2012

Pathology, bias and queer diagnosis : a crip queer consciousness

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Consciousness

ABSTRACT

The medical industrial complex has historically contributed to the oppression and pathology of queer and disabled people in a myriad of ways; through forced medication and institutionalization, as well as denial of self-determination and identity. Queer theory and disability theory both challenge modes of normalcy directly related to both queer and disabled identities by using a lens that encompasses sexuality, gender, embodiment, health and impairment. This paper will use queer theory and disability theory to analyze the ways in which queer and disabled identities are connected and co-constructed, as well as, the ways in which these intersections may expand our thinking in social work. The current diagnosis and controversy around Gender Identity Disorder as a diagnosis in the DSM will be examined through the lenses of queer theory and disability theory, to aid in the continued movement to depathologize queer and disabled identities. It is the perspective of this paper that the liberation of queer people is directly linked to the liberation of disabled people and that trans/queer justice is disability justice.

PATHOLOGY, BIAS AND QUEER DIAGNOSES: A CRIP QUEER CONSCIOUSNESS

A project based on independent investigation submitted in partial
fulfillment of the requirements for the degree of Master of Social
Work

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2011

ACKNOWLEDGEMENTS

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CHAPTER ONE

INTRODUCTION

In recent years, the importance of an intersectional approach to identity politics and social justice issues has become paramount in critical discussions and discourse. Intersecting identity categories such as race, class, gender, sexuality and ability work on multiple and simultaneous levels, acting together to create lived experiences of oppression and/or privilege and social inequalities and/or advantages. The politics of intersecting and co-constructed identities began with the writings of the Combahee River Collective, a black feminist lesbian organization. They released a statement coining the term "identity politics" and stated that sexism, racism and classism are inextricably bound together and that these interlocking systems of oppression cannot be separated or ranked.

> The most general statement of our politics at the present time would be that we are
>
> actively committed to struggling against racial, sexual, heterosexual, and class
>
> oppression, and see as our particular task the development of integrated analysis and
>
> practice based upon the fact that the major systems of oppression are interlocking.
>
> (Combahee River Collective, 1977)

The Combachee River Collective's statement was released in response to the white feminist movement and their inability to speak to or for black women. The Combachee River Collective wished to name and hold accountable the overt and underlying racism present in the white feminist movement (Norman, 2007, p.105). The Combahee River Collective notably stated that the liberation of black women would lead to the liberation of all people since, "our freedom would necessitate the destruction of all systems of oppression" (Combahee River Collective,

1977), spawning new discourse around identity, privilege and oppression, and radical ideas about the interconnections of the struggle and oppression of all people.

Kimberle Crenshaw (1989), a prominent scholar in critical race theory, expanded upon these earlier black feminist writings and recognized the importance of these connections and overlaps, coining the term intersectionality.   Intersectionality, as a concept, recognizes that perceived group membership can make people vulnerable to various forms of bias, yet because individuals are simultaneously members of many groups, complex identities can shape the specific way each person may experience that bias. Not all prisoners are men, not all feminists are white, not all immigrants are Latino, and not all lesbians and gays are white. An intersectional approach provides a reminder that systems of oppression based on class, race, gender and sexuality are bound together often working systemically, and that privileged identities can have as much impact on lived experience as can marginalized ones.

As the Combahee River Collective understood, intersectionality can be used as an approach to the liberation of all people, regardless of the issue or topic at hand. Many social justice organizations have moved away from siloing issues into a single-issue approach to topics that often only represent the experience of dominant groups. This intersectional approach to social justice has expanded the dialogue to include voices and identities that are often silenced and marginalized in movements. This has been most notable in the reproductive rights arena, which has made a move towards reproductive justice, redirecting the focus of activism and organizing to "recognize that the control, regulation, and stigmatization of female fertility, bodies, and sexuality are connected to the regulation of communities that are themselves based on race, class, gender, sexuality and nationality" (Silliman et al., 2004, p.4). Organizations such as The Pro Choice Public Education Project (www.protectchoice.org), The Civil Liberties and

Public Policy Program (www.clpp.hampshire.edu), National Women's Health Network (www.nwhn.org), SPARK! Reproductive Justice NOW (www.sparkrj.org), SisterSong (www.sistersong.net), National Network of Abortion Funds (www.fundabortionnow.org), National Latina Institute for Reproductive Health (www.latinainstitute.org), and others have done collaborative work that highlights these intersections and the importance of intersectional thinking in policy, advocacy and organizing. This ideology is reflected in written papers and articles highlighting the ways in which coalition building across movements can have direct effect on research, institutional change and the reproductive health care needs of marginalized people (Gilliam, Neustadt, & Gordon, 2009; Shapiro, 2005; Sevelius, 2009; Townsend, 2010).

Of huge importance to social workers and social justice work, intersectionality allows us to consider a range of social problems from a perspective of inclusion and understanding making transformative change for diverse populations in many different settings, including health care and mental health services (Murphy et al, 2009). An intersectional approach may function as a mechanism of social justice by changing social institutions and policies that continue to maintain an unequal practice of dominance and privilege (Anderson & Collins, 2004). Not only is embracing an intersectional approach necessary for transformative social change, it is fundamental for addressing concerns specific to a broad range of people, language, nationality, race, ability, and sexuality that every social worker experiences in their work with clients.

> Consequently, a paradigm shift that embraces intersectionality in the most comprehensive manner is both appropriate and necessary to capturing the depth and breadth of human experiences within the complex social contexts that social workers encounter when working in increasingly diverse and global communities. (Murphy, et al., 2009, p. 2)

Scholars and historians of marginalized groups place an emphasis on the inequities of societal structure and power divided along lines of ability, race, class, gender, and sexuality. As the study of disability has become a prominent field of academic inquiry, the connection to and within other marginalized groups has recently begun to emerge in critical discourse and across academic disciplines. Recent scholarship and social justice movements have begun to make clear connections between disability, race, gender and sexuality, and the ways in which systems of ableism, heteronormativity and racism are often used in interlocking systems of oppression to create ideas and binaries of normality and deviance (Asch, 2004; Baynton, 2001; Clare, 1999; Contreras, 2008; Kannen, 2008). Disability theory has begun to challenge and expand, yet again, binary constructions and normative identities (Pothier & Delvin, 2006; Samuels, 2002 Siebers, 2008; Snyder & Mitchell, 2006). In an intersectional approach, it is necessary to consider a critical analysis of disability and ableism in relationship to other lived experiences.

In recent scholarship some authors approach the intersection of queer theory and disability theory from an additive model of identity, making connections between these two academic fields through the experience and perspective of people who identify as both queer and disabled (Clare, 2001; Whitney, 2006). This work has centered on the importance of visibility for queer disabled people, as well as a challenge to the compulsory heteronormative assumptions in popular disability discourse. The experience, scholarship, work, art and writing of people who identify as both queer and disabled has had huge implications for the advancement of the social justice movement, and has been crucial to the awareness and acknowledgement of the intersections of these two fields.

The literature emerging around disability requires us to consider the implications and correlations of queer theory and disability theory for all queer and/or disabled people. While an additive model of identity has been instrumental in beginning to bridge these two disciplines, the similarities in queer and disability history and theory is not necessarily dependent on the existence of people who are both queer and disabled. Similarities in experiential issues arise for both disabled people and LGBTQ people including, familial isolation, high rates of violence, issues around passing and coming out, pathologization by medical and mental health communities, as well as increased stereotyping and discrimination. These are important connections that can provide a link between these schools of academic inquiry. Recognizing the intersections between ableism, transgender oppression and heterosexism is a crucial part of this work. It is for these reasons that an intersectional approach to queerness and disability can provide us with a multilayered complex understanding of all queer and/or disabled people.

Disability, like race, class, gender and sexuality, has been shaped by social, political and economic forces. One of the most obvious ways in which disability and ableism are inextricably linked across disciplines is the commonalities that disability history and identity has with that of all other marginalized and oppressed groups (Baynton, 2001). Historically disabled people have faced serious discrimination, segregation and exclusion in society, much in the same way as other marginalized and oppressed groups. Examples of exclusion and violence throughout history include, but are not limited to, the "ugly laws" that persisted in this country from the 1880's well into the 1970's which made it illegal for people with "unsightly" disabilities to appear in public; laws excluding disabled people from legal marriage; denial of the right of disabled people to parent; the eugenics practices of forced sterilization; and even full blown

genocide in Germany during WWII (Burgdorf, 1980; Galagher, 1995; Pfeiffer, 1994; Schweik, 2009).

Disability studies, like other disciplines, include studies of history, individual narratives, interactions of the oppressed and the oppressor, appropriation of language, internalized representations of self, and the complex formation of modern day identity politics (Kudlick, 2005; Russell, 1998). Like the gay and lesbian movement, disabled people used the momentum of the civil rights movement in the 1960's to forge an understanding and language of identity politics that fueled grassroots activism leading to political change in the decades that followed (Shapiro, 1993). Despite gains through the civil rights era, institutionalized policies, discrimination, violence and stereotyping still disadvantage both queer and disabled people today.

Acts of violence perpetrated against queer and/or disabled people happens with a frequency that is much larger then in the general population. There exists extensive research that indicates that disabled people are at high risk for sexual, physical and emotional abuse (Baladerian, 1991; Sobsey, 1994; Sobsey & Doe, 1991). According to a report from a 2007 US Department of Justice report by the Bureau of Justice Statistics disabled people experience a rate of violence that is 1.5 times higher than people without disabilities (Rand & Herrel, 2007). The exact same rates of violence were found in a 1994 study, which also noted that comparatively, disabled people experience more severe and extensive abuse than their nondisabled peers (Sobsey, 1994). Sobsey (1994) also notes that disabled people may be 5 times more likely to experience multiple victimizations than nondisabled people and disabled people have rates of rape or sexual assault 2 times higher than the rate of nondisabled people (Rand & Herrell, 2007). Other studies have also shown that disabled women are 2 times more likely to experience

domestic violence, sexual assault and abuse than nondisabled women, disabled men, and nondisabled men (Smith, 2008). Again, these studies show clear connections between misogyny, class, ableism and violence.

A parallel experience had been found for LGBT people. A study of gay, lesbian and bisexual adults showed that one quarter of men and one fifth of women had experienced hate crime victimization based on their sexual orientation (Herrick, 1999). In its 2009 report the National Coalition of Anti-Violence Programs (2009) noted that murders of LGBTQ people were at their second highest rate in the last decade and that 79% of the victims of LGBT hate crime murders were people of color with the highest proportion of this number being transgender women or feminine presenting, linking misogyny, racism, homophobia and transphobia. There is substantial research that shows that over 50% of trans and gender nonconforming people reported being the victims of sexual violence (Clemens-Noelle, et al, 2006; FORGE, 2005; Garofalo et al., 2006, Kenagy, 2005). Many studies have noted the difficulty in estimating the number of trans and gender nonconforming people in the US, making researchable rates of violence quite difficult for this population (Stotzer, 2007). Despite this, researchers Kidd & Witten (2008) point out that the violence and abuse trans people experience is a global problem, one that is not localized to the United States and consider global trans violence not only an extremely serious and immediate public health problem, but also "A genocide against a consistently invisibilized minority population" (p.31). This quote is reminiscent of a long and recent history of physical violence, sterilization and murder of disabled people. This includes the genocide and mass murder of mentally and physically disabled people that took place in Nazi Germany, as well as the eugenics movement in America that forcibly sterilized physically and

mentally disabled people (Caplan, 1992; Gallagher, 1995; Lapon, 1986; Miller, 1996; Pernick, 1996).

The threat of violence and the implications for the reproductive justice of both groups are well documented and are important considerations in discussions of homophobia and ableism. Recognizing hate and violence related to disability and queerness is an important dynamic in understanding the lived experience and continued threat of eugenics that hangs over the heads of queer and disabled people, from the search for a "gay gene" to the counseling of women around the "desirability" of having babies with impairments. High levels of violence in both communities point to the ways in which queer and disabled identities are viewed as threatening to larger societal structures and systems. While social desirability makes it difficult to create reliable instruments on which to measure negative attitudes towards marginalized people it is widely understood that stereotypes and discrimination adversely affect the lives and health of queer and/or disabled people, with ableist and heteronormative and homophobic attitudes pervasive on every level in society (Green, et. al, 2005; Harper & Schneider, 2003). "The systemic and continued nature of ableism is evidenced by patterns of treatment that discriminate against people with disabilities in such institutions as health care, education, housing and employment" (Griffin, Peter, & Smith, 2007, p. 335).

> It is part of social and legal convention in the United States to discriminate against, ridicule, and abuse transgender and gender non-conforming people within foundational institutions such as the family, schools, the work place and health care settings, every day. (Grant, Mottett, & Tanis, 2010)

Despite "how far we have come", verbal harassment, discriminatory laws, discrimination in employment, housing, health care, marriage, relationships, parental rights, sexual citizenship rights, media, and environment are daily struggles for queer and/or disabled people.

The passage of anti-discrimination laws and hate crime legislation often do not change societal perceptions of identities, and more often than not are no match to the obvious inequities present in the structure. Laws and increased threats of punishment do not work to change the bias, stereotypes and viewpoints of society, but merely attempt to prohibit certain behaviors. For example, although it may remain illegal for employers to discriminate on the basis of ability and/or sexuality this law does little to prevent this from taking place. A recent survey, "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey", found that trans and gender nonconforming people experience double the rate of unemployment than the general population (Grant, Mottet, & Tanis, 2010). This same survey reports that 90% of trans and gender nonconforming people experienced harassment, mistreatment, or discrimination on the job; 47% of trans people reported experiencing an adverse job outcome such as being fired or denied a promotion because of their gender identity; and 26% reported that they lost a job due to their gender identity (Grant, Mottet, & Tanis, 2010). Even with anti-discrimination laws in place, the current reality for trans and gender nonconforming people reported in this study proves that these laws are having little affect in everyday life. This holds true for disabled people as well, Deal (2007) argues that while more overt forms of discrimination against disabled people have been reduced through policy and law, more subtle forms of prejudice remain prominent in society, continuing to marginalize and oppress disabled people. Deal writes, "Failure to incorporate subtle forms of prejudice into attitude change strategies may result in only blatant

forms of discrimination being challenged, leaving insidious subtle prejudice undermining the lives of disabled people" (p. 104).

Heterosexism, transgender oppression and ableism create lived experiences of exclusion, marginalization, and devaluation. To be viewed as other by dominant cultural values, ideologies and beliefs, can have an enormous affect on a person's health and well being, potentially leading to an "erosion of self esteem, limited achievement, isolation, difficulties in relationships and an (eventual) internalization of one's otherness (Gerrard & Javed, 1998, p.114). The negative effects of othering, stereotyping and discrimination have been well researched and documented in recent years, as contemporary health science has grown concerned with the mental and physical effects of oppression which are now taken as the legitimate focus of health research and intervention (Aguinaldo, 2008; Bahm & Forcuck, 2009; Herek, 1989; Herek & Garnets, 2007; Herek, Gillis, & Cogan, 1999). In addition to the lived experiences of physical violence that many queer and/or disabled people are subjected to, the impact of these studies reveal that significant mental and psychological harm comes from living in an oppressive and restrictive structure and system, not from the individual identity in and of itself.

Lastly, it is well documented the ways in which the medical and mental health fields have pathologized, abused and harmed both queer and/or disabled people (Conrad & Schneider, 1992; Covey, 1998; Drescher & Zucker, 2006; Turner & Stagg, 2006). Institutionalization, forced medication, sterilization, inhuman treatment, forced surgery, and continued silencing and pathologizing from medical and mental health professionals are just some of the abuses experienced by the LGBTQ and the disabled community. Both groups have been subjected to forced "normalization" through a medical model that seeks to "fix" or "cure" all deviance from the "norm". While recent approaches to social work and mental health have rejected this

pathology and abuse, many queer and/or disabled people still experience silencing, pathology, and forced treatment from their providers. One only has to look at the continued and current practices of conversion therapy for LGBTQ people, the surgeries performed on intersex babies at birth, and continued denial and pathology around the sexual citizenship and license including the right to birth and parent children that queer and disabled people face to see that the legacy of this violence present in the history of the medical and mental health fields is still present today. It is for these reasons why this paper considers disability identity, politics and theory in a discussion of queer diagnosis.

