process are undeniable (Ruiz Pellachini, 2012). And while artistic practice may not take place in an official therapeutic capacity, none of my interlocutors could deny that the level of care-taking, working towards wholeness, healing, and understanding that goes on when creating a piece of art individually or with others is therapeutic. As therapy implies care-taking, working towards wholeness, healing and understanding, and art is a creative process, often involving risk-taking and imagination, it makes sense that the art can be beneficial when utilized in the therapeutic process (Robbins, 1994).

Figure 17: Art for the Abled, *3'x4'x3' Tiffany-Ashton Gatsby, Mixed Media Sculpture, 2020*

Societal constructs often turn into public policy that legislates people's lives based on their otherness. Ranit Mishori explains how the Political Determinants of Health directly correlate to policies and laws that impact the health of a nation, from something as simple as seatbelt laws to countries experiencing regime changes, these policies affect health outcomes (2019). Challenging societal constructs that result in the marginalization, stigmatization, and othering of people based solely on inhabiting their bodies is not only a moral imperative but a process that can also lead to powerful forms of healing on a greater scale. Marriage equality, bathroom bills, immigration restrictions, segregation, forced reeducation of indigenous children, slavery, and the Holocaust are all examples of varying degrees of politicized actions resulting from living in an othered body. The resulting damage can lead to poor health outcomes, which can range in severity from stress, anxiety, depression, income inequality, poverty, intergenerational trauma, loss of life, to cultural erasure and genocide. If the act of making art in protest calls attention to major issues, and the maker feels empowered by challenging these legalized structures of inequality, it will result in healing from political traumas. When the artwork sparks a movement for change, it can heal individuals, communities, or even nations. This is a type of healing that no amount of biomedical intervention could ever address, however, art can and does heal in this way and can lead to lasting change and healing.

Community-Based Art In Action

I promised myself that I would at least dedicate one hour a day to just drawing whatever for Inktober to, kind of like, get myself in that art headspace.

~ Rainn

Yeah. But, but, yeah, it's kind of like on and off when I feel like I can do art, too, because sometimes I have limitations. But that's why I'm stoked to see and do something different.

~ Dani

Yeah, what's the disorder? If you're embarrassed about your doodles?

~ Sandy

Community-based art projects have been in existence for quite some time as an approach to art practice wherein participants, with or without the inclusion of outside organizations, create art for their community with the intent or outcome of producing social change (Madyaningrum, Sonn, 2011). The success of these projects is often determined by the enthusiasm of the community that comes together to create, educate, and heal. These projects often rely on various civic institutions, such as local art galleries, museums, and government offices to boost marginalized and disadvantaged communities through diversity and inclusion, but also allows individual and collective artists to have an impact (Borrup, 2009). These projects are typically designed for display in highly visible areas to achieve maximum exposure for the targeted group or area, often a site of resistance, designed to remove barriers to accessibility to the arts, allowing low-income, disabled, and other marginalized communities to celebrate art without facing the barriers of accessibility to galleries and museums. It enables marginalized groups to be part of the conversation, often reserved for the elite and the well-educated. Projects can be as simple as a single artist working with a local business owner to design a mural or as complex as the AIDS Memorial Quilt, bringing visibility and acceptance to the queer community and those living with HIV/AIDS at a time where a diagnosis was highly stigmatized.

As evidenced by my research, engaging people to work together in the creative process is one-way community-based art projects often aid in affecting physical well-being through the capacity of finding a common interest or goal (Borrup, 2009). Through the lens of Crip Theory, an intersectional framework that lives somewhere on the margins of activism and a movement between Disability and Queer Studies, we can utilize art to come together as a community and identify how both compulsory able-bodiedness and compulsory heteronormativity impact our lived experiences within biomedicine, family systems, and broader society (McRuer, 2006). In our case, we processed our exclusion from mainstream society and focused on finding spaces where we were accepted as our whole selves. Projects like the one completed in the Healing Through Art Group are not limited by convention and are often able to bridge the gap between the mainstream art world and the rest of the population that often find themselves without a way to gain formal entry as recognized artists. Like my interlocutors, participants that choose to join in the making process usually do so because they are passionate about the cause and looking to push back on societal issues. The focus is participation as a member of the community and is not based on artistic reputation. We have found a way to engage in a community-based art project that provides a way to create and heal while promoting visibility and demanding social justice.

The long history of community-based arts alongside existing research shows the positive outcomes experienced by participants of art projects similar to the work done in the Healing Through Art Group, including personal, social, economic, and emotional change (MacFarlane, 2017; Newman, et al., 2003). Like the participants in our group, whether we are disabled, marginalized, invisible, queer, stigmatized, or otherwise, our inclusion created a positive outcome. The feeling of participation often translates to self-empowerment when one joins a group of like-minded individuals to resist the status quo and fight for visibility and change. Physical and emotional well-being outcomes are seen in both art makers and members of the public that engage with community art projects.

NAMES Project AIDS Memorial Quilt

Figure 18: NAMES Project AIDS Memorial Quilt. Image from https://www.aidsmemorial.org/quilt

The history of using protest art as activism and a source for community-based healing is a long one. Whether it be post-World War I Dadaists, second-generation feminist artists in the 70s, or works by Black artists leading up to and through the Civil Rights Movement, all of these art movements called attention to broader political issues (MacFarlane, 2021). One powerful example of healing through community building, social justice, and art is The AIDS Memorial Quilt, conceived of by gay activist Cleve Jones and co-founded by Micahel Smith in San Francisco in November 1985 (Fee, 2006). Like so many art movements before it, the idea was born from political activism, where Jones and others were encouraging people to bring signs with the names of people who died of AIDS to a candlelight march in San Francisco as the local death toll exceeded one thousand people, almost exclusively from the Castro neighborhood, where everyone either knew of someone that died or was caring for someone in the final stages of AIDS. However, there was almost no public acknowledgment of how desperate the situation was in the Castro, partially due to fear and stigma, but also because there was no cure and no effective treatments.

When I spoke to Smith in an interview, he compared the fear of AIDS to the current COVID-19 pandemic, wherein individuals were afraid and dreaded becoming infected because everything was unknown and chaotic, and no one was sure if they were next. Our Healing Through Art Group in Seattle started with a very similar underlying feeling. When the fear of the pandemic was at its height, a group of people with similar lived experiences came together in a time where our disabilities isolated us and made us more vulnerable to the pandemic raging on in a world that for some, left us behind. During a vigil at the San Francisco city hall in 1985, the participants plastered their signs on the building, and someone commented it looked like a giant quilt. Jones and Smith began to explore the idea of a community coming together to take care of a family and believed the idea of a quilt was the perfect metaphor for being cared for.

The quilt consists of individual 3'x6' panels designed by the loved ones of people that perished due to the AIDS pandemic to memorialize their lives. The size of the panel was the approximate size of a grave, designed to make a stunning visual impact. Smith acknowledged that the point was to make a political statement and that they did so successfully, partly due to the enormity of the final project. The thought was they were taking their dead to Washington for the March for gay and lesbian rights, that October of 1987, and that the size of the quilt would

Figure 19: AIDS Memorial Quilt Panel, Block 2337, Display Host: Congresswoman Nancy Pelosi. Image from https://www.aidsmemorial.org/virtual-quilt/ca#SFAF

show just how much space those deceased individuals would have taken up if they were still living and could have been there.

A phone chain began with individuals calling gay friends across the country, calling bars and groups to let them know what was happening. As knowledge of the project spread, folx started coming together regularly all over the country, forming informal sewing circles. The group purchased a national mailing list of about two thousand grief counselors, to whom they sent a simple flyer explaining how to work through the grief of losing someone to AIDS by participating in the quilt project. Panel-making workshops were already beginning to work as grief support groups, and once grief counselors became involved, it evolved into a true community program. Additional workshops sprang up organically around the country through word of mouth. Rather than an impersonal plea for participants, the organizers let everyone know their purpose and mission and called for people to participate in helping deal with their grief.