It is the perspective of this paper that the liberation of queer people is directly linked to the liberation of disabled people, and that the implications of this are hugely important to the current work being done in the medical and mental health fields. Recognizing the history and current legacy of the negative affect the medical and mental health field has had on the lives of queer and/or disabled people will allow providers a continued consciousness and greater ability to work towards the undoing of this past and current harm. This paper will use the "queer diagnoses" contained within the DSM and the debates surrounding these queer diagnoses to highlight the ways in which ableism and homophobia work hand in hand to oppress all queer and/or disabled people This paper will attempt to expand the framework used by the medical and mental health profession by focusing on allyship and self-determination through collaborative work with queer and/or disabled people.

The following chapter clarifying will provide a framework for the ways in which the interlocking systems of ableism, homophobia, heterosexism and transgender oppression affect the lives of queer and/or disabled people and offer clarifying definitions of these terms. Chapter Three in this thesis will look at the ways in which bias and pathology create and inform

diagnosis in the DSM, with a specific focus on queer diagnosis. Chapter Four attempts to align causes in common by looking at contemporary queer theory and disability theory and provides a framework for the ways in which these theories challenge constructions of binaries and normalcy by problematizing the ways in which queer and/or disabled identities are co-constructed, pathologized and treated within the medical-industrial complex. Chapter five will begin by looking at the major arguments around inclusion, exclusion and reform of GID in the DSM. In conclusion, this thesis offers a new approach to working with trans and gender nonconforming people that is rooted in disability theory, queer theory, and principles of social justice and allyship.

CHAPTER TWO

METHODOLOGY AND CONCEPTUALIZATION: IDENTITY POLITICS, OPPRESSION

AND COGNITIVE AUTHORITY

This chapter will serve as a basis for understanding terms by offering clarifying

definitions of some of the major ideas used throughout this paper. Identity politics and its

importance in the lives of LGBTQ and/or disabled people will be directly contrasted with some

of the more problematic ways in which the cognitive authority of the medical and mental health

fields pathologize marginalized identities. This chapter will provide the reader with a framework

for the discussion of homophobia, heterosexism, ableism, transphobia, and transgender

oppression with an emphasis on the ways in which these interlocking systems work together to

oppress queer and/or disabled people.

Queerness, Disability and Identity Politics

It is necessary to recognize that language is contentious, especially when dealing with

issues of identity and identity politics. Self-defining as an LGBTQI (lesbian, gay, bisexual, trans,

queer or intersex) person or as a disabled person, has new meaning in the current political

climate where words that were historically used to oppress, such as queer and crip, are used as

self-identification. This reclamation of language is rooted in resistance to the models that

created them. Self-identification has become paramount to identity politics partly due to the ways

in which language has been used both historically and contemporarily to pathologize and

oppress. Variations in discourse appear across contexts, disciplines, languages, culture,

locations, race, class, and a myriad of other factors, all of which influence the way people talk

about their own experience, see themselves in relation to the world, and understand themselves

in context to it. In this way queer and disabled may be best defined by those who self identify as such. In other words, queer and disabled people are those who use the language of queer and/or disabled, in all of its forms, to define themselves and/or their experience.

As Thomas Siebers (2008) a prominent disability theorist notes, " . . .identity politics remains in my view the most practical course of action by which to address social injustices against minority peoples and to apply new ideas, narratives, and experiences discovered by them to the future of progressive, democratic society" (p.15). In many ways, identity politics is a backlash against the cognitive authority of the medical and mental health fields with people claiming power over their experiences and bodies by self-defining in a political and social context.

Many queer and disabled people define themselves, rather than awaiting and receiving a pathologized identity through the medical model. For example, people in the trans community now value and place self-identification over diagnosis and pathology. Therefore, in many cases people understand themselves as trans, transgender, transsexual, gender queer, gender nonconforming, etc., prior to ever having been labeled, categorized or identified by the medical or mental health community. This has been a huge shift in the last few decades, as historically, this has not always been the case for LGBTQ people. For many years LGBTQ people, due to lack of visibility, civil rights, community, awareness, and protections were isolated and marginalized not only from other LGBTQ people but also from society as a whole. LGBTQ identities were not often mirrored in society, and people in the medical and mental health fields were often the first to name experience and pathologize identity for many people. Language that was first used to describe, such as transsexual, gay, lesbian, and queer quickly turned from the

language of description to the language of slurs and oppression when wielded by non-LGBTQ people.

Identity politics, and an increase in awareness and visibility, have allowed people to understand themselves outside of pathology, to reclaim the language of pathology, and to self identify. As a slur, the word queer was originally used against gays and lesbians, to oppress and marginalize them. As Judith Butler notes, the reclamation of the word queer allows, "those who are abjected come to make their claim through and against the discourse that have sought their repudiation" (1993, p.224). Self-identification with the word queer is claimed not only by lesbians and gays, but also by those that it did not originally define, such as transsexuals, bisexuals, BDSM practitioners, trans, gender nonconforming people and intersex people.

Like expansions in what is thought of as disability, queer has come to encompass a broad range of sexualities and practices that fall outside of heteronormative lifestyles and sexualities containing, trans and gender nonconforming people, people who engage in BDSM, gay men, lesbians, bisexuals and intersex people. These embodiments of queer tend to collapse the binary poles of understandings around sexuality and identity which include "chromosomal sex, self-perception of biological sex, masculinity and femininity, being the opposite on all these dimensions of your partner, preferred sexual acts (insertive or receptive), procreative choice (yes if straight, no if queer), sexual fantasies (dominant or submissive), and locus of emotional bonds (should be consistent with sex and sexual orientation)" (Kassoff, 2004, p.162). As queer theorist Sedgwick (1993) notes:

> That's one of the things queer can refer to: the open mesh of possibilities, gaps, overlaps, dissonances and resonances, lapses and excesses of meaning when the constituent

elements of anyone's gender, of anyone's sexuality, aren't made or can't be made to

signify monolithically. (p. 8)

Queer then can be seen not only as a sexuality or gender expression, but an identity that speaks to one's own feelings of dissonance with a multitude of binary constructions.

Since this paper also uses the words transgender and gender nonconforming with some frequency a clearer definition of these terms and their relationship to identity politics will be discussed here. In some instances, the word transgender is used to imply a gender identity that does not match cultural expectations of one's designated birth sex, but the word has come to encompass a variety of experiences that fall outside of the socially constructed norms of gender. Transgender is often used as an umbrella term to encompass the experiences of transsexuals, cross dressers, gender queers, two spirit people, and bi-gendered people, giving it quite a broad range of meaning. Transgender has little relationship to one's sexuality. A person who self identifies as transgender may identify as lesbian, gay, bisexual, queer, asexual, or heterosexual in their sexuality, regardless of their gender identity or expression. This paper uses the term gender nonconforming to,

Describe the self-identification of a spectrum of individuals. This term illuminates the

sociopolitical position of conforming to the gender binary and highlights the concept that

all people are oppressed by the socially sanctioned and imposed requirement to fit into

one category or the other, not just those who are differently gendered. The term includes

a spectrum of differently gendered people while acknowledging that not every person

who is differently gendered identifies as trans, transgender, or transsexual, and not every

trans, transgender, or transsexual person identifies as differently gendered. (Sennott &

Smith, 2011, p. 220)

The term transgender emerged as an identity category rooted in resistance to the psychopathology that surrounded other labels being used by the medical and mental health fields. Typically in the medical model, trans people were labeled transsexual or transvestites, with sex and gender roles on a distinct binary that placed emphasis on heterosexuality, physical desirability and beauty (most notably for trans women) and a shift from one gender or sex to the other (male to female or female to male). People who did not find that their experience matched this medical trans narrative were not considered "true transsexuals" and were denied access to gender affirming treatments. The term transgender came directly from the resistance that many people in the community felt towards this imposed narrative of "transness" and the assumed sexuality and gender binaries that it encompassed. The emergence of the word transgender,

> Represented a resistance to medicalization, to pathologization, and to the many mechanisms whereby the administrative state and its associated medico-legal-psychiatric institutions sought to contain and delimit the socially disruptive potentials of sex/gender non-normativity . . . The emergence of transgender falls squarely into the identity politics tradition. (Currah, Green, & Stryker, 2009, p. 2)

Language in the community of disabled people also has been strongly influenced by identity politics. Historically, one can trace the ways in which language such as cripple, spastic and lame, has moved from technical meanings of diagnosis and description, to stigma and ridicule, as it becomes leveraged as words of verbal abuse in common language and use. The reclamation of the word "crip" by some disabled people as an identity politic is parallel to the use of the word "queer" by LGBT people. "Queer and Cripple are cousins: words to shock, words to infuse with pride and self-love, words to resist internalized hatred, words to help forge politics" (Clare, 1999, p.70). Reclamation of the word crip as an identity has, like queer, moved

outside of those who were originally defined by it. Sandahl (2003) notes, "The term 'crip' has expanded to include not only those with physical impairments but those with sensory impairments as well" (p. 27).

This paper will use the social model definition of disability that makes a critical distinction between disability and impairment. From a medical perspective, impairment refers to "any loss or abnormality of psychological, physiological, or anatomical structure or function" and disability as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (United Nations, 1983: I.c.6-7). In this way disability may be physical, mental, cognitive, sensory, emotional or developmental and may also include many types of chronic illness. Indeed the category of disability itself remains quite expansive and complicated.

> There are differences in type of disability (in a reification of the mind/body split, disability is usually broken down as physical or intellectual), in impact (minor hearing loss versus paralysis), in onset (disability from birth/gradually becoming disabled/suddenly becoming disabled), in perceptibility (having a "hidden disability" and "passing" as non-disabled versus being unable to hide a disability), in variability (most disabilities change across time and space), and in prevalence (disabilities vary by sex, ethnicity, age and environment). (Rohrer, 2005, p. 41)

Like queer, disabled is an unstable, expansive and fluid category. It is for this reason that many disability theorists will use the phrase "temporarily able bodied" to describe people who are currently able bodied. Disability is a fact of human existence, and will affect everyone who lives long enough to become an elderly person, or through the experience of a loved one becoming disabled. This paper uses the term "temporarily able bodied" to bring awareness to the fact that

people who are not disabled, may become so at any time in their lives due to illness, war or age. This is to stress the fluidity of disability categories and to remind others that all humans move through various stages of disability at one time or another in their own lives.

The medical definition of disability is problematic for several reasons, the most notable being the assumption of "normality" and "functioning". While this paper assumes a definition of disability that includes this important distinction between disability and impairment, it is also important to note that this author understands the complications of ascribing normality and its conditions as universal. For example, what it means to have a basic level of functioning in a highly industrialized society may be very different in a non-industrialized setting where traveling distances to retrieve water, a necessity for movement and physical labor to maintain home, food and warmth, may set basic levels of functioning much higher. This paper recognizes the need for cross cultural comparisons, and criticisms of varying societies' standards of structure, function and ability to perform such activities (Wendell, 1996), while utilizing these distinctions between impairment and disability.

Susan Wendell (1996) sums up the politics of disabled self-identification in this way:

> It is important to keep in mind that some people who consider themselves disabled are not identified as disabled by everyone else, and that not everyone who is identified by other people as disabled (either for purposes of entitlement, purposes of discrimination, or others) considers herself or himself disabled. (p. 25)

This same statement can easily be extended for queer people as well. Self-identification then becomes the most reliable and least pathologizing basis for definition. "It is axiomatic that if we do not define ourselves for ourselves, we will be defined by others- for their use and to our detriment" (Lorde, 1984, p. 45).

Interlocking Systems of Oppression

Ableism, transgender oppression, homophobia and heterosexism work together to require bodies to fit into socially constructed expectations and requirements and are enforced through binary systems in society evidenced through values, moral code, laws and policies which disavow a range of gender expressions and identities, sexualities and abilities, enabling an inequity in societal and institutional power. Ableism requires people to look a certain way, function in a culturally "normal" way, and express themselves and think in these ways as well. Heterosexism enforces rigid categories of sexuality, privileging straight heterosexual sex and coupling with real institutional and societal advantages, oppressing both disabled and/or queer people in a myriad of ways. Through these systems of oppression, white, heterosexual able bodied males are often the default assumed and idealized identity, whereby all other expressions of self are deviations that are pathologized, through a variety of individual and systemic levels such as science, medicine, law and policy. Therefore, it is important to understand the ways in which heterosexism, transgender oppression and ableism work together to oppress all queer and/or disabled people. One can begin to understand this by discussing in depth the systems of ableism, homophobia, heterosexism and transgender oppression and how they operate in the lives of queer and/or disabled people.

Homophobia and Heterosexism

The term homophobia was coined in the late 1960's by psychologist George Weinberg as a clinical condition that encompasses the irrational fear and hatred of people who are attracted to other people of the same sex (Weinberg, 1973). In common usage, the term homophobia has been broadened over the years to include discrimination, violence, prejudice, and harassment

towards LGB people. A more nuanced vocabulary seems necessary then to discuss and understand the psychological, social and cultural processes that form oppression, and thus this paper will turn to the use of the word heterosexism for this purpose. Throughout this paper the term heterosexism is used to address the limitations of the term homophobia.

The term heterosexism acknowledges that these systems of fear and hatred are in fact taught, learned, and normalized through socialization, making the issues much more complicated than an "irrational fear". Heterosexism has been defined as:

The overarching system of advantages bestowed on heterosexuals, based on the institutionalization of heterosexual norms or standards that privilege heterosexuals and heterosexuality, and exclude the needs, concerns, cultures, and life experiences of lesbians, gay males, and bisexuals. Often overt, though at times subtle, heterosexism is oppression by neglect, omission, erasure, and distortion. (Blumenfeld, 2007, p. 371)

Heterosexism encompasses all institutions, policies, values and beliefs that support heterosexuality as the only "normal" expression of sexuality. Heterosexism is often used to describe the "systemic displays of homophobia in the institutions of society" and "creates the climate for homophobia with its assumption that the world is and must be heterosexual and its display of power and privilege as the norm" (Pharr, 1988, p. 16). Heterosexism is often used to describe the system of advantage or privilege afforded to heterosexuals in institutional practices, policies and cultural norms that assume heterosexuality as the only natural sexual identity or expression (Herek, 2004). Related terms also include heteronormativity (Warner, 1991) and compulsory heterosexuality (Rich, 1986), both of which also critique the normalization and privilege of heterosexuality on micro, macro and mezzo levels. Although the term homophobia

is used at times in this paper, the reader should also assume an awareness of heterosexism in its more inclusive form.

An important consideration in this discussion is that homophobia, despite its original definition, is often about perceived violations of gender norms, not sexuality. Those most frequently targeted by homophobia are men whose gender expression is culturally viewed as feminine, and women whose gender expression is culturally viewed as masculine.

> What most people view as homophobia in the form of hate crimes perpetrated against LGBTQ people are usually based in some form of gender phobia, that is, that violence and discrimination is based on fear of gender expressions and impressions. After all, one's sexual orientation is not visible but one's gender expression is, making masculine women and feminine men targets of hate crimes. (Sennott & Smith, 2011, p. 6)

Here one can see the ways in which socially constructed binary gender systems act as a central creator of the opposition and oppression of not only lesbians, gays, bisexuals, transgender and queer people, but women and men who do not fit into the social constructions of gender as well.

Similarly, some scholars argue that homophobia is a central and organizing principle of the cultural definition of manhood, "The word 'faggot' has nothing to do with homosexual experience or even with fears of homosexuals. It comes out of the depths of manhood: a label of ultimate contempt for anyone who seems sissy, untough, uncool" (Leverenz, 1986, p. 455). Homophobia can be understood as more than a hatred of gay people, it is also a fear among men of being seen as "not man enough", or as not a "real" man. In this way homophobia is often experienced through social expectations of gender roles. As noted in the following quote, gender roles and homophobia are also bound up in issues of race and racism, complicating further, the notions of masculinity.

Homophobia is intimately interwoven with both sexism and racism. The fear - sometimes conscious, sometimes not - that others might perceive us as homosexual propels men to enact all manner of exaggerated masculine behaviors and attitudes to make sure that no one could possibly get the wrong idea about us. (Kimmel, 2007, p. 329)

Socially constructed binaries force people into either/or sex, gender, and sexuality categories based upon the norms of societal expectations and presentation. These binaries system serve to maintain power and privilege for those people who conform to the norm while marginalizing and oppressing those that do not. Societal privileges are received based on conformity to the roles and expressions of socially constructed sex, gender and sexuality norms and oppression is enacted through heterosexist laws, policies and practices.

Transphobia and Transgender Oppression

Transphobia is a fear or hatred of atypical gender expression or identity, or of people embodying or expressing an atypical gender identity. Hill & Willoughby (2005) define transphobia as "emotional disgust toward individuals who do not conform to society's gender expectations" (p. 533). As with heterosexism and homophobia, it is useful to note the differences between transphobia and transgender oppression. Transgender oppression in contrast to transphobia can be understood as societal discrimination, violence, exclusion and oppression against individuals who do not conform to traditional norms of sex and gender (Sugano, Nemoto, & Operario, 2006, p. 217). Transgender oppression is the oppression of people whose gender expression, gender identity, and/or sex identity does not match the expectations of the dominant norm of society.

People who experience transphobia and transgender oppression include people whose gender transgression is conscious or unconscious, deliberate or not deliberate, and/or intentionally political or apolitical in intent. They include people who identify with terms such as transgender, transsexual and gender queer, as well as others who do not identify with any of these terms, but whose gender expression nevertheless transgresses gender norms. (Catalano, McCarthy, & Shlasko, 2007, p. 221)

This system privileges cisgender (non transgender people) over trans and gender nonconforming people. As an academic term, cisgender attempts to deconstruct the othering of trans and gender nonconforming people by making visible the notion that all people have a gender identity and expression. Cisgender is often used to acknowledge that for most gender *conforming* people, gender expression is socially assumed and therefore invisible. This privileges cisgender people in that there is very little reason to consider their gender identity and its relationship to larger system and structures. This provides cisgender people with a relative safety and comfort in regards to their gender identity that most transgender people do not experience.

Transgender oppression takes place in a variety of ways. On the institutional level non-discrimination laws do not protect most trans people in the United States, and as a result they may be denied education, housing and services, with little or no legal protection. Trans people also occupy a disproportionate percentage of the prison population, indicating targeting and stereotyping by law enforcement, due to this huge gap in institutional protections from violence and harassment. Transgender oppression happens both subtly through words and actions used to reinforce gender norms, to more overt policing of gender expression and behaviors through harassment and violence.

Transgender oppression is maintained and perpetrated through rigid binary understandings of sex and gender roles that are learned, taught and enacted in society. This creates an environment where definitions of masculinity and femininity are enforced through cultural and societal values, norms and policies, which then enable transphobia. Correlations between transphobia and homophobia/heterosexism have been made, but transphobia includes larger issues of transgressive gender roles and gender identity, not just sexual orientation. While this paper will sometimes use the language transphobia, a larger understanding of transgender oppression should be assumed.

An important side note in the discussion of transgender oppression are the differences in attitudes towards trans masculine and trans feminine individuals that are related to large issues around misogyny. If one accepts that western society is dominated by a heteropatriarchal structure and acknowledges that misogyny and heterosexism are prevalent and damaging structures, one can begin to look at the marginalization and victimization of trans women as emblematic of larger structural and institutional problems inherent in a culture that devalues femininity. As pointed out by Serano (2007), in a male centered gender hierarchy, where it is assumed that men are better than women, and that masculinity is superior to femininity, trans women pose a huge threat to these "norms". Trans women then, simply by expressing their femaleness and/or femininity, pose a threat to the hierarchy of maleness and masculinity (Serano, 2007). Trans men on the other hand, "naturally" would want to "be" men, because of the presumed supremacy of maleness and masculinity. As a result of this misogyny, trans women bear the brunt of jokes, harassment, violence, discrimination and hatred in the trans community. In the simplest of examples, it is ok for women to wear "men's" clothing, but as soon as a man wears "women's" clothing, they risk ridicule at best, and physical and institutional violence at

worst. Coupled with the effects of race and class, trans women of color remain subject to the most violence and discrimination in the community, showing the connections between sexism, heterosexism, racism, class and transgender oppression (Gehi & Arkles, 2007; Grant, Mottet, & Tanis, 2011; Xavier, Bobbin, Singer, & Budd, 2005).

Ableism

Ableism, or disability oppression, is the pervasive system of discrimination and exclusion of disabled people. Ableism operates on the individual, institutional and cultural levels to disadvantage disabled people and privilege temporarily able-bodied people. Those people who are targeted by ableism include people with developmental, medical, neurological, physical and psychological disabilities.

Ableism is deeply rooted in beliefs about the value of human life, health, productivity, independence, normality and beauty, all of which are enforced through institutional values and environments that are often hostile to people whose abilities fall outside of what is culturally defined as normal. Ableism is perpetuated by a system of beliefs, policies, norms and practices that create barriers to access, rights, life and choice for disabled people. Ableism is also perpetuated by individual beliefs and actions, from paternalistic perspectives of sympathy and pity towards disabled people, to feelings of fear and dread about becoming disabled (Griffin, Peters, & Smith, 2007).

Ableism must be included in the analysis of oppression and in the conversations about heterosexism, transphobia, and homophobia. Ableism cuts across all movements and dictates how bodies should function against a mythical able-bodied standard. Norms of ability are enforced through structures of racism, heterosexism, sexism, economic exploitation, moral/religious beliefs and age. Ableism has been used to oppress of queer and trans people in a

myriad of ways. Ableism has set the stage for: the institutionalization of queer and disabled people as mentally disabled; intersexed babies to be routinely operated on at birth; communities of color to be understood as less capable, smart and intelligent and therefore "naturally" fit for slave labor; women's bodies to be used to produce children, when, where and how men need them; disabled people to be seen as "disposable" in a capitalistic and exploitative culture where they are not seen as "productive;" immigrants to be thought of as a "disease" that must "cured" because it "weakens" the country; violence, cycles of poverty, lack of resources and war to be used as systematic tools to construct disability in communities and entire countries (Mingus, 2009).

Disability has a long history of being used as "the master trope of human disqualification" (Snyder & Mitchell, 2006, p. 3) and ableism has been and continues to be leveraged against blacks, women, Jews, immigrants, gays and lesbians, and intersexed people as justification for exclusion and denial of basic rights as well as citizenship. Douglas Baynton (2001) writes extensively about the ways in which disability has been used to deny claims of citizenship to "undesirable" groups of people, including women, immigrants and people of color. Disabled people fall outside the same boundaried norms of white heterosexual society as other marginalized groups, and have been deemed deviant through social, economic and political forces, "not only has it been considered justifiable to treat disabled people unequally, but the concept of disability has been used to justify discrimination against other groups by attributing disability to them" (p. 33).

The more that is learned about the history of disability, the legacy of ableism and its use for the continued exclusion of all non normative (i.e. white, straight, male) bodies and identities the more clear becomes the major role that disability has played in actually defining what it

means to be "other". Disability then becomes one of the most important aspects of understanding the ways in which society constructs expectations of normality, and how this is tied into political, social and economic factors. A critical discussion of race, class, gender or sexuality, cannot be had without careful consideration of the ways in which disability has been used in the social construction of the other. Ableism should be considered in every aspect of academic inquiry for its deep connection to othering, exclusion and pathologization of non-normative bodies and identities and its deep connections to heterosexism and transgender oppressions. Critical questions to ask oneself when considering the interplay between heterosexism, transgender oppression and ableism is what a "fix" or a "cure" means for queer and/or disabled people directly intersecting queer rights and disabled rights with reproductive justice. Issues around sterilization, health care, parental rights, sex and sexuality, and reproductive health are paramount issues for queer and/or disabled people.

Ableism negates queer bodies, most obviously, trans and intersex bodies as different, inferior, in need of "fixing" and/or a cure, by privileging certain types of idealized bodies over others. Transgender oppression also continues to reinforce binary views of gender identity and gender expression, thereby continuing to impose gender on disabled people by disallowing self-determination of gender and gender expression. Heterosexism continues to oppress all queer and disabled people by privileging one type of relationship over others, negating these relationships, and rendering invisible sexualities and relationships that fall outside of these normate categories. As will be evident in the next section of this paper, the belief systems that enforce ableism and heterosexism are difficult systems to untangle given their roots in medical and mental health pathology and the role of science and medicine in the pursuit to "fix" and "cure" both queerness and disability

The Medical-Industrial Complex, Medicalization and Cognitive Authority

As stated previously, it is important to acknowledge the ways in which language has been used against the very groups that it seeks to define, particularly in regard to queer and/or disabled people through ableism, heterosexism and transgender oppression. Throughout history medical and mental health providers have defined people and their experiences, without including the voices and experiences of the group it seeks to define. This points to extreme inequities in power and a legacy of homophobia, transphobia and ableism, with major social, political and economic affects. Both queer and disabled people have been forcibly treated through medication, surgery and sterilization. Both queer and disabled people have been housed in dehumanizing institutions, and have been subjected to attempts to "cure" and "fix" bodies and identities. Queer and/or disabled people continue to be silenced in their awareness and understanding of themselves and their experiences through providers' abuse of power and authority as well as poorly designed and executed research that marginalizes, others, labels, names and categorizes queer and disabled people (Conrad & Schneider, 1992; Covey, 1998; Drescher & Zucker, 2006; Turner & Stagg, 2006). The reclamation of words associated with identity is an important part of queer and disabled history in relationship to the problematic legacy of the medical and mental health model of pathology.

The medical-industrial complex is a term coined in 1971 by Barbara Ehrenreich in her book *The American health empire: Power, profits and politics*. The term medical-industrial complex refers to the multibillion-dollar health industry composed of doctors, psychiatrists, hospitals, nursing homes, insurance companies, drug manufacturers, hospital supply and equipment companies, real estate and construction businesses, health systems, consulting and accounting firms, and banks. As defined by Ehrenreich, the concept of a medical-industrial

complex conveys the idea that an important and primary function of the health care system in the United States is to make a profit (Ehrenreich, 1971), making patient care, efficacy and self-management a sideline to the bigger motive of money.

While the health care industry has certainly contributed to improvements in the health status of the population, it has also strengthened and maintained the private sector of industry and business for the wealthy, protecting a multitude of vested interests, including the big business of drug companies which jeopardizes the care, trust and health of many patients (Angell, 2004; Kassirer, 2005). Another critique of the profit driven motives of the medical-industrial complex is that this system does not look at the contributions of social factors such as environmental degradation, war, poverty, racism and other forms of oppression to illness (Jones & Rainey, 2006; Kurtz, 2009). Searches for cures and miracle drugs provide profits that continue to line the pockets of the rich and wealthy while ignoring the experiences and external factors that contribute to illness and disability in the people affected.

> The 'rule of rescue' posits that humans will make much larger sacrifices to save those already in trouble than to reduce the statistical risk of future peril . . . our impulse for justice favors assisting the person who is ill over the person who is poor, and we ignore the critical task of preventing people from being either poor or sick. (Sage, 2010, p. 45)

Illness is solely located on the individual, placing blame on groups of people and doing little to prevent the root causes of illness in society. Unrelenting searches for cures in attempts to "fix" defective and marked bodies can often contribute to ableism, heterosexism and homophobia, placing emphasis on desirability, a work force driven by capitalism and consumerism, sexualities focused on reproduction and the denial of alternative experiences to the mythical white male able bodied norm.

The medical-industrial complex and its reliance on money and profits has a vested interest in disability and disease and continues to medicalize what are often termed "deviant" bodies and identities. McGann & Conrad (2007) define medicalization as follows:

> Medicalization is the process whereby previously non-medical aspects of life come to be seen in medical terms, usually as disorders or illnesses. A wide range of phenomena has been medicalized, including normal life events (birth, death), biological processes (aging, menstruation), common human problems (learning and sexual difficulties), and forms of deviance. The medicalization of deviance thus refers to the process whereby non-normative or morally condemned appearance (obesity, unattractiveness, shortness), belief (mental disorder, racism), and conduct (drinking, gambling, sexual practices) come under medical jurisdiction. (¶ 1)

Medicalization also expands the category of deviance to those who reject the offerings of the medical-industrial complex. People who refuse psychiatric medications, resist "corrective" surgeries, or reject standards of health and beauty may often be seen as deviant in this model. The cognitive authority of medical and mental health providers often contributes to medicalization, submission by patients to medicalization and the implications and label of deviance.

Addelson coined the power of the medical and mental health field to describe bodies and experiences to others and ourselves as "cognitive authority" (1983). Cognitive authority is often based in heterosexist and ableist assumptions, that contain culturally constructed binaries of normality around beauty, bodies, sex, gender and sexuality, that often are in direct contrast to queer and/or disabled people's self and identity. In the current medical-industrial complex, disabled and/or queer people often lack a voice in this cognitive authority and must seek

approval and validation from professionals, either by providing descriptions of symptoms and ailments or internal senses of self and gender, or through stated desires to receive or not receive surgery, drugs, and medical treatment.

A recent study in 2009 explored clinicians' beliefs about patient self-management (Hibbard, Collins, Mahoney, & Baker, 2009). The study showed that clinicians "strongly endorse that patients should follow medical advice but are less likely to endorse that patients should be able to make independent judgments or take independent actions" (Hibbard, et al., 2009. p. 65). This information is directly related to clinicians' perceived role in monitoring access of gender affirming treatments to trans and gender nonconforming people by utilizing a diagnosis of GID and policing identities. Clinician's beliefs about patient self-management also affects disabled people's ability to self define their own housing, work and medical treatment in accordance with their own internalized understanding of their own bodies and selves. What may be inferred from this study is that clinicians do not like to give up the power inherent in their role. They most often believe that they know what is best for their clients, and do not trust their clients to know what is best for themselves. The author of the study notes:

> The clinicians' views, reported here, on the relative importance of patient competencies are out of step with emerging professional codes and standards of performance. They are also out of step with larger health policy directions that seek to engage consumers and patients to be informed and activated managers of their own care. (Hibbard, et al., 2009, p. 71)

It is important to consider the future of therapy with queer and/or disabled people as inhabiting a role that includes working in partnership, and supporting clients in their roles as independent actors with expertise in the needs of their gender and identity.

Often, the very labels and diagnoses that are questioned and challenged by activists in the queer and disabled communities are required for access to basic needs, and being "diagnosed" is often the first step in receiving services. Based on these diagnoses many providers make recommendations for treatments and cures, whether they be through surgery, psychotropic medications, housing and living recommendations such as institutions or group homes, therapy, and hospitalization. The goal of the medical model is to "cure" disability, to get rid of disability, to "fix" the body. For many disabled people, acceptance of medical recommendations often means conforming to society's expectations of acceptable bodies and minds based on a binary system of able versus disabled bodies, where normality is based on cultural standards of beauty and acceptable "healthy" bodies. The view that all disabilities require some form of medical treatment is widely held and this often requires, surgery, drugs and submission from the "patient". As Colligan (2007) notes, the medicalization of disability can lead to problematic constructions of normalcy, pathology and oppression:

> People with disabilities have been subjected to pacification through the medical gaze's fixation on essentialized and internalized bodily truths . . . The benevolence and charity that have been extended to these individuals rests on their willingness, through medical treatment, physical retraining, and mental acquiescence, to strive to achieve normative standards of bodily appearance and physical, linguistic and cognitive use. (p. 485)

Because providers of health care benefits and services to disabled people are often the ones defining who needs and is deserving of their help (Muller, 1979) rejection of treatment recommendations can mean being labeled as "resistant" or "ungrateful", even "unworthy", of basic assistance. Providers decide who is and is not considered disabled, and who is and is not eligible for assistance, sometimes based on an individual's decision of "normative" standards of

functioning, presentation and appearance. Medical professionals, mental health workers and social service providers often walk a dangerous line in this unequal distribution of power, and a real danger lies in the potential for allowing bias and prejudice, clouded in paternalistic sympathy, pitying and help, to affect the distribution of services to individuals.

In some cases, being labeled as disabled by providers may become extremely important to people for access to basic services. This creates fear and concern imbedded in clients and patients around accurately describing experiences and symptoms in order to be understood and believed by doctors and properly diagnosed. Being denied disability status disqualifies people from services that are often required for basic survival. One then must be "disabled enough" or have the right kind of disability and the right symptoms that can be measured by standard tests and procedures. Similarly one must be "impaired enough", and providers must decide whether or not a person is capable of working and/or performing all other tasks of daily living. Obviously, there is considerable room for subjectivity here, as many people may not fit neatly into providers' ideas of disability, symptoms and/or functioning and assessments of the ability to complete the "tasks of daily living" are subject to personal beliefs and cultural norms.

Often, "A patient is sent to a psychiatrist for evaluation when the doctor fails to determine what is wrong. The psychiatrist, convinced that the doctor has found nothing wrong, will naturally find a reason for the undiagnosed illness, a mental reason" (Jeffreys, 1982, p. 175). Countless people who experience chronic pain and illness remain undiagnosed, and are often labeled as mentally ill, their physical experience questioned and invalidated by doctors, therapists, social service workers, and employers due to a lack of a clear diagnosis making people ineligible for services and supports. The recent medical history and literature documenting conditions such as fibromyalgia, multiple chemical sensitivity (MCS), and chronic

fatigue syndrome (CFS) point to the contentiousness and problems surrounding diagnoses, the limitations of biological laboratory tests, and troublesome debates concerning the psychological versus the biological etiology of these conditions due to inconclusive and complicated testing procedures (Hooge, 1992; Phillips, 2010; Wolfe, 2009). Science it seems is a less then universal truth, and more often a social construction with bias and prejudice present towards the very people it seeks to "define", or help. Often this leads to the devaluation of people and their experiences, misdiagnosis and continued and unbelieved suffering.