Whether a panel was constructed by several community members or by an individual family member or lover, the act of making a panel was about storytelling, either telling the story of a lost life or telling a story of the maker's relationship with the person memorialized in the panel. The process of working on a panel produces a cathartic experience for many that participated. The workshop experience became a collaborative effort, with almost no one completing a panel alone. During our conversation, Smith described the intense emotional support that came with the process. People came alone and left with friends who shared a common lived experience that only they had the understanding and capacity to grieve together for. The stigma surrounding AIDS deaths was severe during this time, and many people in small towns could not tell their friends or church groups why they were grieving. These panels became the gravestones they made to honor those they lost. The sheer volume of loss was made apparent shortly before the project deadline when over eight hundred quilt pieces arrived by mail one night, mostly from mothers and families. This went on for several days as packages came from grief counselors, church groups, and impromptu workshops, showing the overwhelming power that community-based art has to bring people together to grieve and heal.

This art installation piece was first displayed on the National Mall in Washington, DC, in 1987 to coincide with the National March on Washington for Gay and Lesbian Rights. Smith referred to the installation as the world's most colorful cemetery. The installation gained worldwide attention for both LGBTQ rights and the AIDS pandemic, and the event kicked off a twenty-city tour that raised over a half-million dollars for AIDS service organizations that year. The National AIDS Memorial in San Francisco is the current custodian of The Quilt, stating that "the panels of The Quilt have been hand-sewn by members of the public as a way to transform loss and heartbreak into healing and hope" ("Learn More" n.d.). The project is still ongoing as the world's largest community art project, currently memorializing over 100,000 people, creating awareness, promoting equal rights, and healing wounds.

According to Smith the grieving, art, and community coming together drove the success of the Quilt project. Not only was art used to educate, but it was a method of bridge-building that brought diverse communities together. People were able to memorialize their loved ones and communally grieve through creating art. Some individuals with AIDS even made their own quilt panels to process their impending death by celebrating their lives. Not only did this community-based art project have the power to help individuals grieve, but the mass visibility of the project was also able to draw attention to an issue and touch more people than the founders thought possible. Even people not familiar with the details of the project are likely familiar with it generally. For my mother, who is both deeply religious and homophobic, it was an opportunity to humanize the AIDS pandemic and refocus the issue from a ‘gay disease’ to something that has tragically taken the lives of thousands of people that were once someone’s child, sibling, parent, lover, or friend.

Smith feels that the success of the AIDS Quilt proves that by tapping into the longer genealogy of community-based arts, there is an opportunity to move forward with new community-based arts projects intended to have a broad reach with a cohesive theme and message designed for participation by specific groups. Smith argues that to date, there has not been another community-based arts project focused on the queer-disabled community that comes close to rivaling the AIDS Quilt, stating that it is the most recognizable and successful community-based arts project ever created. However, the legacy of art spurring on an activist movement is a long one, making it possible that a new and different community-based arts project for the queer-disabled community has the potential to reach large-scale success and recognition that may one day rival that of the AIDS Quilt.

Tangled Art + Disability

One of the newer community-based arts projects I was introduced to at the 2020 Common Field Convening, an annual convention for arts organizations and organizers, many of which that focus on queer and disabled issues, was Tangled Art + Disability in Toronto. I was in search of artistic spaces specifically for the queer-disabled population and was excited to find this organization. Tangled Art + Disability is a charitable organization that began in 2003 as Abilities Arts Festival, is driven by Disability Justice, and is completely led by those who identify as Mad or disabled. The identity marker, Mad, is a reclaimed term pertaining to those that may identify as mentally ill, disabled, or neurodiverse and is also used as a way to reframe mental health outside of the biomedical realm (Beresford, 2020; Brontsema, 2004; Linton, 1998). The organization promotes artists with disabilities, inspires disabled youth to participate in the arts, and provides opportunities for disabled artists to share their work with a broader audience. In addition to supporting artists, the organization ensures all of its exhibitions are completely accessible. When I spoke to Sean Lee, the Director of Programming, he described the organization as a “built community of different artistic practices and lived experiences contributing to this new understanding of what our worldly engagements can be if we center disability as a difference that matters.”

Their gallery space is located in the arts district of downtown Toronto, bringing Disability Arts into the larger conversation. The Canada Council for the Arts and the Ontario Art Council introduced funding directed specifically towards disability art which allowed for the expansion of Tangled Art + Disability and has heralded in the beginning of what Lee considers a golden age for disability arts. While their original focus was to create a space completely for and run by Mad and disabled individuals, they began partnering with other organizations to increase awareness, accessibility, and participation in the arts. Lee feels that one of the most exciting things about Tangled is how involved they have become around developing policies and best practices around accessible curatorial work, beginning with "Smithsonian Guidelines for Accessible Exhibition Design,"[13] and further adapting it from a Disability Justice informed and community driven basis to publish a complete "Accessibility Toolkit: A guide to making art spaces accessible" [14] which they feel better meets the needs of the Mad and disabled communities. The toolkit deals with basic exhibition accessibility, but expands into how to frame surrounding events, and communicating calls for submissions. The toolkit also coaches artists on how to develop more plain language ways of thinking about their art to ensure easier translation into American Sign Language (ASL) for the d/Deaf and audio description for the visually impaired, while encouraging artists to utilize multisensory practices in their exhibitions.

Lee is an artist that identifies as living in a queer, racialized body and found that during his arts management education, there was a strong focus on queer-racialized communities and Feminist Arts, but disability was kept entirely outside of that conversation. At any time disability was addressed, it was done so either through the lens of accommodations or Art Therapy, but never through a political lens of Disability Justice or Disability Arts[15], a movement by disabled persons that used both art and politics to affect change. Lee says that because Disability Arts is getting more attention and funding, he is starting to see some changes take place in academia and in the greater arts community. Because people are beginning to realize that ableism is upholding systems of oppression, the hope is that institutions will begin to more critically examine their hegemonic ableist structures and begin to tear them down. Lee stresses that the change goes beyond thinking solely of physical accessibility, but a much broader movement towards equity for the Mad and disabled communities that has been largely supported by queer and trans advocates and activists, helping to push the movement forward.

While Tangled Art + Disability does not specifically label itself as a queer-disabled venture or have specific queer-disabled programming, all of their programs embody queerness in some way. Lee acknowledges that most if not all of the staff identify as queer, and does not think any non queer people have worked for the organization. He calls out the tangle between queerness and Disability Arts, and how there are so many blurred lines of advocacy in the arts

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[13] "Smithsonian Guidelines for Accessible Exhibition Design" - Smithsonian Institute https://www.sifacilities.si.edu/sites/default/files/Files/Accessibility/accessible-exhibition-design1.pdf

[14] "Accessibility Toolkit: A guide to making art spaces accessible" - Tangled Arts + Disability https://tangledarts.org/wp-content/uploads/2018/10/Accessibility_Toolkit-1.pdf

[15] "About Us" - National Disability Arts Collection and Archive. https://the-ndaca.org/about/

community that strengthen the bonds between artists and their activist work. While many artists that work with Tangled Art + Disability work independently, Lee strongly feels that they emerged as an artists' collective emerging from a Disability Arts perspective. They focus less on curating solo shows for disabled artists, but rather encourage exhibits that engage a broader portion of the disabled arts community coming together to work in concert. While Lee acknowledges that one of the goals is for the Disability Arts movement to spread into other spaces, the building of a vibrant Disability Arts community in a space that is designed to do so is critical, as ableism is the current standard in most spaces. When disabled artists come together in dedicated spaces for exhibitions designed for disabled folx by disabled folx, participants experience radical acceptance and understanding where disability visibility is celebrated.