One of the vestiges of an individual model of disability, with deep roots in the workings of charity organizations, are decisions around who is worthy of help and who needs help. Often this is model is based on diagnosis, as well as an individual's acquiescence to "fix" bodies that do not conform to societal expectations of functioning and disability. This model places stigma and blame on the individual with the implication of inherent fault or responsibility lying somewhere within the individual. The assumption then for many disabled people (particularly when talking about mental illness) has been that a person could control or change their situation if they wanted to, but they are too weak, powerless, immoral and/or evil to do so.

The parallels of queer and disability pathology and othering have been most often noted with parallels to disabled and intersexed people. In describing both queer and disabled experiences of pathology in the medical-industrial complex Colligan (2007) notes:

Both are subjected to anomalous classification, medical management, silencing and shame; both groups titillate the projected, and often repressed fantasies of outsiders, and both intersexed and disabled organizations are challenging the assumptions that underlie these negative images to reclaim their own impassioned, desirable and desirous bodies. (p. 45)

These similarities may easily be extended to other queer identities as well, particularly to those that are trans and/or gender nonconforming.

The history of gender nonconformity in psychology and psychoanalysis has been embedded in a pathologizing medical model. In the mid 20th century, gender difference was seen as a pervasive mental disorder and even as psychosis (Siomopoulos, 1974), and a diagnosis of Gender Identity Disorder (GID) remains in the current DSM-IV (APA, 2000). Trans activists have argued that the diagnosis and criteria of GID eliminate the power of the trans person to self identify, undermining the entire framework of the therapeutic relationship. GID as a diagnosis implies that there are no healthy and functional trans people "who are able to seek medical and surgical treatments for their own actualization without being labeled mentally ill" (Lev, 2005, p. 42). It is argued that a diagnosis of GID does not allow for diversity of experience of trans and/or gender nonconforming people by reinforcing, "Stereotypical sexist and heterosexist assumptions regarding normative male and female experience, and serves to reify a traditional gender based hegemony" (Lev, 2005, p. 43). It has largely been acknowledged by postmodern theory that gender is a social construct that lies on a continuum (Bornstein, 1994; Butler, 1990; Freud, 1996). Many trans people are gender queer and do not identify within the binary system of man or woman.

> The medical approach to our gender identities forces us to rigidly conform ourselves to medical providers' opinions about what 'real masculinity' and 'real femininity' mean, and to produce narratives of struggle around those identities that mirror the diagnostic criteria of GID. (Spade, 2003, p. 28)

GID can be seen as the medicalization and pathology of gender identity and limits the expressions of self and narratives of experience, thereby imposing society's patriarchal and heterosexual norms and values onto trans people's bodies and lives.

Nevertheless, many trans and gender nonconforming people must rely on the medical and mental health profession for validation of their experience in order to seek gender-affirming treatments such as surgery and hormones. Often, trans people come to therapy with a full understanding of their gender identity, and more knowledge about the benefits and costs of gender affirming treatment than their providers, but due to the medicalization of trans bodies, they are still forced to seek gender identity validation from mental health providers. Additionally, many trans people access therapy solely for the purpose of securing gender affirming treatments, but as reported in the study mentioned above, many clinicians do not believe in the ability of clients to self manage their care and to decide what medical procedures they may or may not want and act as gatekeepers to surgery and hormones. The Standards of Care (SOC) are the basis for the medical model in providing gender-affirming treatment to trans and gender nonconforming treatment. The SOC are a set of guidelines or "recommended requirements" for working with trans and/or gender nonconforming people (WPATH, 2001). Professionals who adhere to these standards of care are known as "gatekeepers" and hold authority to state whether or not a person is eligible, worthy of, or significantly distressed enough in their present physicality, to be diagnosed with gender identity disorder (GID) in order to qualify for gender affirming treatment. It is not enough to have an internal understanding of your own gender, due to the legacy of the medical model; trans and gender nonconforming people must be validated, approved, and believed by the cognitive authority of professionals. Like disabled people, trans and gender nonconforming people worry about how to best present

themselves to social service professionals in order to be diagnosed appropriately. This often means "fitting" a provider's definition of trans in a myriad of ways, from textbook identity development, to binary gender presentation, and socially acceptable sexuality and practices. The SOC and the medicalization of trans and/gender nonconforming people's experience will be discussed in more detail in the Phenomenon Chapter of this thesis.

Validation of one's gender identity by professionals in order to access treatment is similar to the ways in which a person's physical symptoms and descriptions of illness must be verified with tests, validated and proven for a proper diagnosis. If this cannot be accomplished to the satisfaction of science, a person's experience is devalued entirely and classified under a mental or psychological condition. This is the last step for the medical model, when "truth" based in evidence, cannot be sufficiently gathered. Psychiatry often receives people who cannot be physically diagnosed by western medicine. The disease then must be in the mind. Arguably the most stigmatized experience for any individual in society is to be labeled as mentally ill. The medical model holds fast to rigid acceptance of binary systems and constructions of gender, sex, and sexuality as well as a rigid role of acceptable "normality". Disabled and trans bodies are "other", and in need of cure, rehabilitation and assimilation under a doctor's watchful eye.

The authority to have one's descriptions of self, experience and body, believed and accepted as truth is often not in the hands of queer and/or disabled people. People in positions of power who often diagnose, define and label an individuals' experience hold cognitive authority. Rarely is it held by those who are seeking services, or identified as patients. This creates an unequal distribution of power, determining who receives benefits and/or treatments that may in some cases improve the overall well-being and quality of life for some, and necessary survival for others. These are just some of the examples of the ways in which the power of definition

may have a large affect on an individual and/or groups economic, social and psychological well-being. In these contexts it is important to ask who is doing the defining, and what the functional and ideological implications of this power of cognitive authority is.

This paper moves outside the realm of language used as self-definition by including discussions of pathology and diagnosis. Therefore, this paper will be mindful and thorough in its understanding of the words used to describe identity in order to discuss the politics of queerness and disability.   One cannot begin to talk about pathology of identity without considering the systems in place that maintain systemic oppression, namely, heterosexism, ableism, and transgender oppression, all of which work intersectionally to oppress queer and/or disabled people.

CHAPTER THREE

PHENOMENA: THE DSM, PATHOLOGY, BIAS AND QUEER DIAGNOSES

The Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) is the main

classification of mental disorders used by mental health professionals in the United States and

increasingly around the world (Cooper, 2004). This book, the "bible" of psychiatry, clinical

social work, and psychology, "represents a major way of organizing psychiatric knowledge,

research efforts and therapeutic approaches" (Kirk & Kutchins, 1994, p. 71). While, in principle,

psychiatric diagnosis were created as tool to help both clients and providers, real attention must

be paid to the ways in which the power of language and cognitive authority is unequally

distributed across the hierarchies of diagnoser and diagnosed within the medical-industrial

complex. One must remember that, "a diagnostic label . . . has profound influence on what we

think of people so labeled and how they think of themselves" (Hare-Mustin, 1997, p. 105).

Diagnoses can exert a significant negative effect on the lives of people who are receiving these

labels, extending into the social, cultural and legal arena. Diagnostic labels can create problems

with employers and the military, can result in the loss of child custody, health insurance, and the

right to make decisions about one's legal affairs and own medical care (Benjet, Azar, &

Kuerston-Hogan, 2003; Caplan, 2004; Simon & Gold, 2010). Diagnoses are also sometimes

necessary for people to access services and benefits in health coverage and income, and

instrumental in accessing treatment and support for trans and gender nonconforming people. The

cognitive authority of professionals, presumed objective, professional, and backed by research,

give the diagnosis enormous, often unquestioned and unchallenged, power with real and lived

implications for people's experiences and lives.

The DSM has become the pre-eminent organizing rubric not only for diagnosing patients

in the mental health system, but also for textbooks of psychiatry and psychology, for

deciding on insurance reimbursements, and for much government-funded mental health

research. This reliance on a single point of view, which has come to have the status of

law, should raise concern, no matter what its content. Such apparent unanimity seals off

opportunities for intellectual debate and dialogue from which new ideas flow and deeper

insights are generated. (Hare-Mustin & Marecek, 1997, p. 112)

The DSM represents the culmination of diagnosis and the ultimate authority in naming mental

disorders and its contents should be carefully considered and critiqued given the weight of the

material contained within. An open assessment of values and beliefs that are inherent in the

upholding and creation of diagnosis reveals that these categories are not created from neutral,

objective or universal positions. At their worst, as will be discussed later in this chapter,

psychiatric diagnosis can recapitulate sexism, homophobia, transgender oppression, and ableism

of larger society. Therefore it is unethical to assume that diagnoses are always useful (Braun &

Cox, 2005; Caplan, 2004; Conrad, 1992; Jiminez, 1997; Kirk & Kutchins, 1988; Offman &

Kleinplatz, 2004; Rosenberg, 2006). Critical thinking about the ways in which diagnoses may be

rooted in bias and assumption and the challenges present in diagnosing individuals is important

to the ethical and responsible work of social workers and providers in the mental health field to

prevent harm and future abuse (Cosgrove, 2004; Marecek, 1993).

A complete and full understanding of the problematic ways in which diagnosis has been

used, as well as the bias involved in the creation of these categories, seems essential to the

education of any competent and ethically minded therapist and yet it is largely missing from the

education of many professionals (Wiley, 2004). Additionally, while many students have

concerns and conflicts regarding the DSM and diagnoses, schools have steadily increased

content in course work around the DSM since 1986, without necessarily expanding or

encouraging critical thinking around its cognitive authority (Newman, Dannenfelser, &

Clemmons, 2007).   It is essential, then, given the implications inherent in the use of the DSM to

consider the ways in which these labels are created, who is instrumental in their construction, as

well as the biases and assumptions that may be instrumental in the creation of these categories.

Therefore this chapter will begin with some of these important and relevant critiques.

The DSM has undergone numerous textual revisions since its inception in 1952, with the

addition and deletion of a substantial number of diagnoses, categories and subcategories. In the

seven years between the 1987 and 1994 editions, for example, the number of categories and

subcategories increased from 297 to 374 (Caplan, 1995). Two other major revisions followed in

1994 with the publication of DSM-IV and again with a text revision of DSM-IV in 2000. The

American Psychological Association (APA) notes that these revisions "represented major

advances in the diagnosis of mental disorders and greatly facilitated empirical research" (APA,

2000, p. xxvi), citing empirical literature and data as the cause for these revisions. As the APA

increasingly justifies the expansion of diagnoses and categories on the basis of empirical

evidence and research, this research and evidence has routinely been called into question by

critics.

Most troublesome is the increasing number of links between drug companies, research

and diagnoses that are being uncovered in the medical-industrial complex. The interest of drug

companies in diagnosis is obvious, finding a diagnostic label that fits a drug's reaction to a

person's body and/or mind will make the marketing and FDA approval of that drug easier, faster

and more profitable. Drug companies have been linked to research money that is used to

advance diagnostic categories and concerns about funding sources and outcomes of studies are

vast, thereby linking the DSM to questions of validity and reliability of diagnostic categories

(Angell, 2000; Bodenheimer, 2000; Davidson, 1986; Friedberg et. al., 1999; Korn, 2000). Even

more disturbing, is the direct link of strong financial ties between DSM-IV panel members who

are responsible for developing and modifying the diagnostic criteria for mental illness, and the

pharmaceutical industry.

> Of the 170 DSM panel members 95 (56%) had one or more financial associations with
>
> companies in the pharmaceutical industry. One hundred percent of the members of the
>
> panels on 'Mood Disorders' and 'Schizophrenia and Other Psychotic Disorders' had
>
> financial ties to drug companies. The leading categories of financial interest held by panel
>
> members were research funding (42%), consultancies (22%) and speakers bureau (16%).
>
> (Cosgrove, et al., 2006, p. 156)

These ties suggest monetary incentives for the creation of diagnoses and this should be cause for

alarm among professionals in the mental health field. Nosological boundaries are ever

expanding in today's world, again calling into question the authority of diagnosis and the

reliability of books such as the DSM.

> Though it has become routine, many Americans still find it unseemly that diagnosis can
>
> be shaped in part by advocacy groups and Web sites, or that disease-targeted research
>
> funding can be determined in part by lobbyists, lay advocates, and journalists, and not by
>
> the seemingly objective and inexorable logic of laboratory findings . . . And in the private
>
> sector, we have seen in the past half a century how pharmaceutical industry research and
>
> marketing decisions have helped reshape both medical and lay notions of emotional
>
> illness and its treatment. (Rosenberg, 2006, p. 410)

This calls to mind the countless ads on television for drugs that can treat a variety of concerns among the American population. This kind of direct market advertising of medications caters to medicalization and the medical-industrial complex by luring in potential consumers and has an incredible impact on the role of diagnosis and its relationship to society.

Additionally, the DSM has been criticized as increasingly becoming a tool for managed care and insurance companies, as providers utilize categories and diagnosis that will secure payments and justify medication prescription, regardless of symptoms and treatment planning. Psychiatrists often change previous diagnoses based on medication changes and/or adjustments with the justification that insurance will not pay unless the diagnosis matches the medication prescribed. This issue has also been documented in literature suggesting it is a common problem (Braun & Cox, 2005; Kirk & Kutchins, 1988; Pomerantz, 2003). Many therapists and clinicians use diagnostic labels to aid in the choice of appropriate treatment and potential outcomes. Unfortunately this method has not been proven reliable, but rather it has been shown that many problems experienced by patients are not in fact psychiatric symptoms, and that there is little relationship between diagnoses, patients' problems, and the psychotropic drugs prescribed (Harris, Hilton, & Rice, 1993; Quinsey, Cyr, & Lavallee, 1988).

Explaining and defining mental illness is a complex, ambiguous and controversial arena. There are a wide spectrum of explanations and theories of mental illness including biological perspectives (Andreasen, 1984), philosophical interpretations (Foucault, 1965), and rejection of mental illness as anything other then a social construction (Szasz, 1961, 1970, 1974). In its origins the DSM did not question what does or does not constitute a disorder but instead represented an "accretion of psychosocial problems brought into psychiatric practice. Diagnoses were there because they represented phenomena that psychiatrists treated and what psychiatrists

treated was based on the field's origins in medicine and penology" (Drescher, 2010, p. 452). In

1980 a major revision resulted in the publication of DSM-III, which sought to define what is and

is not a disorder using the criteria of dysfunction and distress and recognizing "disorders" as

existing in psychosocial circumstances and environments (Spitzer, 1981). While diagnoses,

symptoms, and classifications have changed throughout these revisions, the APA's definition of

a disorder has largely remained the same. The APA (2000) states that a mental disorder,

> Must currently be considered a manifestation of a behavioral, psychological, or biological
>
> dysfunction in the individual. Neither deviant behavior (e.g. political, religious, or
>
> sexual) nor conflicts between the individual and society are mental disorders unless the
>
> deviance or conflict is a symptom of dysfunction in the individual. (p. xxxi)

This definition has been seen as problematic because the DSM does not distinguish deviant

behavior that is caused by a psychiatric disturbance from deviant behavior that is labeled so due

to social customs and norms, but from a mentally stable individual (Kirk & Kutchins, 1996; Lev,

2005; Wakefield, 1997). Notably Lev (2005) argues that although the authors of the DSM-IV

do acknowledge the difficulties and limitations of defining abnormal and dysfunctional

behaviors they do not also attempt to offer a definition of mental health or functionality. Lev

(2005) states that, "the consequence and impact of this ambiguity on individuals who express

'deviant' political, religious, and especially sexual lifestyles has been under-examined" (p. 37).

What society views as deviant versus what is caused by illness becomes the discretion of the

clinician, leaving room for diagnosis to be based on personal bias and value systems. Many have

argued that the DSM, is over inclusive, lacks reliability and validity, is increasingly a tool used

for billing insurance companies and managed care, encourages pathologizing diagnostic labels,

pathologizes nonmedical conditions leading to unnecessarily medicating clients, and is often a

way to pathologize other variations in human diversity and experience (Brown, 1994; Cooper, 2004; Kirk & Kutchins, 1996; Lev, 2005; Pomeroy, Holleran, & Franklin, 2003; Rapport, 2006; Szasz, 1974; Wakefield, 1997). For the purpose of this paper and thinking critically about GID in the DSM-IV, the most notable critique of diagnosis is its use as a tool of social control.