Figure 20: Mad Ones: Flourishing, *Exhibition 2018. Laura Burke. Image from https://tangledarts.org/exhibits/mad-ones-flourishing/*

Lee stated that unfortunately, the Tangled Art + Disability space is sometimes misunderstood as a space for art therapy, which is exactly what the space is not. While Lee acknowledges that the space often provides for collective or community-based healing, he is hesitant to label it as such because of incorrect assumptions made regarding Disability Arts and disabled artists. Because of the history of institutional violence towards disabled persons, people sometimes assume that certain disabled people only do art in a therapeutic setting or as part of a therapeutic process, rather than intuiting that there are prolific disabled artists creating works with the intention for exhibition. Lee feels it is important to ensure that the space focuses on rebuilding the harm that has been inflicted upon the disabled community from years of outsider arts that co-opt the aesthetics of disability without acknowledgment (Siebers, 2005). Positioning

Disability Arts as both an avant-garde art movement and an identity politics movement, paralleling the emergence of Feminist Arts, Queer Arts, Black Arts, and Indigenous Arts correctly frame the discussion surrounding the intentionality and focus of disabled artists, acknowledging their lived experiences navigating in an othered body.

Gloria Swain, a Mad artist, seniors' rights, and Black mental health advocate who works to challenge systemic oppression of Black women and trans folx, spent time as an artist in residence with Tangled Art + Disability. Lee had originally challenged Swain's desire to describe her artistic process as a form of therapeutic healing, worrying that her practice may lose a certain amount of credibility if it was accidentally linked to art therapy. However, she expanded on her experience with art and healing, explaining to him that her madness was not necessarily caused by misfiring synapse in the brain, but rather by the way state-sanctioned police violence, intergenerational trauma, and systemic racism impacts the Black community so that mental health issues are often unmitigated, exposing the racist links to the manifestation of madness in the Black community. For Swain, madness is political, and her art mitigates that and is therefore political in itself, transforming the act of using art to heal into part of that political statement, not just for the artist, but for the intersectional communities in which she identifies as well. Like many other artists, Swain's personal healing journey becomes a strong political touchstone for her community.

Healing Through Art Meetup Group

Figure 21: Selfie collage by author, Healing Through Art Group, 2020.

Continuing in the long tradition of community-based arts projects designed to impact social change, I set out to create a group that would use art to both heal and create change for the queer-disabled community. The "Healing Through Art: For the Queer-Disabled Community" Meetup Group was designed to conduct participant-observation for this research, the goal being to create a piece of artwork together with a cohort of queer-disabled individuals for public display and evaluate if others found healing through art. Creating art in this way is nothing new. We joined in a long tradition of artists who embarked on a journey of protest and activism with the goal of community healing. We achieved that goal and so much more in the process. During each meeting, participants were permitted to bring their whole and complete authentic selves. We shared deeply personal experiences, gave each other advice, challenged each other's ideas, supported each other, and we did so while creating art.

The art-making process and the discussions of our lived experiences often overlapped or were tangled in an indistinguishable ball. Recognizing, appreciating, and allowing for each others' differences made for unstructured conversations that started off rather stiff and formal and ended as if we were chatting with old friends. Some meetings were spent with very little focus on the artwork, as we shared stories of medical inconveniences and disasters that were happening to us in the midst of a global pandemic. Rainn was unable to obtain his prescription medications, Dani's routine infusions were diverted to a new location due to COVID-19 protocols, JC was unable to find a new mental health counselor, and my MRIs were all canceled. There were moments that we tried to step away from the stress of the moment, and we worked on meditative doodling, where I would set a timer and play some nature sounds in the background while we focused our attention on everything that was happening around us, something that made us angry, or a small gratitude for the day. We would then talk about our doodles and share them on camera. At first, we were holding on to the physical drawings as we thought they would eventually be pasted onto a giant closet door. When that became logistically impossible, we began uploading our work to a shared Google Slides file. Not all of the meditative doodlings made it to the final project, but some of the participants told me they started doing them on their own when they were bored or stressed.

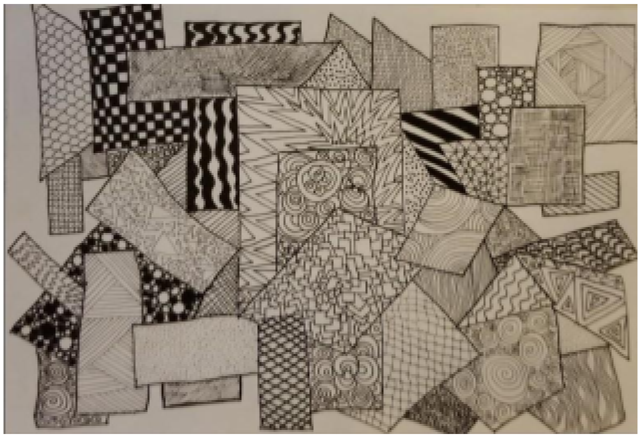


Figure 22: Meditative doodling. Image by author.

We admitted we were unsure of how to do art together in an online space, so we began experimenting. We tried meditative doodling sessions where we would play peaceful music and scribble away for ten minutes or so while reflecting on a particular thought or experience. I asked everyone to take a pic of their drawings with their phones and text or email them to me. I was determined to have physical, artistic evidence of our journey together, as that was the integral piece of my research. But nothing was making sense in the space. I thought about mailing art supplies or clay out to people. One idea was to paste all of our drawings onto a closet door to symbolize us coming “out of the closet” not just with our queerness but also disclosing our disabilities. While we all liked the idea, it still seemed logistically difficult from a remote meeting perspective.

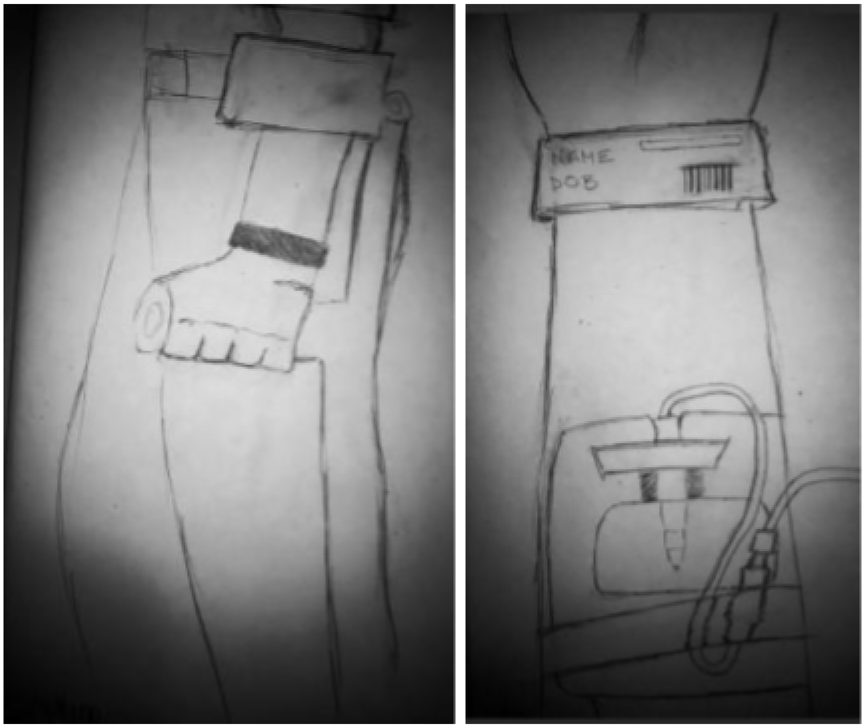
As I am also a current art major, I was fortuitously simultaneously enrolled in a course focusing on collage making and conceptual art. While I was so initially focused on creating a physical art for this research, it never occurred to me that we could move our art in the same way we moved ourselves; out of the physical space and into the virtual world. The possibilities with collage are limitless. So we began experimenting with ideas on various ways to express our experiences through collage, looking to the Dadaists and feminist artists for inspiration (Knelman, 2021). One thing shared by a few of us was the tendency to photo document time in the hospital. Dani is at the hospital a minimum of twice weekly for intravenous fluids and tends to take selfies each time. Rainn has taken selfies whenever they were admitted for inpatient mental health treatment. I had been taking hospital selfies as well for years, not necessarily on every visit, but quite often. We realized that we could create selfie collages that related to our identities as a disabled person juxtaposed to a selfie collage representing our queer identities, resulting in a visual representation of our divided selves and how we have trouble bringing our whole selves into each of these spaces. We used Google Slides as a tool to share our work collectively, as we could easily create and upload images into that shared space while we were chatting together during our meetings or in our spare time.

When we made the shift to focus on collage, the excitement was more palpable as it felt like we were approaching the project with more intentionality and a specific purpose. Our goal was to represent disparate parts of ourselves through collage, representing the fracture of our identities not coalescing in the same space. We made collages of our disabled selves and of our queer selves. The approach each artist took in representing themselves was as unique as the individuals themselves. Some respondents branched off, creating more drawings or using

Figure 23: Selfie-Collage by Rainn, Healing Through Art Group, 2020

photography, while others focused on different types of collage work. While the work was not specifically aimed to embody Disability Arts, in many ways we honored the spirit of that movement with our work (Eisenhauer, 2007). For me, this was an opportunity to work collaboratively with other artists who shared the same understanding of living in a queer-disabled body. This allowed me to think in a completely new creative direction, as I was no longer worried about needing to take breaks, pushing through pain, or trying to explain any of my limitations. Everyone in this creative space carried judgement-free compassion for one another in a way I had never experienced.

The weekly meetings evolved into a few of us getting together and chatting as if we were old friends sharing war stories. We would often be playing with photos on one screen while Zooming together in another window. This was a space where we all felt we truly belonged and were understood by one another, an experience not many of us had. We shared stories about our friends and family members who are often oblivious to our needs as disabled people, or who we struggled with because of our queer identities. We discussed insurance coverage woes, trying to find the right doctor, our many traumatic experiences in hospital ED's everywhere, and relationship and dating drama. We were able to laugh about the times we almost died, yell about the times people treated us inhumanely, and complain about everything and anything without feeling judged. Through this process of creating, we were actively challenging ableism through our queered disability-focused art and we were excited to see where the final results would lead (Eisenhauer, 2007).



Figures 24 & 25: Drawings by Dani, Healing Through Art Group, 2020

The linked film, *Queer & Disabled: Healing Through Art*, was created from the collective work done within the space of the group. Watching the video is perhaps the best way to understand and absorb what happened in our group sessions and how impactful of an experience this was for our community of queer-disabled individuals. The audio is composed of clips taken from dozens of hours of discussions and interviews from this amazing group of interlocutors. This film not only allows viewers to understand the challenges we face as queer-disabled individuals, but it demonstrates the power of spaces designed for people to bring their whole selves and the power of healing through art, embodying the spirit of Disability Arts (Eisenhauer, 2007). This piece was presented at the 2021 Society for Disability Studies annual conference, *SDS@OSU: DEEP SIGH: (Re)Centering Activism, Healing, Radical Love, Emotional Connection, and Breathing Spaces in Intersectional Communities*. The artistic work that came from this research is now accessible to anyone interested in learning more about this research topic. This artwork now inhabits a virtual space, taking its humble seat in a vast and long history of community art that seeks to foster change.

QUEER & DISABLED

HEALING THROUGH ART

Queer & Disabled: Healing Through Art

(click the link to watch the video)

Creating Our Own Communities: A Space For Resistance

> *You know I can go to a group, and I can be a mom, or I can be a lesbian, or I can, you know whatever. It's like I feel like I'm really honestly often leaving parts of myself out of a conversation because it just feels extraneous, which is not very fun. I would like to be able to bring my whole self to wherever I am, and I'm working hard to do that, like to not be in the closet about any of these things.*
>
> - *Sandy (she/her/hers)*

Sandy summed up in just a few sentences what so many of us had been feeling and not necessarily been able to articulate for so long. As queer-disabled individuals, we are forced to adapt to the spaces we are in when those spaces should be adapting to accommodate us. While I was conscious of the performativity of my gender, sexuality, disability, ethnicity in various situations, I had not really formulated the thought that queer-disabled people could thrive in their own space. I can pinpoint the first time I started to get a glimmer of that idea.

The Odd Ones Out

In the summer of 2018, I was invited to participate in an adventure healing pilot program for young adults with MS by an established organization that focused solely on young adults with cancer. They consulted with a few MS associations, but they were basically in uncharted territory, and I was selected as one of the first fourteen guinea pigs. I was excited for the opportunity to inhabit a space designed specifically for individuals with MS, as that is often a part of myself that is the most misunderstood. Upon arrival in Montana, I was greeted at baggage claim by a tall man in a blue tutu and narwhal hat and a short man in a pink tutu, wearing a poop emoji hat. They introduced themselves as The Butcher and Twinkle Toes. I was told I had until dinner to come up with an appropriate nickname. It was awkward and weird and felt very queer. I loved it. It gave me the brief hope that this was potentially a place that I could show up as my whole self and would not have to hide any part of my identity.

There were fourteen of us with MS and about twenty crew members assisting with the event, most of them from either San Francisco or Denver. We all stayed in a large riverside cabin for the next seven days. There was a whole camera crew and videography team, a registered dietician, a chef, three paramedics, three or four “camp moms” (all cishet men), some folx from the corporate office just there to have fun, and a team of world-class white water kayak instructors. The folx with MS started looking sheepishly around the room as we realized we would not be paddling around a calm lake but were hitting Class II+ to Class III- rapids, something that seemed in direct opposition to recommended activities for people with MS. Commence deep breathing.

All of the MS folx were assigned to two different bunk areas while the organization folx were off in a separate part of the cabin. We felt a bit like kids at camp and formed some quick camaraderie as we noticed that the surroundings were not at all designed for individuals with MS. There were numerous stairs, some with no handrails, bunk beds, and one bathroom for about ten people. There is a great variety of ability levels within the MS community, which can include problems with balance, mobility, muscle weakness, and often bladder and bowel issues are a factor, so this was a potential recipe for disaster. We were invited to a metaphorical space that was intentionally designed for people living with MS, but the physical space was not designed for disabled bodies. This was just another instance that reinforced the erasure of our identities and the ignorance to not accommodate our needs.

Figure 26: Time on the River, *Tiffany-Ashton Gatsby, 2018. Possible first exploration with collaborative art, signed by a majority of the people at the adventure healing trip.*

While all of us were from different backgrounds, we shared the common bond of MS. We got into the familiar groove of conversation, "What MS meds are you on?" and "When were you diagnosed?" before we bothered asking where someone was from. There were three queer folx there, all of us with MS. We spotted each other immediately and established without direct acknowledgment that we had a safe space with each other that was palpably different. When the three of us were together, we were simply ourselves.

As the days went by, some little microaggressions started popping up here and there. An antisemitic "joke," comments about they/them pronouns being plural, and then refuses to use correct pronouns. One of the queer folx that had top surgery was walking around outside in swim trunks and was told to put their top on because it was inappropriate. We were also being pushed beyond our physical limits, saying we had to keep going in order to be proud we made it all the way through. Frankly, we were a bit surprised when so many people there were so "progressive." The entire event was designated as a 'healing space,' complete with sharing circles, but our conditions were medicalized and then invalidated and they wanted our queer identities completely erased.