Philosophers, activists, and historians, have long critiqued diagnostic categories as not based solely on medical knowledge, but largely on political and social factors (Foucault, 1965; Illich, 1976; Stainton Rogers, 1991; Zola, 1972). Diagnoses reveal prejudice, bias and assumptions reflective of societies' norms and values at any given time in history, and concepts of mental health and normality cannot be understood without looking at cultural norms and values (Brown, 1990; Foucault, 1965).   There is a substantial body of writing that argues mental illness and diagnosis are social constructions, created to enforce social mores and norms. Thomas Szasz (1970), a psychiatrist, and critic of the moral and scientific foundations of psychiatry, asserts that the aim of medicine in enforcing social control, "We call people mentally ill when their personal conduct violates certain ethical, political, and social codes" (p. 23). Behaviors and conduct that receive attention from the psychiatric community are largely dependent on the social climate of the time.

Throughout history, diagnosis and treatment have sometimes been used as a way to control the behavior of and maintain power over certain groups of people. It has been noted that, "medicalization is one of the most effective means of social control and that it is destined to become the main mode of formal social control" (Pitts, 1971, p. 391). Many see the medical and mental health fields as enforcers of these norms, and diagnoses as means of social control (Conrad, 1992; McKeown, et al., 1998; Szasz, 1961). As Reynolds (1973) notes, professionals through cognitive authority control conversations and discussions around the treatment of

behaviors, removing them from the public realm and placing them solely in the hands of the perceived psychiatric authority.

> The increasing acceptance, especially among the more educated segments of our populace, of technical solutions- solutions administered by disinterested politically and morally neutral experts- results in the withdrawal of more and more areas of human experience from the realm of public discussion. For when drunkenness, juvenile delinquency, sub par performance and extreme political beliefs are seen as symptoms of an underlying illness or biological defect the merits and drawbacks of such behavior or beliefs need not be evaluated. (p. 220-221)

In effect, the voices, beliefs and experiences of people and individuals are silenced and controlled by the dominant professional with the cognitive authority to "treat" perceived disorders.

Psychiatry's use of psychotropic medication is also an overt and obvious form of social control. "Psychoactive drugs, especially those legally prescribed, tend to restrain individuals from behavior and experience that are not complementary to the requirements of the dominant value system" (Lennard, 1971, p. 57). Psychiatric medications are often prescribed to "fix" non normative behavior, regardless of whether or not an individual perceives this behavior to be a problem. For instance, a person may be treated with a mood stabilizer after a series of verbal altercations with a partner. A child may be given an antipsychotic when they are unable to control their anger or comply with authority. A woman may be prescribed an anti anxiety medication when she describes difficulty interacting with male managers and bosses. Prescribing drugs that control behavior, whether that behavior is restlessness, psychosis, depression, sleeplessness, anxiety, or drug abuse, all require a diagnosis that states the deviance

is a medical problem. This medical perspective of diagnosing illness individualizes problems, rather then looking outside of the individual and into society for the root of problems and behavior. "Rather then seeing certain deviant behaviors as symptomatic of problems in the social system, the medical perspective focuses on the individual diagnosing and treating the illness, generally ignoring the social problem" (Conrad, 1975, p. 19). Looking for complex problems solely located in the individual rather then in the social system creates a vicious cycle of patient and prescriber, since no medication, diagnosis or treatment given to an individual can help shift problems that are often rooted in systemic oppression and violence, racism, classism, misogyny, and homophobia. All of these critiques noted above, including the rise in pharmacology and genetics, the pathology of deviance, the role of psychiatrist as expert, and diagnosis as law, should give professionals due reason to pause in their use of diagnosis and examine the root and implications of their use.

Nevertheless, health researchers continue to minimize the role of social influences on their work (Caplan et al., 1992) and proponents of the DSM overlook the fact that psychiatric disorders are cultural constructs (Chrisler & Caplan, 2002). Human beings need and desire to name and classify things. As evidenced by the numerous revisions the DSM has gone through and is currently undergoing, diagnosing and classifying mental disorders is not a "science", but largely subject to the mores and culture of the United States at any given point in history, making the strong argument that diagnoses are culturally constructed. This constant revision is evident proof of the contentiousness of diagnosis pointing to its use as not only a scientific document, but also as a "revisable political manifesto for the psychiatric profession" (Pilgrim, 2007; Wilson, 1993). Diagnoses are contentious, unreliable and often reflect bias in an attempt to challenge, condemn and control non-normative behavior.

Without re-examining the ways in which the DSM and psychiatry name, apply, and hand out diagnosis which reflect racist, homophobic, misogynist and ableist oppression, professionals continue to standby complacently as cognitive authority enacts social control over "deviant" bodies, and experiences. It should be no surprise, or hidden truth to any provider that historically, science, psychology, psychiatry and the "helping professions" have recapitulated larger societal oppression and violence towards all oppressed and marginalized people (Caplan, 1995; Greene, 1995; Javed, 2004).

Racism in Diagnosis: Past to Present

Natural human diversity in race, gender, sexuality, and disability, have been pathologized by psychiatry and enforced through diagnosis throughout history and this practice continues to this day. The bias present in the modern day medical and mental health fields can be traced to roots of racism, ableism, sexism, homophobia, and classism evidenced in diagnosis, both historical and modern. An obvious example of the ways in which bias continues to inform the ways in which diagnosis is used to oppress people is by looking at the history of racism in diagnostic categories. Historically in the 19th century, diagnosis such as "drapetomania", a disorder that prompted slaves to run away, and "dysathesia ethiopica", a disorder used to describe slaves who were disobedient, refused to work, or fought with their masters (Cartwright, 1851), are obvious examples of diagnosis used as social control and reflecting overt racism. More then simply a historical side note, these diagnoses were used to impact public law and policy by dictating immigration and citizenship laws. Social control enforced through diagnosis, was a major tenet of the first federal immigration act of 1882, which prohibited entry to the United States of any "lunatic, idiot, or any person unable to take care of himself or herself without becoming a public charge". Legislation in 1907 added "imbeciles" and "feeble-minded

persons", with regulations directing inspectors at entry points to exclude persons with "any mental abnormality whatever . . . which justifies the statement that the alien is mentally defective". "Aliens" of course, were people of different races, and ethnicities and this criterion for mental illness is skewed against a backdrop of racism and fear of difference imbedded in the immigration policies of the time, allowing for a considerable amount of discretion and bias in the justification for refusal of entry into the United States. An interpreter at Ellis Island noted, "over fifty percent of the deportations for alleged mental disease were unjustified" based on "ignorance on the part of the immigrants or the doctors and the inability of the doctors to understand the particular immigrant's norm or standard" (LaGuardia, 1961, p. 65). Arguments of the mental and physical deficiencies of ethnic groups were used as arguments of the justification of their exclusion (Grayson, 1913). Immigrants were more likely to be seen as "mentally defective" and some believed that up to half the immigrants from southern and eastern Europe were "feeble minded" (Baynton, 2001; Trent, 1994).

These arguments were again used in creating the 1924 immigration act which instituted a national quota system based on ethnic origin and severely restricting immigration of peoples from "undesirable" ethnicities and races by basis of diagnosis. Notably, during the late 19th century foreign born people occupied an unusually high percentage of patients in mental hospitals and asylums. For instance, 80% of the population at the New York Lunatic Asylum between 1847 and 1870 were immigrants (Grob, 1973). The eugenics movement backed by scientific racism claimed to prove the inherent supremacy of Anglo Saxons over other races and ethnicities and informed psychiatric thinking and discourse around immigration policies. Theilman (1985) describes the beliefs held by psychiatrists around early immigrant populations.

There was considerable feeling among psychiatrists that the immigrant population

harbored a large number of 'mental defectives' who would taint future generations of

Americans if not restricted . . . Some practitioners were also deeply concerned about what

might happen to the state of American mental health if the racial mixture of the nation's

population was substantially altered. (p. 299)

Psychiatrists often justified exclusion of immigrants from the United States by attributing mental

illness to non-Anglo people, often appearing before health organizations to endorse restrictions

(Bancroft, 1914; Dawes, 1925; Pratt, 1884; Russell, 1908; Swift, 1913; Woodruff, 1901). This is

exemplified in the quote below:

All those familiar with mental disease among the Japanese in California testify to the

remarkable tendency to suicide in that race, not only in depressed conditions but in

conditions in which suicidal tendencies, in other races, are not frequent. The strong

tendency to delusionary trends of a persecutory nature in West Indian negroes, the

frequency with which we find hidden sexual complexes among Hebrews and remarkable

prevalence of mutism among Poles, even in psychoses in which mutism is not a common

symptom, are familiar examples of racial traits upon mental diseases. (White & Jelliffe,

1913, p. 258)

In particular, Forester Pratt, a Michigan psychiatrist, politician and member of the Association of

Medical Superintendents of the American Institutions for the Insane (AMSAII), a precursor of

the American Psychological Association (APA) was focused on immigration restrictions among

the "defective people" of Europe and Asia. He offered a resolution to the AMSAII urging

Congress to restrict these "defective" classes of immigrants to the United States. His resolution

was passed unanimously (Thielman, 1985). This shows once again how psychiatric discourse

and cognitive authority is inextricably and problematically linked to ideological views of racism. It is important to connect this legacy of racism in diagnosis to 21st century abuses of cognitive authority which still contain the legacy of these biased and racist beliefs.

Studies have shown that a disproportionate number of students of color are seen as having a disability, mentally retarded, or emotionally or psychologically dysfunctional in comparison to their white peers often largely due to bias in testing, ethnic and linguistic differences, and larger issues of institutionalized racism (Blanchett, Klinger, & Harry, 2009; Donovan & Cross, 2002; Ford, Blanchett, & Brown, 2006; Harry & Klinger, 2006). Compared with all other groups combined, African American students are 2.99 times more likely to be classified as having MR, 1.17 times more likely to be classified as having autism, and 1.65 times more likely to be identified as having developmental delay (US department of Education, 2003). In contrast, Hispanic students are about twice as likely as white students to be classified as having MR and/or with a developmental delay (U.S. Department of Education, 2003). It is also worth noting the ways in which schizophrenia became a highly racialized label in the United States during the civil rights movement. A shockingly disturbing ad from the makers of the drug Haldol in the 1974 depicts an angry African American man with his fist raised in the air and the caption "Angry and Belligerent? Cooperation often begins with Haldol" (Metzel, 2010). This ugly vestige of bias and racism continues today as reported by a 2005 *Washington Post* article:

> Although schizophrenia has been shown to affect all ethnic groups at the same rate, the scientist found that blacks in the United States were more than four times as likely to be diagnosed with the disorder as whites. Hispanics were more than three times as likely to be diagnosed as whites. (Vedantam, 2005, p. 1A)

African Americans, by refusing to conform to a racist and oppressive society, beginning with protests during the civil rights movement, were pathologized, and their anger was diagnosed as mental illness. This trend, gone unexamined, continues to point to inherent and unchecked racism in the medical and mental health fields, and African Americans continue to be diagnosed with schizophrenia and medicated in larger numbers than their white peers (Hampton, 2007; Neighbors, Jackson, & Campbell, 1989; Trierweiler et al., 2006). Here then is historical evidence pointing to the ways in which ableism and racism overlap and the ways in which this legacy of racism in psychiatry and diagnosis continues to operate currently in the medical-industrial complex.

Misogyny and Sexism in Diagnosis: Past to Present

Debates around gender specific diagnoses, in particular in relation to women's bodies and functioning, also reveal social biases, misogyny and sexism present historically and recapitulated contemporarily in the mental health field through diagnosis. As with the historically inherent presence of racism in psychiatry, women's experiences in the medical and mental health fields are nothing short of an embarrassment to the scientific community. In the 1800's diagnosis such as neurasthenia, nervous prostration, dyspepsia, and hysteria were common diagnoses believed to be caused by the wandering of a women's uterus within her body (Ehrenreich & English, 1978; Lev, 2005). Based on these diagnoses women were forced into institutions and asylums, subjected to lobotomies, hysterectomies, clitoridectomies, and removal of their ovaries (Geller & Harris, 1994), and gynecological surgeries were performed on women in mental hospitals up until the turn of the 20th century (Barrus, 1898; Witte, 1902). "Women's mental problems almost always stemmed directly from their reproductive capacity, reflecting morally charged traditional beliefs about women's nature and roles" (Jiminez, 1997, p. 155), with childbirth and

menstruation posing the biggest threats to women's mental stability (Barrus, 1898; Tomilson, 1899). The stories of Frances Farmer, Charlotte Perkins Gilman, and Elizabeth Parsons Ware Packard reflect the common experience of women diagnosed with mental illness and confined and "treated" against their will due to unorthodoxy in lifestyle. Notable, is that all of these women are white, as African American women remain nameless, unheard, and unseen, but were most likely even more adversely affected than their white peers by psychiatry and medicalization.

The 1960's saw changes in gender roles, new understandings of sexuality, and not surprisingly, a resurgence in diagnosis based on bias and social control of women. As the feminist movements began to challenge traditional stereotypes and gender roles, the diagnosis of hysteria reemerged as a prominent diagnosis of women (Guze, 1967; Halleck, 1967). Hysteria contained the same pejorative legacy of previous misogyny and diagnosis in the mental health field as in the 19th century, and there were very few changes to this diagnosis and symptoms. Like pathologizing the behavior of African American men who refused to accept racist laws and behaviors, similarly, psychiatry sought to diagnosis women who dared to step outside of traditional gender roles of wife and mother.

Contemporarily, women continue to be misdiagnosed and unfairly stigmatized with Borderline Personality Disorder and Dissociative Identity Disorder, disproportionately among women who have experienced trauma (Caplan, 1995; Kutchins & Kirk, 1996). The impact of childhood sexual abuse, sexual assault, and domestic violence perpetrated and complicity enabled by a misogynist and patriarchal society are often invisiblized through the use of these diagnoses, placing the "disorder" on the individual (Herman, 1992; Miller, 1994). Shockingly, premenstrual dysphoric disorder, (PMDD), remains a mental disorder in the DSM-IV, despite

continued debate on the ethics, lack of empirical basis, and obvious social and political consequences this has on women, including shaming of experience, enforcing social taboos and pathology on the normal bodily functions of women, and the continued medicalization of women's bodies (Beausang & Razor, 2000; Kleinplatz, 2001; Koff & Rierdan, 1995; Offman & Kleinplatz, 2004). It seems as though the menstrual cycle and reproductive cycles of women have never lost their fascination for psychiatrists, and the cycles of oppression, misogyny, and sexism of diagnosis continue on. Social workers, psychiatrists and medical and mental health professionals, it seems, all would do well to openly acknowledge these embarrassments of "science" and begin to work towards a model that consciously works to undo some of the previous harm the "helping professions" have caused.

<div align="center">Homosexuality in the DSM: Past to Present</div>

This paper will now turn to the history and current state of queer diagnoses within the DSM, beginning with the history of the inclusion and subsequent removal of homosexuality as a diagnosis. "Nowhere are the moral implications of etiological theories more apparent then in the modern history of homosexuality's status as a psychiatric diagnosis" (Drescher, 2010, p. 431). Drescher (2010) also notes that across history discourse around homosexuality has been tied into cultural values and norms.

> Official pronouncements on the meanings of same sex behaviors were once primarily the province of religions, many of which deemed homosexuality to be 'bad'. However as 19th century Western culture shifted power from religious to secular authority, homosexuality received increasing scrutiny from among others, the fields of law, medicine, psychiatry, sexology, and human rights activism. (p. 432)

By the early part of the 20th century, most psychiatrists viewed homosexuality as pathological (Bieber et al., 1962; Rado, 1940, 1969; Ovesey, 1965, 1969). In 1952 the APA published the first edition of the DSM (DSM-I), in which it classified homosexuality as a "sociopathic disturbance" (APA, 1952). It appeared again in the DSM-II as a perversion (APA, 1968). This labeling of homosexuality as a mental disorder and pathology in the DSM occurred despite a vast amount of non-psychiatric research from people proving homosexuality as a normal and common experience of humanity, which commonly presented as non-pathological (Ford and Beach, 1951; Hooker, 1957; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, & Martin, 1953). American psychiatry ignored this growing body of work and even expressed outward hostility towards research and findings that conflicted with their own (Lewes, 1988). Homosexuality was removed from the DSM in 1973, largely due to the work and protests of gay activists who claimed psychiatric theories, which purported homosexuality to be a disorder contributed in great part to homophobia and stigma in society (Drescher, 2010; Duberman, 1994). Activist Barbra Gittings (2008) was at the forefront of this work and describes the climate for gays and lesbians in the medical and mental health fields as such:

> We were denounced as immoral and sinful. We were punished as criminals and lawbreakers. We were labeled "sick" and needing "cure." We were mostly invisible as gay, which made it hard for gay men and lesbians to develop good social lives and to create a movement to battle injustice and prejudice. It's difficult to explain to anyone who didn't live through that time, how much homosexuality was under the thumb of psychiatry. The sickness label was an albatross around the neck of our early gay rights groups—It infected all our work on other issues. Anything we said on our behalf could be dismissed as "That's just your sickness talking." The sickness label was used to justify

discrimination, especially in employment, and especially by our own government. (p.