While it was amazing that we could share our experiences with MS so openly and be so understood by so many people was definitely a first for me. But then I had to keep that other part of me tucked away. Whether it was switching between body language and communication styles, use of my assistive devices, choice of hair and wardrobe, performative gender and queerness, and performative disability was not just a part of my life, but something the other queer folx in the space were doing as well (Hall, 1999; Janika, 2015). The combination of our multiple identities is compounded; we are then the disabled minority in the queer community or the queer minority in the disabled community. We were experiencing a genuinely immersive version of living as a "minority within a minority [...] on the margins of a margin" (Vernon, 1999, pg. 387) that week. When the three of us went off to talk, it was different. There was a tighter bond and a deeper understanding. We did not have to perform signals of belonging. And we were not othered within a broader marginalized group where we were legitimate in-group members. We were simply ourselves.

The act of making art together during the trip was grounding. We would sit drawing or knitting during some of our off-river downtimes, and I brought some watercolors along. I wanted to make a collaborative piece to commemorate the event, so I made a little river painting and had everyone sign it with their camp name. The queer crew made a few pieces of art designed to claim our space and our right to be there. We added to the collection of flags hanging around the cabin, announcing that we have MS are queer and we deserve a place on the river. It was a small gesture, but it felt powerful. While the entire event was well-intentioned, it did not allow all of us to show up as our whole selves. We were seen as patients, which is part of who we are, but that is not entirely how we center ourselves in the world. Getting a chance to express ourselves artistically created a small space of time where our whole identities were brought back into focus.

Because we were a pilot program, we had continued contact with the corporate office doing surveys and interviews on what needed to change to make it more accessible for people with MS, and what was done right. I took that opportunity to point out that the queer participants were not allowed to show up as ourselves and were forced to create our own space. The following year, one of the corporate officers that were refusing to acknowledge pronouns invited me to attend a corporate program with them the next summer. One of their pharmaceutical sponsors was donating some significant funding for the purpose of diversity and inclusivity training and they wanted me to speak about my experiences. I was in shock, not only that they wanted me to come back, but that they wanted me back as their queer spokesperson to help secure more inclusive training for their programming.

I spoke to a group of investors about how my experience the previous year shaped me and what a difference it would make for future participants if it was ensured that the staff was more inclusive of LGBTQ+ individuals. The interviews were filmed to show in a promotional video for the upcoming program. To me, this proved that the small acts of resistance made by three queer-disabled folx on a kayaking trip did in fact have ripple effects that made a difference in an organization. This was an important step in gaining recognition that everyone deserves a space not solely for one fragment of the self, but their whole selves. It also proved that it is possible to integrate spaces in a way that would accommodate everyone's diverse needs, not just within this organization, but in a broader context within the world.

Space: The First Frontier

The layered marginalization of our community, coming at us from so many angles, has created a need for healing, not only from the medicalized effects of our disabilities but because our lived intersectional identity establishes a source of emotional trauma. When seeking out support and care, whether that be biomedical care or otherwise, we do so with the expectation of finding support for our emotional and medical wellbeing. Unfortunately, this is not always the case. While we may find treatments along the way, and our wounds and bodies may heal fully or partially, we are not often given the opportunity to be our whole self. And as experienced by myself and my respondents, it is almost impossible to fully process or heal in a space where we cannot bring our entire selves wholly and without judgment. However, when that space is found, healing at the community and individual level is possible through the community-based arts centered around reclaiming our queer and disabled identities (Eisenhauer, 2007; Meyer, 1999).

I shared the story about my adventure healing experiences with my weekly Healing Through Art group. No one was surprised that the three queer people in a group of cishet individuals, disabled or otherwise, would have been only partially accepted. As queer-disabled people, we are met with unique challenges with which few other groups can identify. We are labeled as “other” even when associating with people that should prove to be allies. Our personhood is stratified into one of the lowest layers of society. Some of us can easily mask or hide our queerness or disabilities when feeling the need to assimilate for safety. For others, they are marked and judged on site. Dani worried that doctors might not treat them if they were too open with their gender identity and would often not disclose their status, especially in an unfamiliar ED (Crenshaw, 2016).

Space is a high-value commodity for disabled individuals, and it is often difficult to claim it due to the societal perceptions of disability (Wendell, 1996). Being othered is nothing new for me or for my respondents. After a significant MS flare had me hospitalized for a week in 2014, I used a walker as a mobility aid for some time. I was constantly subjected to stares and pitying looks. When taking the bus, people would often not make space for me in the disabled seating area, some even making comments implying that I was too young to be disabled, so I must be faking. Kai, one of my interlocutors, reported losing consciousness on a Seattle bus because they were afraid to advocate for themselves and ask for a seat. Kai is in their early twenties and does not look like what society expects a disabled person to look like, and they were afraid to attempt to claim that space for fear of confrontation (Linton, 1998). Unfortunately, many people expect disability to present itself explicitly, so one can be othered for appearing disabled. But like Kai, who was struggling with their abilities, they were othered for not appearing disabled.

In addition to public spaces and biomedical spaces, family spaces are also challenging for queer-disabled individuals. Before and after my experiences with disability began, I was continually being harassed for my queerness by my mother. Before coming out, I was constantly told that I often dressed and acted too masculine and that it was unnatural and abnormal. When I first attempted to come out, my mother called me a degenerate and threatened to pursue full custody of my child. My mother proceeded to cut herself out of every photo of us together in her possession, including baby photos and birthday parties because she did not want to relive memories that would disgust her. JC, one of the interlocutors, was kicked out of their religious midwestern family when they came out as trans. They were homeless on and off for years before they found their way to Seattle and got into transitional housing. While some of JC's family members are now more accepting, they still do not speak to their father. When home is not a space where you can show up as your whole self, where else do you go to find a space that is accepting and welcoming?

These types of experiences are old news to other queer-disabled people and those living with various intersectional identities. The ideas of compulsory cis-heteronormativity and able-bodiedness permeate society to the point that the illusion that it is unnatural to be anything else takes a stronghold on dominant society, which is why so many of us stay closeted or attempt to pass as not having a disability (Linton, 1996: McRuer, 2006 & 2016). Queerness and disability share a sordid past. Both labels have been criminalized, pathologized, stigmatized, and penalized financially (Garland-Thompson, 2001; McRuer, 2006). Teachers had to hide their queerness to avoid termination, intersex persons have been surgically altered without consent, and disabled persons have been subjected to arbitrary income limits when relying on SSDI, keeping them in poverty. HIV-positive people had to hide their diagnosis to seek or keep employment, and as Smith pointed out in regards to those memorialized on the AIDS Memorial Quilt, individuals with AIDS were often ostracized from their families. Many died alone while their families lied about their cause of death or grieved in silence.

On their own, these offenses are damaging to populations of queer and disabled peoples. However, the people experiencing multiple oppressions of living in a queer-disabled body, the intersection of these identities compound the marginalization and oppression individuals are experiencing (Crenshaw, 1991; Venrnon, 1999). Places like Tangled Art + Disability create space for queer-disabled individuals to not only exist free from compounded marginalization but enable and empower them to create their art for maximum visibility to push back against the dominant societal narrative and begin the process of community-level healing.

Despite the advances made to destigmatize queerness and disability, stigma and discrimination are still prevalent globally. Admittedly, living in predominantly liberal regions of the United States, it is now easier to be queer but not necessarily easier to be disabled. I have yet to speak to a queer or disabled identified person who has never experienced any form of stigmatization or marginalization, whether overtly or in microaggressions. Spaces in cities that are designated as safe spaces or queer spaces still have significant issues. Despite the commodification of queerness evident in Seattle's Capitol Hill neighborhood, I have experienced harassment and have had slurs yelled in my direction very recently (McRuer, 2006). I have faced barriers to accessibility to art coursework here at the University of Washington, a progressive university with robust Disability Resources for Students. I have been told that it might be easier to pursue different types of artistic practice rather than seek accommodations for my disability, whether that be for a fear of liability, or implicit bias, I am unsure. These are just some examples that highlight the importance of creating spaces for queer-disabled individuals where we can be free of harassment, judgment, assumptions, and othering.