289)

Gays and lesbians were subject to aversion therapy, lobotomies, shock therapy,

psychoanalysis, and incarceration in mental hospitals, all centered on the belief that

homosexuality was immoral, wrong, and harmful to both individual and society (Jay, 2000;

Terry, 1999). This is imperative to understanding the enormous implications of homosexuality

as a diagnosis, as well as the impetus for the struggle to resist such labels and medicalization by

the LGBT community. Gay activists disrupted the 1970 and 1971 annual meetings of the APA,

educational panels were held explaining the stigma caused through the diagnosis of

homosexuality and gay psychiatrists spoke against the diagnosis, appearing only in disguise for

real fear of the professional consequences of coming out (Bayer, 1981; Drescher, 2010; Gittings,

2008; Silverstein, 2009).

The controversy over homosexuality compelled the APA to consider and define exactly

what a mental disorder was and concluded that a mental disorder, "causes subjective distress or

were associated with generalized impairment in the social effectiveness of functioning" (Spitzer,

1981, p. 211). It was then decided that homosexuality did not fall under this definition of

disorder, and in 1973 the APA removed the diagnosis of homosexuality from the DSM-II (Bayer,

1981; Spitzer, 1981; Stoller, 1973). Although 1973 is often quoted as the year that

homosexuality was removed from the DSM, a closer look reveals that this is not entirely true.

The APA disturbingly released a statement making it clear that it was not endorsing

homosexuality as normal stating:

If homosexuality per se does not meet the criteria for a psychiatric disorder, what is it?. . .

Our profession need not now agree on its origin, significance, and value for human

happiness when we acknowledge that by itself it does not meet the requirements for a

psychiatric disorder. Similarly, by no longer listing it as a psychiatric disorder we are not

saying that it is "normal" or as valuable as heterosexuality . . . No doubt, homosexual

activist groups will claim that psychiatry has at last recognized that homosexuality is as

"normal" as heterosexuality. They will be wrong . . . We will in no way be aligning

ourselves with any particular viewpoint regarding the etiology or desirability of

homosexual behavior. (APA, 1973, p. 2-3)

Clear in its belief that while homosexuality was not a disorder nor was it "normal", the DSM-II

adopted the diagnosis Sexual Orientation Disturbance (SOD) in place of homosexuality. This

diagnosis saw homosexuality as an illness only if the individual themselves found their

homosexuality distressing and wanted to change it (Spitzer, 1981; Stoller, 1973). "The new

diagnosis served the purpose of legitimizing the practice of sexual conversion therapies (and

presumably justified insurance reimbursement for those interventions as well), even if

homosexuality per se was no longer considered an illness" (Drescher, 2010, p. 435). Contrary to

what one might think, removal of homosexuality as a diagnosis from the DSM did not end the

pathology of homosexuality by psychiatry.

In DSM-III, the diagnosis of SOD was dropped and changed to Ego Dystonic

Homosexuality and was not revised again until 1986, becoming Sexual Disorders Not Otherwise

Specified in the revised edition of the DSM-III (APA, 1980; APA, 1987). When SOD was

dropped in 1980, Ego Dystonic Homosexuality (EDH) took over as the new queer diagnosis,

"which referred to the subjective experience of unhappiness and contrasted with syntonic

behavior or one's comfort with their same sex desires" (Lev, 2005, p. 41). Eventually, almost 14

years after homosexuality was supposedly removed from the DSM, EDH was removed from the

revision of the DSM-III due to the difficulty of untangling the complicated arena of internalized homophobia, that is negative views of homosexuality learned and internalized through and due to the real and lived experience of stigma, bias, and violence as a homosexual person, and one's own true dystonia. So while it seems that the APA has finally accepted homosexuality as a normal variant of human diversity, it again failed to let sexuality alone, and still to this day includes the diagnosis of Sexual Disorders Not Otherwise Specified in the most recent version of the psychiatric bible, DSM-IV-R.

The diagnosis of Sexual Disorders Not Otherwise Specified includes the criterion "Persistent and marked distress about sexual orientation" (APA, 2000, p. 582). This criterion, as Lev (2005) notes, is "presumably not commonly used to treat heterosexuals who are unhappy with their sexual orientation" (p. 41). The APA through its continued inclusion of diagnosis focused on the sexual lives of humans, perceives sexuality as deviant, non normative and pathological, a problem contained within an individual, rather then purported as problematic through oppressive societal forces such as homophobia, heterosexism, patriarchy and capitalism. The pathology of difference continues, albeit under a new name.

Gender Identity Disorder and the DSM: Past to Present

Like homosexuality, medical scrutiny of gender non-conformity began in the 19th century, and much of the current understanding of trans and gender nonconforming people is rooted in the medical discourse that arose out of this time period. Notable sexologists of the time including Richard von Krafft-Ebing, Magnus Hirschfeld, and Havelock Ellis "occupied themselves with teasing out the fine distinctions between 'sexual aberrations' that have come to be called homosexuality, transvestism, and transsexuality" (Hausman, 1995, p. 111). The goal of these researchers was to decriminalize what was thought of as "sexual deviance" with the belief

that sexual behaviors have medical, biological and scientific origins (Ellis & Symonds, 1897; Havelock, 1897; Hirschfeld, 1910; Krafft-Ebing, 1886). As Lee (2008) explains,

> Those who conducted this research expressed concern over the criminality of so-called sexual deviances given that they believed such behavior to have medico-scientific etiologies; indeed, early sexological research was driven largely by benevolent desires to shift these sex paradigms from discourse around moral culpability to discourse around medicalized study. Research during this era of trans discourse fixated upon classification of discrete sexological conditions and ultimately resulted in a sort of sexualized taxonomy that, in large part, persists today. (p. 450)

The classification systems that were developed were rooted in ideas of labeling, categorizing and sub-categorizing identities in order to determine who is and is not eligible for sex reassignment surgery (SRS).

By the 1920's physicians in Europe began to perform the first sex reassignment surgeries (Hertoft & Sorenson, 1978; Hirschfeld, 1923; Hoyer, 1933). It was not until 1952, when Christine Jorgensen made national headlines in US newspapers when she returned from Denmark a trans woman after undergoing SRS that trans identities and gender affirming treatments became a seminal topic in the US medical and psychiatric field (Denny, 2004; Drescher, 2010; Jorgensen, 1967; Meyer-Bahlburg, 2010). Jorgensen's sex reassignment surgery was the subject of a great amount of public and professional controversy and a report of her surgery was published in the Journal of the American Medical Association in 1953 (Hamburger, Sturup, & Dahl-Iverson, 1953). Following Jorgensen's experience and the widespread reporting of her SRS, numerous clinical papers and books were written on the subject of gender dysphoria

and SRS (Benjamin, 1954, 1966; Green & Money, 1960, 1969; Pauly, 1965; Stoller, 1964). In many ways, Jorgensen, made SRS and transgender people a salient issue in the United States.

Harry Benjamin is largely responsible for the developmental of the medical model of trans identity with the publication of his seminal work, *The Transsexual Phenomenon* in 1966. In his book he categorized two types of gender dysphoria, transsexualism and transvestism (Benjamin, 1966).

> Transsexuals were identified as people who had life long cross gender identity dysphoria, lack of erotic cross dressing, strong dislike for their genitalia, a persistent desire for sex reassignment surgery, and a sexual attraction to those of their same natal (birth) sex. Transvestites on the other hand, were defined as heterosexual males who have a primarily male gender identity and who cross dress for erotic reasons but expressed no desire for SRS. (Lev, 2005, p. 43)

Benjamin's classification system is important because he also distinguished "true" transsexuals, those who requested SRS, from other "less severe" transsexuals that did not request or require surgery (Benjamin, 1966). This is the origin of the still widely held belief in the medical and mental health fields that all "true" trans people want or require surgery, thereby allowing the cognitive authority of medical professionals the capacity to determine who is and is not truly trans and therefore who is and is not eligible for SRS. Another major characteristic of Benjamin's classification system of transsexuals was misery, a desperate unhappiness and depression present in character and mental status (Denny, 2004). Benjamin believed that providing "true" transsexuals with medical intervention could alleviate some of the pain and misery they experienced through their severe dysphoria, while psychotherapy was sufficient treatment for milder cases of transsexualism (Benjamin, 1966).

In 1966 a gender clinic was opened at John Hopkins University in New York to provide transsexuals with SRS, and medical and psychiatric and psychological services to aid in their sexual reassignment, and following suit, a number of other gender clinics opened around the country (Denny, 2004). Research and diagnosis of gender related disordered began in earnest with a zeal for classification of types of gender dysphoria (Lev, 2005). Classification of "true" transsexuals became extremely important to the justification of gender affirming surgeries and treatment, and many researchers noted that the most successful transitions happened when people were classified as "true" transsexuals (Landen, Walinder, Hambert & Lundstrom, 1998; Walinder, Lundstrom & Thuwe, 1978).

Despite the emergence of advanced medical interventions and treatments and visibility for trans and gender nonconforming people, many people in the medical establishment still incorrectly conflated gender identity with sexual orientation and there was substantial resistance and disagreement with gender affirming surgeries and treatment (Hertoft & Sorenson, 1978; McHugh, 1992; Socarides, 1969). Because the transsexual model of classification was a medical one, the supposition was that transsexualism was a form of mental illness. Medical practitioners and psychiatrists viewed trans and gender nonconforming people as mentally ill, confused or repressed homosexuals, having character or personality disorders, neurotic, psychotic, perverted and/or masochistic (Baastrup, 1966; Blumer, 1969; Ostow, 1953; Siomopoulos, 1974; Socarides, 1969; Spensley & Barter, 1971; Weidman, 1953). Opponents of SRS argued that the way to treat mental illness was through the brain, and that compliance with patients' requests for SRS was feeding into mental illness manifested through sexual perversion (Wiedeman, 1953). Proponents of gender affirming hormones and treatments argued that SRS was the only viable treatment for "true" transsexuals and that SRS should be considered a viable

treatment option, but only in the most serious of cases. Benjamin wrote, "my principle argument was that we doctors should be as conservative as possible in advising sex-reassignment surgery or in performing such an irrevocable operation" (Benjamin, 1969, p. 6).

The gender clinics that opened all closed by 1979 due to backlash from the medical establishment, most notably in the form of a paper that was given by Jon Meyer, the director of the John Hopkins Gender Identity Clinic that claimed no improvement in male to female transsexuals that had undergone SRS (Meyer & Reter, 1979). Meyer's study has been critiqued as being methodolically unsound, and a case has been made for scientific fraud (Blanchard & Sherridan, 1990; Fleming et al., 1980; Ogas, 1994; Oppenheim, 1979), but the report made national headlines, and the damage was done. Of the 40 gender clinics that had opened across the United States, only three survived, two of which became private, and one which no longer offered surgical treatment (Denny, 2002). "For more then a decade it was accepted without question from the general public and by most professionals- including many in the field- that sex reassignment had been definitively shown to be ineffective" (Denny, 2002, p. 39).

Harry Benjamin went on to form the Harry Benjamin Gender Dysphoria Association (renamed the World Professional Organization for Transgender Health or WPATH) and distributed his Standards of Care (SOC), a strict set of guidelines for the medical treatment of trans individuals which include the ongoing involvement of medical and mental health professionals as gatekeepers holding access to gender affirming treatments, and a "real life test" where individuals seeking gender affirming treatments are required to live and work in their new gender 24 hours a day 7 days a week for one year prior to treatment. The SOC are still in use and undergo periodic revisions. In the latest version, updated in 2001, the real life test is now called "real life experience" and one letter from a mental health professional is required for

hormones, and two letters from professionals are required for surgery (WPATH, 2001). The inherent problems of the SOC will be discussed in greater detail later in this chapter.

The medical model of trans identities was hugely responsible for legitimizing trans experience and made available gender affirming treatments to many trans people by turning what was once thought of as a moral problem into a medical one. This of course did not come without a price. The medical of model of trans identities was predicated on a binary system of genders subject to intense scrutiny and classification. SRS changed males into females and females into males, with no room for gender diversity and expression. People who were accepted into the gender clinics were required to dress and behave in the extremes of masculine and feminine behavior (Bolin, 1988; Denny, 1992). Those who fell outside of this were labeled "non transsexual" and were denied treatment. Emphasis was placed on one's ability to pass as a member of the opposite gender and on sexual attractiveness.

> A clinician during a panel session on transsexualism said he was more convinced of the
>
> femaleness of a male-to-female transsexual if she was particularly beautiful and was
>
> capable of evoking in him those feelings that beautiful women generally do. Another
>
> clinician told us that he uses his own sexual interest as a criterion for deciding whether a
>
> transsexual is really the gender she/he claims. (Kessler & McKenna, 1978, p. 113)

Not only is there an extreme abuse of cognitive authority present in this statement, but a continued emphasis on binary gender roles and heteronormativity. Individuals were often rejected on the basis of sexuality, age, marital status, job status and appearance in their new gender role (Denny, 1992). For the hundreds of individuals who were able to get treatment from the gender clinics, just as many were rejected due to binary and heterosexist beliefs. In a system that punished its clients for truth telling, many people in the community began to tell stories that

were consistent with the expectations of caregivers, and exemplified the text book trans narrative.

> The preoperative individual recognizes the importance of fulfilling caretaker expectations in order to receive a favorable recommendation for surgery, and this may be the single most important factor responsible for the prevalent mental-health conceptions of transsexualism. Transsexuals feel that they cannot reveal information at odds with caretaker expectations without suffering adverse consequences. They freely admitted to lying to their caretakers about sexual orientation and other issues. Although caretakers are often aware that transsexuals will present information carefully manipulated to receive surgery . . . they only have to scrutinize several of their most prominent diagnostic markers available in the literature to realize the reason for the deceit. If caretakers would divorce themselves from these widely held beliefs, they would probably receive more honest information. (Bolin, 1988, p. 63)

The binary gender belief and heterosexism of the gender clinics worked to silence the experience of a vast majority of trans and gender nonconforming people. Cognitive authority denied treatment to these individuals, marginalizing voices and experiences and forcing individuals into a medicalized transsexual narrative in order to receive gender-affirming treatments.

The medical community has continued this trend of medicalizing gender identity by coining the terms gender dysphoria and GID. The first two publications of the DSM, the DSM-I (APA, 1952) and the DSM-II (APA, 1968) did not include any diagnosis for gender identity. Instead diagnoses under the sexual deviations section, such as homosexuality and transvestism, were often used in place. In 1980 ,in the DSM-III, transsexualism and gender identity disorder of childhood (GIDC) was introduced into the manual as diagnosis for gender dysphoria in adults

and children (APA, 1980). In the DSM-III R, gender identity of adulthood and adolescence, non-transsexual type was added (APA, 1987). In the DSM-IV, diagnoses for gender dysphoria were collapsed into one diagnosis gender identity disorder (GID) with different criteria for children and adults (APA, 1994, 2000). The term transsexual was replaced with GID, but the DSM-IV still bases the diagnosis on distinguishing the various types of trans identities and gender variance to determine eligibility for diagnosis and treatment recommendations (APA, 2000). In diagnosing and defining GID the DSM-IV-TR states:

> There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis. There must be evidence of strong and persistent cross-gender identification, which is the desire to be, or insistence that one is, of the other sex . . . To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning. (APA, 2000, p. 576)

The DSM-IV also includes a diagnosis of Transvestic Fetishism, for people who are designated male at birth and cross dress for "erotic" purposes. A description of autogynephilia is also present in the diagnosis, whereby "sexual arousal is produced by the accompanying thought or image of the person as female" (APA, 2000, p. 574). No such category exists for people who are designated female at birth who cross dress or are aroused by thoughts of themselves as males. This points to misogyny through the pathologization of femininity and female bodies. In other words, it is abnormal for a natal male to wear dresses and be aroused by thoughts of themselves with female genitalia, but perfectly understandable for a woman to be aroused by the thought of herself with a penis. It seems that due to the number of sex shops selling strap on dildos to

people who are designated female at birth, this would be of interest to psychiatry, but again, a heterosexist patriarchy would never pathologize the desire for a penis.

One of the major problems with the diagnosis of GID in relationship to the medical model of transsexualism is that there are only a small number of people who actually fit the diagnostic criteria of GID. Many trans women are perfectly content with their genitalia and do not desire SRS. Many trans people do not come to a full understanding of themselves until much later in life and therefore do not fit the typical trans narrative that insists one must have always felt uncomfortable in the gender that matched their designated sex at birth. Many trans people have diverse gender presentations, trans women can be butch and trans men can be feminine, and a trans identity does not always make the binary distinction of masculine and feminine. Many trans people are happy, healthy and functioning in their lives, prior to and after receiving gender-affirming treatments. Many trans and/or gender nonconforming people have no desire for surgery or hormones. Trans people have a diverse and complicated sexuality, much in the same way that all other groups of people do. Trans women may be lesbians and trans men may be gay. Not all trans men were lesbians before coming out as trans.

It has largely been acknowledged by postmodern theory that gender is a social construct that lies on a continuum (Bornstein, 1994; Butler, 1990; Freud, 1996). GID does not allow for diversity of experience of trans and/or gender nonconforming people because GID reinforces, "stereotypical sexist and heterosexist assumptions regarding normative male and female experience, and serves to reify a traditional gender based hegemony" (Lev, 2005, p. 43). Many trans people are gender queer or bi gendered and do not identify within the binary system of man or woman.

The medical approach to our gender identities forces us to rigidly conform ourselves to medical providers' opinions about what "real masculinity" and "real femininity" mean, and to produce narratives of struggle around those identities that mirror the diagnostic criteria of GID. (Spade, 2003, p. 28)

GID is the medicalization and pathology of gender identity and limits the expressions of self and narratives of experience thereby imposing society's patriarchal and heterosexual norms and values onto trans people's bodies and lives.

A diagnosis of Gender Identity Disorder (GID) in the DSM, allows for the pathologization and policing of difference in the medical and mental health fields through cognitive authority. This diagnosis gives therapists and other health care providers the power to decide who is and is not "truly transsexual" and who is and is not eligible and ready in the eyes of the medical-industrial complex to receive gender-affirming treatments. Medical and mental health professionals thereby, "decide as a society who is normal and what should be done with people who deviate from society's expectations-counseling being only one of the more benign choices" (Freud, 1996, p. 334). Since a diagnosis of GID in the DSM suggests that there is a disordered way to express gender, implied by the very name of the diagnosis, then there must be a normative, non-disordered way to express gender and that, "all other gender expressions can be compared to that and found not only deficient, but diagnosable as mentally ill" (Lev, 2005, p. 47).

The legacy of Harry Benjamin, the SOC, and the medical model of trans identities have cemented the requirements for qualification as a "true transsexual". The Standards of Care for Gender Identity Disorder, (SOC) was written by the World Professional Organization for Transgender Health (WPATH) and has stated that its purpose as follows:

> To provide flexible direction for the treatment of persons with gender identity disorder . . . The SOC provide recommendations for eligibility requirements for hormones and surgery. Without first meeting these recommended eligibility requirements the patient and the therapist should not request hormones or surgery. (SOC, 2001, p. 1&7)

These "recommended requirements" are used by most mental health providers to enforce the role of "gatekeeper" between client and provider and access to services. This document outlines the way in which therapists can "assess" whether or not they believe a client in the statement of their own identities while policing and controlling what people can and cannot do with their bodies. The SOC and access to gender affirming treatments are contingent on a diagnosis of GID.

GID as a diagnosis implies that there are no healthy and functional trans people "who are able to seek medical and surgical treatments for their own actualization without being labeled mentally ill" (Lev, 2005, p. 42). One of the criteria for a diagnosis of GID is that "the disturbances cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA, 2000, p. 581). It seems then, that one must be sufficiently impaired in their life and functioning, completely unable to live their lives or go on another day unless they receive gender-affirming treatments. While this may be true for some people who experience real emotional distress as a result of their gender identity, this is certainly not the experience of all. In fact, many people in the community *like* being trans and often the distress and impairment that people feel is a symptom of society and its attempts to force identities into socially constructed binaries. It is distressing to be oppressed everyday for the expression of self, it is distressing to be denied health care, jobs and housing, assistance, parental and marriage rights due to one's gender identity. This is not the fault of the individual but the fault of an oppressive society and culture that enforces a systemic model of oppression onto the lives of

trans people. Trans people are not impaired in their functioning, but society clearly is. Building a therapeutic framework based on this activist/allyship model is one of the ways providers can begin to build socially just, competent and respectful practices with trans people.

The diagnosis and criteria for GID remove the power of the person to self identify, undermining the entire framework of the therapeutic relationship. It is not enough to simply identify ones own gender or gender identity; it must be proven with the help of a licensed medical professional. Only then with the help of this "gatekeeper" may a person receive a letter acknowledging the "truth" in a person's self identified gender. This letter is often the only way people can access gender affirming treatments, as most surgeons and endocrinologists make this letter a requirement for services. Utilization of the diagnosis of GID and the writing of letters has caused a widespread mistrust of therapists and their role of gatekeepers by the trans community. It remains a double bind for many trans people who "need" these letters in order to access gender-affirming treatments and seek therapy for this purpose alone. The problems inherent in each of these "recommended requirements" of the SOC are many, and beyond the scope of this paper. It is a tool that is used for the "protection" of providers, doctors, therapists, and surgeons. What is implied here is that trans and gender nonconforming people are not reliable or trustworthy, nor should they be believed in what they say, or in the statement of their own identities. Only professionals with cognitive authority are capable of deciding who is a "true transsexual" or "trans enough" to receive treatment.

Some people believe that a diagnosis of GID is necessary in the DSM because it facilitates insurance coverage and disability protections. It is believed that having a diagnosed condition that must receive necessary care will allow people to utilize healthcare to access gender affirming treatments. Proponents of GID argue that removing the diagnosis from the

DSM would make surgery and treatment a class issue, accessible only to the rich who are able to pay out of pocket (Gorton, 2005). It seems as though transition is *already* a class issue, complicated by not only the cost of surgery, but of psychiatric evaluation and documentation. A medical model of trans identity heavily disfavors low-income trans people because they do not have the economic means to access a diagnosis of GID, letters for gender affirming treatments, or for the cost of hormones and surgeries themselves (Lee, 2008; Spade, 2003). The problem of economic access to sophisticated health care is dramatically affected by the fact that trans people, due to widespread institutional and systemic discrimination in education, employment, and housing, are disproportionately more likely to live in poverty (Grant, Mottet, & Tanis, 2011). This is especially troubling because access to many legal rights is often conditional upon the medicalization of trans identities and cognitive authority. For instance, if someone is unable to afford surgery (or doesn't want surgery), then they are not legally allowed to change their gender on their birth certificate, and in some states are prohibited from marrying their same sex partners without a gender change in legal documents.

Access to surgery is seldom covered by insurance and transition is a costly endeavor. In the last five years a small number of private insurance companies have begun to adopt policies that allow coverage for gender affirming treatments; for the majority of people, however, access to surgery is seldom covered by insurance due to policy exclusions (Gehi & Arkles, 2007; Gorton, 2007). To date the cost of gender affirming treatments has been largely borne by the individual utilizing these services (Gorton, 2007). There has been success in the legal arena where lawsuits have successfully won suits against state Medicaid programs requesting payment for gender related surgery and successful suits against prison officials requesting access to hormone therapy while incarcerated (Lee, 2008). However, this makes trans and gender

nonconforming people dependent on time consuming and extensive legal proceedings and dependant on finding appropriate and affordable legal counsel, making this an ineffective and burdensome way to access treatments.

No state includes Medicaid health coverage specifically for transition related health care, and 24 explicitly exclude coverage for transition related care (Gehi & Arkles, 2007). For the remaining states that do not have specific exclusions, "Transition related care may still be denied based on interpretation and application of a more general exclusion such as for so-called experimental or cosmetic treatments (Gehi & Arkles, 2007, p. 9). These exclusions specifically reproduce hierarchies of race and class, as those who cannot afford gender-affirming treatments or the cost of the few private insurance companies who do support transition related costs are dependent on state insurance. Despite the adoption of a medical model and medical evidence that supports the necessity of transition related care, trans and gender nonconforming people are refused transition related treatment showing "the contradiction between the medicalization of trans experience(s) and government's refusal to recognize the legitimacy and necessity of trans health care" (Gehi & Arkles, 2007, p. 7). A diagnosis is desirable for service providers in order to act as protection from being sued while also providing insurance companies with the power to *exclude* trans people from gender affirming treatments.

Gender variance is a natural and normal part of human diversity that has existed throughout society and history (Feinberg, 1996). Pathologizing human diversity has long been a tool used to force white capitalist patriarchal ideas of normality onto society as means of social control. Currently the DSM is in its fifth revision process and GID is one of the most highly contested diagnoses (Ehrbar, Winters, & Gorton, 2009). It is unlikely that GID will be removed from the DSM, but instead it well be reformed, much in the same way that homosexuality was

reformed in 1973. Despite the medical model of trans identities and treatment, trans people are still unfairly excluded from treatment, stuck in a system that disadvantages low income people, while still being held to the medical model's cognitive authority and power of trans related treatment through a diagnosis of GID and the SOC.

CHAPTER FOUR

DISABILITY THEORY AND QUEER THEORY

Queer theory and disability theory have recently emerged as prominent academic disciplines that problematize the construction of binaries and pathology of queer and disabled people. This chapter will begin by giving a brief overview of these two theories and then attempt to bridge these two disciplines as they effectively challenge both compulsory ablebodiness and heterosexuality. Finally, queer theory and disability theory will be applied to the co-construction, treatment and pathology of queer and disabled people within the medical-industrial complex.

Queer Theory

As previously stated in this thesis, queer is a contentious term, with roots in psychoanalysis, feminism, sexology, lesbian and gay studies, HIV/AIDS activism, postmodernism and post structuralism. Queer as used in identity politics signals resistance to oppression based on gender and sexuality and is rooted in the reclamation of the word from a slur commonly leveraged against gay men. Queer "derives its force precisely through the repeated invocation by which it has become linked to accusation, pathologization, insult" (Butler, 1993, p. 226). Queer can refer to gays and lesbians, to the LGBT community in general but has a more complex meaning as well. Giffney (2009) says,

> Queer is more often embraced to point to fluidity in identity, recognizing identity as
> historically-contingent and socially constructed fiction that prescribes and proscribes
> against certain feelings and actions. It signifies the messiness of identity, the fact that
> desire and thus desiring subjects cannot be placed into discrete identity categories, which

remain static for the duration of people's lives. Queer thus denotes a resistance to identity or easy categorization, marking a disidentification from the rigidity with which identity categories continue to be enforced and from beliefs that such categories are immovable . . . it functions to designate a political persuasion, which aggressively challenges hegemonies, exclusions, norms and assumptions . . . When signaling an unapologetic, anti-assimilationist stance, queer champions those who refuse to be defined in the terms of, and by the (moral) codes of behavior and identification set down by the dominant society. (p. 2-3)

Queer is often understood as a fluid definition, often based in opposition to "normalcy" and in resistance to presupposed categories. It is not a static thing, and is ever evolving. Queer is often summed up in statements like, "queerness can never define an identity; it can only ever disturb one" (Edelman, 2004, p. 17). Similarly, Halperin (1995) states:

Queer does not name some natural kind or refer to some determinate object; it acquires its meaning from its oppositional relation to the norm. Queer is by definition whatever is at odds with the normal, the legitimate, the dominant. There is nothing particular to which it necessarily refers. (p. 62)

As one can see, not everyone is queer in the same way, and as described above, queer can move outside the realm of sexuality and encompass other aspects self and politics, not only gender, but questions what is perceived as "normal", "natural", or essential to human beings and culture. Queer can then be described as an identity category, an anti identity or anti assimilationist position, a politic, or an academic discipline.

Having its roots in the word queer, queer theory, as a discipline is no easier to define or describe then the word queer itself. Some theorists argue "there is not 'queer theory' in the

singular, only many different voices and sometimes overlapping, sometimes divergent

perspectives that can loosely be called 'queer theories'" (Hall, 2003, p. 5). This is also

exemplified by Berlant & Warner (1995) who argue:

> It is not useful to consider queer theory a thing, especially one dignified by capital letters.
> We wonder whether queer commentary might not more accurately describe the things
> linked by rubric, most of which are not theory . . . It cannot be assimilated to a single
> discourse, let alone a propositional program. (p. 343)

Queer theory then, is not a unified body of work, but rather, a set of theories and ideas that utilize

queer for its purposes. Queer theory is purposely slippery in that it functions as a "mode of

questioning while simultaneously interrogating the structural formation of such questions, at the

same time as being self-reflexive about the process of interrogative thinking" (Giffney, 2009, p.

1). Queer theory encourages us to engage, to ask questions while searching for meaning, and

takes very seriously the meaning of words and the power of language. Queer theory has

converged with just about every other academic discipline imaginable, for its usefulness in

questioning power and norms. Feminist theory, LGBT studies, postcolonial theory,

psychoanalysis, disability, Marxism, post structuralism, critical race studies, and religion all find

intersections with queer theory (Bell & Valentine, 1995; Boyarin, Itzkovits & Pellegrini, 2004;

Hawley, 2001; Johnsons & Henderson, 2005; Kassoff, 2004; Namaste, 2000; McRuer, 2006) For

the purposes of this thesis, then, queer theory, in all of its forms, remains a useful way of

thinking about, questioning, unpacking and unraveling the complexities of identity, oppression

and power, and its relationship to the medical-industrial complex, queer diagnoses and disability.

Queer theory emerged out of a critique of feminist theory and gay and lesbian studies.

Queer theorists understood these disciplines as working within structures that are limiting,

hierarchical and exclusionary and therefore preventative to transformative change (Callis, 2009; Minton, 1997; Seidman, 1994). Queer theory is based in the deconstruction of social norms and institutions and aims to denormalize stable, binary identity categories. It has pointed to some of the current limitations in identity categorization with particular emphasis on how not only the dominant majority, but LGBTQ people themselves often lock into ideas and understandings of self and identity which in turn can prohibit self expression and understanding and cause potential difficulties in connection across identities.

> Queer theorists understand that identities are always multiple, or at best composites, with an infinite number of ways in which 'identity components' (e.g. sexual orientation, race class, nationality, gender, age, ableness) can intersect or combine . . . Identity constructions functions, if you will, as templates defining selves and behaviors and therefore as excluding a range of possible ways to frame one's self, body, desires, actions and social relations. (Seidman, 1994, p. 173)

In this way, queer theory challenges the way identity categories have been used and framed in Western identity politics, psychiatry, psychology, and the medical-industrial complex. In particular, the use of the words homosexual and heterosexual can be traced to the ways in which psychiatry and the medical profession sought to categorize people's behavior and understand these behaviors in terms of a specific natural identity. The normalization of homosexuality is viewed as an enforcer of the truth of an individual's sexual self and being that enforces moral boundaries and hierarchies. It is premised on notions of resistance, that are decentered from mainstream norms, and not contingent upon inclusion, but rather restructuring hierarchies by looking and critiquing the ways in which these identity categories have been formed and maintained. Queer is intersectional and political:

Every person who comes to a queer self-understanding knows in one way or another that her stigmatization is intricated with gender, with the family, with notions of individual freedom, the state, public speech, consumption and desire, nature and culture, maturation, reproductive politics, racial and national fantasy, class identity, truth and trust, censorship, intimate life and social display, terror and violence, health care, and deep cultural norms about the bearing of the body. Being queer means fighting about these issues all the time, locally and piecemeal but always with consequences. It means being able, more or less articulately, to challenge the common understanding of what gender difference means, or what the state is for, or what "health" entails, or what would define fairness, or what a good relation to the planet's environment would be. Queers do a kind of practical social reflection just in finding ways of being queer. (Warner, 1991, p. 6)

Queer theory becomes relevant to all people in that it problematizes the sex/gender binary system, and provides the opportunity to resist all forms of normativity, including patriarchy, racism, classism, and ableism.