Figure 27: Collage by Rainn, Healing Through Art Group, 2020

Until just a few years ago, Rainn was only out to a few friends, even hiding their sexuality for the first three years they worked at Starbucks, an extremely progressive company with an LGBT inclusion policy dating back to 1988[16], yet they still feared that coming out would not be safe. When they moved to Seattle, they started at one of the shops on Capitol Hill. When they found out that location was nicknamed *GayBucks*, it was easier to come out. And despite policies for disability accommodations, they rarely disclose their mental health issues unless they are hospitalized and miss work. They worry they will never be able to work their way up in a company carrying the stigma of mental health illness (Scheid, 2005). While both Rainn and I actually grew up in Southern California in what are considered progressive areas, we still did not always feel like we could show up anywhere as our whole selves. I moved to the San Francisco Bay Area, a beacon of gay rights and activism, and worked for a company where my coworker and I were closeted the entire duration of our employment. After we both left the company, we got together to catch up, and he mentioned a boyfriend. I was so shocked, "Why didn't you tell me?!?!" when I realized I had never told him either.

Dani mentioned having sought out a space designed for queer-disabled individuals for a long time. They said that they wanted to have a conversation about their disability without worrying that mentioning their partner's pronouns might derail a conversation. Dani recalls attending a seminar at the Gates Foundation where the speaker began the presentation by acknowledging everyone's differences and stating that if people needed to sit, stand, stretch or leave to take care of themselves, they should do it. Dani shed tears at the announcement as it was the first time that anyone acknowledged they had permission to make themselves comfortable. Dani had to move around during the meeting to stay comfortable, and no one stared at them or asked questions. This was Dani's first experience at a Disability Justice event, and they were moved that they were essentially given permission for self-care. The act of making space for people that fall outside of the accepted norms just does not happen in more spaces as it should because of the lack of awareness of the needs of people with disabilities. They knew that finding spaces like this was important not only for themselves but for others as well.

In various parts of the country, while there is increasing number of organizations that provide support for the queer community and the disabled community separately, the intersection of that support is not happening often enough. There are an increasing number of medical clinics designated for the LGBTQ+ population and centers specifically designed for various disabilities and chronic conditions are also more prevalent. However, even within these spaces, a disabled person may still experience harm when visiting a queer clinic as often as a queer person may experience harm in a medical center designated for their condition. Within the biomedical system, there is the ability of creating spaces specifically for queer-disabled persons wherein they can seek healthcare for their whole selves without worrying about judgement or lack of understanding. A recent study of the Australian healthcare system examined the experiences of queer-disabled persons, concluding that providers needed to focus on both inclusive practice and meaningful inclusion (O'Shea, et al., 2020). Inclusive practice goes beyond physical barriers, but includes holistic access and doing everything necessary to ensure there is no social exclusion or

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[16] "Timeline: Starbucks history of LGBTQ inclusion" - Starbucks https://stories.starbucks.com/stories/2019/starbucks-pride-a-long-legacy-of-lgbtq-inclusion/

marginalization when accessing services, while meaningful inclusion focuses more on including queer-disabled persons in every step of developing programs from the initial plans to the day-to-day operations to ensure meaningful transformations of policy and practice are benefiting the queer-disabled population (O'Shea, et al., 2020).

The shame of being marked "other" is significantly different than when we choose to mark ourselves, owning all of the parts of our identity. Having spaces where we can show up and be accepted as our whole selves seems like one of the most basic human needs that, in theory, should take no effort to fulfill. All of the respondents agreed that this is, unfortunately, an area where the struggle is significant as we live in bodies that are so often rejected (Wendell, 1996). Finding a space whereas queer-disabled individuals can come together as a community to share our commonalities and wholeheartedly embrace each other's differences is the first step in our journey to healing. The ability to then use these spaces together as a community to create art designed to push back against homophobia, ableism, and the marginalization of our queer-disabled bodies will have the power for healing us not only as an individual, but as a fully whole community.

Looking to the Future

I and all of the interlocutors that participated in this research study came to many of the same conclusions based on having similar lived experiences. We collectively concluded that living in a queer-disabled body often leads to biomedical interventions that may cause emotional trauma. We have the ability to take action and attempt to heal that trauma, and that often requires us to turn to our community for validation and support and to seek out spaces where we can bring our whole selves freely and without judgment. By tapping into the well-established history of community-based arts, we become empowered with the ability to draw attention and visibility to the struggles we face on a continual basis. The process of healing becomes less about ourselves as individuals, but more so about the collective community, and by focusing on the wellbeing of the community, the byproduct becomes the healing of the self.

We are living in a time where public perception is rapidly shifting. Each younger generation is becoming more and more progressive, and identifying as queer is more normalized than I have witnessed in my lifetime. Social movements are getting people aware of problematic issues with marginalized communities. There is still a long way to go, but it gives me hope for the future. That also means that work to empower the queer-disabled community is more important than ever before, especially when it comes to visibility.

One of the things that Dani feels may impact positive change is the shift of disability representation in the media. There are now some TV shows that feature disabled actors playing roles as disabled people when previously it was thought that disabled people would not have the stamina or ability to play those same roles. The representation is getting better as shows depict real people with real issues, not portraying disabled people as villains, weak, or even heroes

(Anders, 2018). The Netflix show, *Special*, is a comedy written by and starring Ryan O'Connell[17], who fictionalized his experiences as a gay man with Cerebal Palsey, who is more afraid of disclosing his disability than his queer identity. O'Connell's character brings attention to issues like ableism, dating while disabled, and gay sex. Selma Blair[18], a celebrity with MS, is using a cane on the red carpet and doing interviews despite impairment in their ability to speak in an attempt to normalize disabled bodies. A recent contestant on *The Voice*[19] spoke openly about EDS, which really excited Dani as it is getting more attention, and friends are sending them articles and interviews talking about EDS. Bringing attention to these individuals then in turn brings more visibility to the disabled or queer-disabled communities.

As visibility increases and queer-disabled populations become more normalized, there is a great opportunity for positive change within biomedicine as well. Dr. Kevin Wang, a queer physician at Swedish Medical Center in Seattle, experienced first-hand the health disparities that existed in the treatment of gay patients, leading him to launch a training curriculum for both physicians and students and the First Hill campus of Swedish Family Medicine[20]. A 2009 article in the Lancet[21] stressed the importance of healthcare workers receiving training in the lived experiences of persons with disabilities, and in 2016 a group of physician-educators with disabilities addressed the Association of Academic Physiatrists at their annual convention, encouraging the formation of a Task Force on Disability Education for Medical Students[22]. Positive changes are clearly happening, so it is more important than ever to keep issues of sensitivity and equity in healthcare for the queer-disabled population in the forefront in order to capitalize on this momentum.

The research conducted for this study is bringing visibility to the queer-disabled community, and this is only the beginning. I plan to continue presenting this research in conjunction with the art film at related conferences and art exhibitions, and I may seek publication for parts of this work. I will be focusing on my artistic practice and completing a capstone honors exhibition during my next year, further exploring queer-disabled community-based art. Upon completion, I plan on using this research as a foundation for further

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[17] "Ryan O'Connell on Special Season 2, His Character's Sex Education" - Advocate https://www.advocate.com/exclusives/2021/5/17/ryan-oconnell-special-season-2-his-characters-sex-education

[18] Selma Blair Is "Making a Deeper Positive Connection" with Her Body After Her Multiple Sclerosis Diagnosis - Harper's Bazaar https://www.harpersbazaar.com/celebrity/latest/a36164265/selma-blair-body-beauty-multiple-sclerosis-diagnosis/

[19] Cami Clune - NBC's The Voice https://www.nbc.com/the-voice/credits/credit/season-19/cami-clune

[20] "Seattle physician improves healthcare for LGBTQ patients" - Kiro 7 News https://www.kiro7.com/news/local/seattle-physician-improves-healthcare-lgbtq-patients/UKJX4R4E7FBW3ETXTPBIBXVS7I/

[21] "Disability and the training of health professionals" - The Lancet https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)62050-X/fulltext

[22] "Competency-Based Curriculum Development to Meet the Needs of People With Disabilities: A Call to Action." - Thomas Jefferson University https://jdc.jefferson.edu/cgi/viewcontent.cgi?article=1039&context=rmfp

study and artistic practice. The goal is to continue the research in a graduate program, taking a deeper look at biomedical care for the queer-disabled community while specifically focusing on how spaces for the queer-disabled community combined with community-based art can lead to community-level healing. Using both Tangled Art + Disability and the NAMES Project AIDS Memorial Quilt as models, the hope is to find funding to open workshop spaces designed specifically for the queer-disabled community. The goal is that many more individuals like me will also seek to create these types of workshops, further expanding the movement. These spaces will enable individuals to work on a cohesive community-based arts project for public installation meant to promote visibility, push back against marginalization, and provide emotional, political, and community healing.

Epilogue

> *I decided to try to shoot for the honors program and I already know what my thesis will be. I decided it's going to be horticultural therapy because it's kind of still a new emerging field. And there's only one school in the US right now that has it. It's been so beneficial for me. And when you take it through the lens of the pandemic, I think there's gonna be a lot of studies and stuff that I could build off.*
>
> *~ Rainn (they/them)*

Since the conclusion of our Healing Through Art group, I have kept in contact with a few of the respondents. Some are interested in participating in future research. In contrast, others feel that we made a genuine connection with a group of queer-disabled people we would otherwise have not come into contact with. We hope to someday meet in person for a reunion art session once everyone is vaccinated and our physicians clear us for socializing. I have a vision of us in a park on a sunny day, accommodating everyone's individual needs for comfort, with assistive devices used with pride, throwing paint-filled balloons at each other until we are one big queer-disabled rainbow.

Riley found an LGBTQ-focused health clinic where they are not just comfortable with their medical providers but happy about them. They are hoping this will open a new chapter for them to not only be able to address some of their gender-related health concerns but that their chronic pain treatment may be approached with more compassion. Riley was able to join a recreational online dance group that was able to have their first fully vaccinated in-person performance, rekindling their love of dance but now approaching the practice more compassionately.

Dani found a partner that also has EDS. While their partner was more recently diagnosed, they have finally found someone with genuine compassion for their health conditions. Dani was worried that the relationship would not last because Dani had to cancel their plans so many times when they first started dating. However, for the first time, their partner completely understood and had to cancel plans a few times themselves. Several months later, their relationship is thriving, and Dani reports never having felt happier with the decision to date someone with the same disability.

Rainn discovered their love for plants during our groups when they began making little pots and decorating them during some of our sessions. Rainn has since become a member of several plant swap groups on Facebook and is exploring the idea of pursuing graduate studies in horticultural therapy. Rainn enjoyed the creative process so much that they have set up a plant propagating station in their apartment, comparable to a mini greenhouse. They have also set up an entire art studio in the space where they are now doing witty designs on shirts, pots, and various other items geared towards the plant daddy community[23]. They even have a logo and are now selling their items on Facebook and are in the process of building an inventory for an Etsy shop.

This entire process has excited and invigorated me. Next year, I will be continuing my research from the perspective of arts practice, further exploring the work done with the queer-disabled community and healing through art. I hope to engage in person with other community members (if possible, depending on COVID-19 protocols) to work on a larger-scale installation piece involving flameworked glass elements and small sculptural elements, installed in prominent locations throughout the city combined with a performative aspect and documented on film intended to provide visibility to the queer-disabled community. I also plan on continuing to work on documenting interactions with biomedicine to create a larger film and performance pieces pushing back against the biomedical system, hegemonic cis-heteropatriarchy, ableism, and highlighting the issues queer-disabled persons deal with simply by existing in a medicalized and often desexualized body.

On a personal note, I decided to try something new and have gone on a few dates with a doctor. It came in handy when I had a laryngospasm at dinner and she was able to jump in and assist until I could breathe again. The idea of a professional patient and biomedical professional dating is quite amusing to me. Especially so for me personally as I am researching deficiencies within the biomedical system as related to patient care. It has made for some very interesting and funny dinner conversations and some spectacular advice for my upcoming surgery. The surgery is intended to resolve some recurring problems experienced in part because of complications from MS. During the recovery process, a few former members of the Healing Through Art Group offered to provide company during my recovery, as I am sure that I will be in need of community support. A community that I know will allow me to bring my whole self to heal. And of course, we will no doubt do some amazing art. Together.

Figure 28: Tiffany-Ashton Gatsby, May 2021. Image by author.

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[23] Definition - Plant Daddy - Urban Dictionary https://www.urbandictionary.com/define.php?term=Plant%20Daddy

References

Anders, P. Screening Gay Characters with Disabilities – NOTCHES. https://notchesblog.com/2018/02/27/screening-gay-characters-with-disabilities/

Anzaldúa, G., Castillo, A., & Alarcón, N. (2001). "La prieta." *Debate Feminista*, 2001-10-01, Vol.24. 24, 129-141.https://alliance-primo.hosted.exlibrisgroup.com/permalink/f/lvbsh/TN_cdi_crossref_primary_10_22201_cieg_2594066xe_2001_24_662

Baker, K. & Beagan, B. (2014). Making Assumptions, Making Space: An Anthropological Critique of Cultural Competency and Its Relevance to Queer Patients. *Medical Anthropology Quarterly* 28(4):578-598 https://anthrosource-onlinelibrary-wiley-com.offcampus.lib.washington.edu/doi/full/10.1111/maq.12129

Beresford, P. (2020, September 13). 'Mad', Mad studies and advancing inclusive resistance. *Disability & Society*. https://doi.org/10.1080/09687599.2019.1692168

Berne, P. (2015). Disability Justice: A working draft. Sins Invalid. https://www.sinsinvalid.org/curriculum. https://www.sinsinvalid.org/s/Patty_Berne_DJ-Working-Draft.docx

Birch-Bayley, N. (2019, December 19). "A Queer Word: Linguistic Reclamation through Political Activism in the Case of Queers Against Israeli Apartheid (QuAIA)." *The English Languages: History, Diaspora, Culture.*

Borrup, T. (2009). 5 Ways Arts Projects Can Improve Struggling Communities. Project for Public Spaces. https://www.pps.org/article/artsprojects

Boujaoude, M. (2020)."Relentless: The Social Identity of Chronic Illness and Disability". Easter Kentucky University Honors. https://encompass.eku.edu/honors_theses/800

Brontsema, R. (2004). A Queer Revolution: Reconceptualizing the Debate Over Linguistic Reclamation. *Colorado Research in Linguistics*, 2003 vol. 17. https://journals.colorado.edu/index.php/cril/article/view/255

Buckner, J., & Morrissey, K. (2016). *How can we talk about it? : Disrupting heteronormativity through historic house museums.* Seattle: University of Washington.

Cooper, A. (2019). Hear Me Out: Hearing Each Other for the First Time: The Implications of Cochlear Implant Activation. *Missouri medicine*, 116(6), 469–471. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6913847/

Crenshaw, C. (2016). "Sick of It." In Sharman, Z. (Eds.) *The Remedy: Queer and Trans Voices* *in Health and Health Care*. (pp. 157-164). Vancouver: Arsenal Pulp Press. https://ebookcentral-proquest-com.offcampus.lib.washington.edu/lib/washington/reader.action?docID=4714990

Crenshaw, K. (1991). “Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color.” *Stanford Law Review*, 43(6), 1241-1299. doi:10.2307/1229039

Cyrus, J. (2020). “Challenging Heteronormativity in Museums: A Deeper Look at A Queer History of Fashion from the Closet to the Catwalk.” *University of Toronto Art Journals*, *8*, 2 - 18. Retrieved from https://utaj.library.utoronto.ca/index.php/utaj/article/view/34651

Eaves, Emery R. (2015). “Just Advil”: Harm reduction and identity construction in the consumption of over-the-counter medication for chronic pain. *Social Science & Medicine* (1982), 146, 147-154.

Eckhert E. (2016). A Case for the Demedicalization of Queer Bodies. *The Yale journal of biology and medicine*, *89*(2), 239–246. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4918872/

Eisenhauer, J. (2007). Just Looking and Staring Back: Challenging Ableism through Disability Performance Art. *Studies in Art Education*, 49(1), 7-22.

Fee E. (2006). The AIDS memorial quilt. *American journal of public health*, 96(6), 979. https://doi.org/10.2105/AJPH.2006.088575

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: a systematic review. https://doi.org/10.1186/s12910-017-0179-8

Garland-Thomson, Rosemarie. (2001). Reshaping, re-thinking, re-defining: feminist disability studies. Washington, DC: Center for Women Policy Studies.

Hall, K. (1999). Performativity. *Journal of Linguistic Anthropology*, 9(1‐2), 184-187.

Janicka, I. (2015). Queering Girard—De-Freuding Butler: A Theoretical Encounter between Judith Butler’s Gender Performativity and René Girard’s Mimetic Theory. *Contagion: Journal of Violence, Mimesis, and Culture*, 22, 43-64. doi:10.14321/contagion.22.1.0043

Kirschner, S. R. (2013). Diagnosis and its discontents: Critical perspectives on psychiatric nosology and the DSM. *Feminism & Psychology*, 23(1), 10-28. https://journals-sagepub-com.offcampus.lib.washington.edu/doi/full/10.1177/0959353512467963

Knelman, S. (2021). The Women Artists Who Find Freedom in Collage. Aperture. https://aperture.org/editorial/the-women-artists-who-find-freedom-in-collage/

Köksal, Ö., Özdemir, F., Armağan, E., Öner, N., Sert, P. Ç., & Sigirli, D. (2013, January 1). Is routine pregnancy test necessary in women of reproductive age admitted to the emergency department? *World Journal of Emergency Medicine*. https://doi.org/10.5847/wjem.j.issn.1920-8642.2013.03.003

Learn More. (n.d.). Retrieved from https://aidsmemorial.org/theaidsquilt-learnmore/

Linton, S. (1998). Claiming disability: Knowledge and identity (Cultural front (Series)). New York: New York University Press.

Linton, S. (1998). Disability Studies/Not Disability Studies, *Disability & Society*, 13:4, 525-539 https://www.tandfonline.com/doi/abs/10.1080/09687599826588

MacFarlane, R. (2021). A Brief History of Protest Art. Format. https://www.format.com/magazine/features/art/brief-history-protest-art

Madyaningrum, M. E., & Sonn, C. (2011, July 1). Exploring the meaning of participation in a community art project: A case study on the Seeming project. https://doi.org/10.1002/casp.1079

Mattingly, C. (2014). *Moral laboratories: Family peril and the struggle for a good life*. ProQuest Ebook Central https://ebookcentral.proquest.com/lib/washington/reader.action?docID=1711014&ppg=201

McRuer, R. (2016). Compulsory able-bodiedness and queer/disabled existence. In *The Disability Studies Reader*, Fifth Edition (pp. 396-405). Taylor and Francis.

McRuer, R., & Berube, M. (2006). *Crip Theory: Cultural Signs of Queerness and Disability.* New York: NYU Press. muse.jhu.edu/book/7696.

Meyer, M. (1999). Reclaiming the Discourse of Camp. (Eds.) De Gay, J. & Goodman, L. In *The Routledge Reader in Gender and Performance* (pp. 281-284). Routledge. https://alliance-primo.hosted.exlibrisgroup.com/permalink/f/lvbsh/TN_cdi_informaworld_taylorfrancisbooks_10_4324_9780203143926_57_version2

Murtagh, D. & Lobban, J. (2018). Reclaiming life through art. In Art Therapy with Military Veterans (1st ed., Vol. 1, pp. 215-226).Routledge.https://books.google.com/books?hl=en&lr=&id=9GBQDwAAQBAJ&oi=fnd&pg=PA215&dq=reclaiming+identity+through+art&ots=C3YKt6_xzd&sig=BUcNwod3ZpfBFTIpOKyRDlTUsew#v=onepage&q=reclaiming%20identity%20through%20art&f=false

Nichols, P., Rogers, E., Clark, M., & Stamp, W. (1968). The acceptance and rejection of prostheses by children with multiple congenital limb deformities. Artificial Limbs, 12(1), 1. http://www.oandplibrary.org/al/1968_01_001.asp

Newman, T., Curtis, K., & Stephens, J. (2003). Do community-based arts projects result in social gains? A review of the literature. Community Development Journal, 38(4), 310-322. www.jstor.org/stable/44258895

Olshaker, J. S. (1996). Emergency department pregnancy testing. The Journal of Emergency Medicine, 14(1), 59-65. https://www-sciencedirect-com.offcampus.lib.washington.edu/science/article/pii/0736467995020497

O'Shea, A., Latham, J. R., McNair, R., Despott, N., Rose, M., Mountford, R., & Frawley, P. (2020). Experiences of LGBTIQA+ People with Disability in Healthcare and Community Services: Towards Embracing Multiple Identities. *International Journal of Environmental Research and Public Health*. https://doi.org/10.3390/ijerph17218080

Peacock, S. & Patel, S. (2008). Cultural Influences on Pain. *British Journal of Pain*, 1(2), 6-9.

Robbins, A. (1994). *A multi-modal approach to creative art therapy*. London: Jessica Kingsley.

Ruiz Pellachini, M. A. (2012). Redefining key components in art therapy: A survey of art therapists' perspectives (Order No. 1518069). https://search.proquest.com/docview/1039267595?accountid=14784

Scheid, T. (2005). Stigma as a barrier to employment: Mental disability and the Americans with Disabilities Act. *International Journal of Law and Psychiatry* Vol. 28, Issue 6, pp 670-690 https://doi.org/10.1016/j.ijlp.2005.04.003

Siebers, T. (2005). "Disability Aesthetics." *PMLA: Publications of the Modern Language Association of America*, 120(2), 542-546.

Snowden, L. (2003, February 1). Bias in Mental Health Assessment and Intervention: Theory and Evidence. *American Journal of Public Health*.https://doi.org/10.2105/AJPH.93.2.239

Stuckey, H. L., & Nobel, J. (2010). "The connection between art, healing, and public health: a review of current literature." *American journal of public health*, *100*(2), 254–263. https://doi.org/10.2105/AJPH.2008.156497

Vernon, A. (1999). "The Dialectics of Multiple Identities and the Disabled People's Movement." *Disability & Society*, 14(3), 385-398.

Wellbery, C. (2011, November 1). Flaws in Clinical Reasoning: A Common Cause of Diagnostic Error. *American Family Physician.* https://www.aafp.org/afp/2011/1101/p1042.html.

Wendell, S. (1996). *The rejected body: Feminist philosophical reflections on disability.* New York: Routledge.

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