In its most basic form, queer theory attempts to deconstruct heteronormative sexualities and practices, as well as to deconstruct gender and sexuality. In doing so, rather then studying individuals, that is homosexuals or heterosexuals, queer theory looks at the intricacies of power and language that claim that defining people based on sexual and gender categorizations is normal and natural. That is to say, queer theory focuses on gender and sexuality as constructions largely contingent on culture, time, place and history.   In a sense, the stability of categories such as heterosexual, lesbian and gay, become constructed on the basis of the historical and cultural position of the individual, reliant in many ways on a gendered identity (Watson, 2005). The binary social constructions of heterosexuality and homosexuality are relevant only to certain

historical moments and times, and therefore, are not innate types of sexuality (Seidman, 1994).

Michael Foucault (1980) proposed this idea and for many his work provides the framework for

queer theory:

> As defined by ancient civil or canonical codes, sodomy was a category of forbidden acts;
> their perpetrator was nothing more then the juridical subject of them. The nineteenth
> century homosexual became a personage, a past, a case history, a life form . . . Nothing
> that went into the total composition was unaffected by his sexuality. It was everywhere
> present in him: at the root of all his actions . . . because it was a secret that always gave
> itself away. (p. 43)

Foucault's classic statement shows the ways in which subjects, in this case homosexuals, are not

natural facts, but are produced by social factors which then propel people into building

community and politics (Epstein, 1987; Seidman, 1994). Foucault believes that experiences such

as madness, sexuality, illness and crime have become the objects of institutional knowledge

inherent in psychiatry, and the penal and medical system. These identities became inherent to

individuals, and science and medicine ascribe these individuals with characteristics and traits

instead of acts and behaviors, subjecting these individuals to disciplinary power. In this way

Foucault ideas describe how identity is historically and culturally created, rather then inherent

and natural to particular identities. Many queer theorists, such as Alexander & Yescavage

(2009), have expanded upon Foucault's understanding of the cultural and historical context of

identities,

> Our interests in engaging in certain erotic behaviors became signs of who we actually are
> as people- signs of our identity. If you're a man and want to have sex with men, you are
> 'homosexual'. That is who you are, not just something you do. (p. 51)

Earlier this thesis, explored the ways in which trans and gender nonconforming identities have been established and created by the medical-industrial complex. Queer theory has highlighted the ways in which the continued propagation of the heterosexual norm by the medical and mental health fields has contributed to the marginalization and pathology of queer sexuality and identity in favor of a normative (read heterosexual and gender conforming) notion of self inherent in these narratives.

Judith Butler's book, *Gender Trouble*, is considered one of the seminal texts of queer theory (Butler, 1990). Relying heavily on Foucault, Butler asserts "those historical and anthropological positions that understand gender as a relation among socially constituted subjects in specifiable contexts" (Butler, 1990, p. 15). Gender then is fluid and changing in response to different contexts and times. She is clear to state the ways in which the construction of sex leads to the presumption of gender as well as the presumption of sexuality, and presumes that these are all free and independent of one another, but that it is only through cultural configurations that these connections seem "natural". Butler (1990) goes further in her critique of the social constructions of gender and states, "There is no gender identity behind the expressions of gender; ... identity is performatively constituted by the very 'expressions' that are said to be its results" (p. 25). She sees gender as a performance, what is being done at a particular time in relationship to culture, rather then just who you are. Through this lens, normative gender categories, such as man and woman become destabilized as natural and normal, and instead become sites for fluidity and deconstruction.

Foucault's ideas about power are also important to queer theory. His work describes power as relational, as opposed to something that is possessed. Power, Foucault claims, is not owned or excised by the dominant majority, but is inherent in all relationships and interactions

between individuals. Power is everywhere. This reconceptualization of power provides individuals with the possibility of resistance through reinvisioning discourse. Queer theorists have utilized Foucault's notion of power by resisting and confronting homophobic discourse. Judith Butler, who promoted subversive strategies for parodying the heterosexual norm, by producing competing discourses, and by exposing the falsehood, that an original gender or sexuality exists (Watson, 2005). Like Foucault, she calls for subversive action as a way to undo these systems because after all, gender and other identities are not one's "core", but rather an effect of one's performance. Queer theory largely understands this view of gender and sexuality, but can be applied to any aspect of identity that is confined by a binary and/or cultural and historical system.

It is in these influential works of Judith Butler and Michael Foucault, as well as other notable queer theorists such as Eve Kosofsky Sedgwick (1990) and Teresa de Lauretis (1991) that one can trace several hallmarks of queer theory.

1) A conceptualization of sexuality which sees sexual power embodied in different levels of social life, expressed discursively and enforced through boundaries and binary divides; 2) The problematization of sexual and gender categories, and of identities in general. Identities are always on uncertain ground, entailing displacements of identification and knowing; 3) A rejection of civil rights strategies in favor of a politics of carnival, transgression, and parody which leads to deconstruction, decentering, revisionist readings, and an anti- assimilationist politics; 4) A willingness to interrogate areas which normally would not be seen as the terrain of sexuality, and to conduct queer "readings" of ostensibly heterosexual or nonsexualized texts. (Stein and Plummer, 1994, p. 182)

Queer theory explores the shifting construction and contemporary meanings of sexuality based on the idea that the binary division of the world into the sexual categories of heterosexual/homosexual is historically and culturally constructed. Queer theory locates power in this binary as a site that is fixed and contested, and theorizes how identities do or do not fit into this scheme. Warner (1991) describes the prevalence of homophobia and heterosexism and positions queer theory as a challenge to these norms,

> Because the logic of the sexual order is so deeply embedded by now in an indescribably wide range of social institutions, and is embedded in the most standard accounts of the world, queer struggles aim not just at toleration or equal status but at challenging those institutions and accounts. The dawning realization that themes of homophobia and heterosexism may be read in almost any document of our culture means that we are only beginning to have an idea of how widespread those institutions and accounts are. (p. 6)

One of the most exciting things about queer theory is just how queer it actually is. That is to say, queer theory is constantly shifting and changing encompassing ideas, identities and experiences that fall outside of gender and sexuality. Sedgwick (1993) describes queer theory as in constant evolution shaped by intersectionality.

> A lot of the most exciting recent work around "queer" spins the term outward along dimensions that can't be subsumed under gender and sexuality at all: the ways that race, ethnicity, postcolonial nationality criss-cross with these *and other* [sic] identity-constructing, identity-fracturing discourses, for example. (p. 9)

These ideas are useful in the consideration of the ways in which queer identities are constructed, pathologized and "treated" within the medical-industrial complex. That is to say, categories of trans identities, as well as LGBTQ models of identity in psychology and psychiatry are

contingent upon a narrative based on dominant perceptions located in place and time. GID, as a diagnosis, enforces these understandings of LGBTQ identity by naming, legitimizing and creating moral codes, rules and sets of behavior that form trans and gender nonconforming identities. These structures create the narratives of trans and gender nonconforming experience that one must live by in order to receive a diagnosis of GID and receive gender-affirming treatment. Participation in this system creates hierarchies of trans experience and isolates those that fall outside of these narratives.

For those working in the medical and mental health field, Foucault's notion of power is acutely relevant. Consideration of GID, its relationship to the cognitive authority of the medical and mental health fields, and the ways in which queer theory calls for a revisioning of these relationships is crucial to this work. The use of the diagnosis, the assumed "need" for diagnosis, and the constraints of the Standards of Care in relationship to narratives and lived experiences recapitulate a hierarchical system of power. The ways in which providers and LGBTQ people seeking services can resist and reinvision these powers will be discussed fully in the discussion chapter of this thesis.

Disability Theory

Historical and contemporary representations of disability may allow one to learn much about the social and cultural expectations of everyone, much in the same way critical analysis of gender and sexuality has shaped discussions of sex and gender for non-queer people. Thinking critically about the ways in which disability, like queerness, has been socially constructed points to parallels in pathology of both groups and the ways in which the medical-industrial complex has used disability as well as queerness in the creation of the "other". Kudlick (2005) speaks to

the effects of medicalization on marginalized groups as well as current liberatory practices that

resist definitions of normality in the following quote:

> It was only after the Enlightenment and the subsequent development of medicine as a
>
> respected field of social intervention that human characteristics such as minority race,
>
> female or queer sexuality, and physical or mental handicap came to be perceived as
>
> problems in need of professional management. This medicalization of society has
>
> affected virtually every marginal group. However, it had a particularly large impact on
>
> those deemed physically and mentally anomalous, who found themselves categorized,
>
> institutionalized, and often made targets for sterilization justified by medical science . . .
>
> Just like women, people of color, Jews and sexual minorities, many with disabilities have
>
> come to equate breaking free of medical definitions as a form of liberation and a way to
>
> contest historically contingent ideas of normality, even as they acknowledge that
>
> medicine has also benefited their lives. (p. 559)

By setting up a model of normal body (i.e. straight, temporarily able bodied, white male) the

medical model is also responsible for constructing disability as queer, which is other, and outside

the norm of able bodied. Initially disability was seen as punishment for sin or as a moral

problem and disabled people were thought of as being in need of help, care or cure. Later came

Social Darwinism, which, was followed closely by the eugenics movement. As there were major

advancements in medicine, biology and science, and the medical model picked up all of the old

tenets of the deficit model, society began to view disabled people as "lacking" some vital

function that medicine could "fix". This individual model of disability arose out of a medical

model which defined disability as an individual deficit requiring medical intervention to make

bodies and minds "normal" (Clare, 2001; Dewsbury et al., 2004). This individual model of

disability is still widely used in the medical-industrial complex today and is present in much of social work thinking and literature. The individual model of disability is norm based, and has been blamed for categorizing and creating normal models of bodies and abilities. This has resulted in increased stereotyping and discrimination, and prejudice against those whose bodies' fall outside of these created bounds of normality.

In the twentieth century, critiques rooted in social construction, discredited the individual model of disability and lead to the creation of the social model of disability which, "place the cause and responsibility for the problems that affect disabled people squarely on society itself, rather than on the individual, and take the position that the needed changes must occur in the society, not in the individual" (Rothman, 2003, p. 9). Modern disability theory has largely embraced a social model of disability. Wendell (1996), proposes a model of disability as social construction,

> In my view, then, disability is socially constructed by factors such as social conditions that cause or fail to prevent damage to peoples bodies; expectations of performance; the physical and social organization of societies on the basis of young, non-disabled, 'ideally shaped', healthy adult male paradigm, of citizens; the failure or unwillingness to create ability among citizens who do not fit the paradigm; and cultural representations, failures or representations, and expectations. (p. 45)

The social model of disability believes that it is not the impairments within the body that is the problem, but society itself, and that impairments do not become "disabilities" until limitations are presented in the form of access to basic human needs. (For example, not having use of one's legs and using a wheelchair is an impairment that becomes a disability when there are no access ramps for entering and leaving a building). That which creates the disability is the environment,

and society's inability to accommodate the differences in a wide variety of basic human needs. The problem then lies outside of the body and within society. For these reasons, this paper uses the language, disabled person, rather than the language, a person with a disability, because of the important distinction between impairment and disability within the social model.

While the social model of disability has been useful in "redefining disability in terms of a disabling environment, repositioning disabled people as citizens with rights, and reconfiguring the responsibilities for creating, sustaining and overcoming disablism" (Humphrey, 2000, p. 63) the social model is not without its critiques. It has been argued that a social model of disability fails to account for the lived and real experiences of bodily difference and experiences of chronic pain (Clare, 2001; Rembis, 2010; Shakespeare, 2006). Critics argue that focusing on environmental conditions does not fairly represent the experiences of gawking, chronic pain, staring and body shame that many individuals experience. "There are disability thinkers who can talk all day about the body as metaphor and symbol but never mention flesh and blood, bone and tendon- never even acknowledge their own bodies" (Clare, 2001, p. 364). Additionally, many feel that the social model does not account for the intersections of gender, race, ethnicity and sexuality as they overlap with ableism (Ferri & Gregg, 1998; Mays, 2006).

Feminist theories of disability have done much to widen disability theory to include gender, race, sexuality, ethnicity, and class. Through a critique of societally enforced gender roles that equate masculinity with strength, health, and independence, feminist disability theorists have highlighted the ways in which disability and disabled people are viewed as weak and dependent, typically feminine characteristics, leading to troublesome assumptions about gender and disabled people. They critique the ways in which society views disabled men as effeminate and/or asexual based on their strength and health and place particular emphasis on the

stereotypes and assumptions that disabled women experience due to gender roles and norms.

This is exemplified in the work of Eli Clare (1999),

> To be female and disabled is to be seen as not quite a woman; to be male and disabled is
> to be seen as not quite a man. The mannerisms that help define gender- the ways in
> which people walk, swing their hips, gesture with their hands, move their mouths and
> eyes as they talk, take up space with their bodies- are all based upon how nondisabled
> people move. A woman who walks with crutches does not walk like a "woman"; a man
> who uses a wheelchair and a ventilator does not move like a "man". The construction of
> gender depends not only upon the male and female body, but also upon the nondisabled
> body. (p. 112)

Because some disabled bodies are unable to perform gendered behaviors in "passable" ways,
disabled people are often viewed as genderless, or less than male or female and thereby are often
also viewed as sexless (Sandhal, 2003).

Theorists have also pointed out the ways in which disabled women have been silenced,
and their rights to privacy, sex education, sexuality, birth control, reproductive health, the right
to bear children have been ignored or marginalized due to stereotypes and bias, and disabled
women are often subjected to sterilization, abortions and questions around their ability to care for
their children (Dotson, Stinson, & Christian, 2003; Ferri & Gregg, 1998; Garland-Thomson,
2002; Kallianes, & Rubenfeld, 1997; Mays, 2006; Sayce, & Perkins, 2002; Waxman-Fidduccia,
2000).

Through the social model of disability many feminist theorists, researchers and activists
have begun to deconstruct the dominant assumptions surrounding disabled sexuality and the
ways in which social, cultural and environmental barriers have long oppressed the expression of

disabled people's sexuality (Finger, 1992; Fine & Asch, 1988; Garland-Thomson, 1997; Hahn, 1988). Often issues of sex and sexuality for disabled people has focused on issues such as divorce, abuse, sterilization and lack of privacy (Wilkerson, 2002). Disabled people have often been portrayed as child-like and in need of protection, with little or no conversations on self-identification of sexuality and/or pleasure (Tepper, 2000). The literature has moved from a negative and discriminatory view of disabled people as not being acceptable candidates for reproduction, or as even capable of having sex for pleasure, to a depiction of disabled people celebrating, exploring and vocalizing their sexualities through first person narratives (Tepper, 2000; Wilkerson, 2002). The social model which gave way to the exploration and theorizing on the sexuality of people with disabilities has its limits in that it focuses heavily on civil rights, often overlooking issues of self love and self worth that are crucial to a healthy sexuality (Shakespeare, 2000). Due to the social model's roots in a male dominated activist culture and research practice, gender normative sexualities are often assumed, presenting contradictions to the very nature of disabled sexuality which oftentimes defies norms and expectations (Rembis, 2010). Rembis (2010) notes the importance of challenging these norms,

> The future of (dis/abled) sexualities depends not on disabled men's ability and willingness to "challenge" dominant assumptions by admitting that they are more "feminine" in their love making and that this can actually be "positive". Nor does it necessarily depend on disabled women who "defy" stereotypes by marrying and bearing (or adopting) and raising children. (p. 56)

This way of thinking and advocating for disabled sexuality serves to reinforce the heterosexual matrix. Instead, there is a push to challenge "normal" institutions such as marriage and monogamy and the ways in which these systems exclude and marginalize a range of experiences

and sexualities (Wilkerson, 2002). By challenging normative beliefs of sexuality (i.e., that men are dominant, that sex is only penetrative, that sex can only be between two people) disability theorists have pushed the focus on sex as vital and important to happiness (Shakespeare, 2000).

Additionally, it has been argued that sexual stereotyping has been used to oppress all minority groups. Wilkerson (2002) believes that sexual agency should be a key political strategy for all oppressed people:

> Sexual democracy should be recognized as a key political struggle, not only because of the importance of the basic human right to sexual autonomy, but also because a group's sexual status tends to reflect and reinforce its broader political and social status. I understand sexual agency not merely as the capacity to choose, engage in, or refuse sexual acts, but as a more profound good which is in many ways socially based, involving not only the sense of oneself as a sexual being, but also a larger social dimension in which others recognize and respect one's identity . . . In my view, the socially based aspects of sexual agency constitute a hierarchy in which those who are most socially privileged on various axes of social difference (including sexual orientation along with race, class, age, and gender expression among others) are, other factors being equal, most likely to be considered respectable, and therefore worthy citizens. (p. 35)

Sexuality and sexual agency is a key political struggle in the liberation of all oppressed groups. In many ways, aspects of queer theory have been used to deconstruct disabled sexuality, adding another dimension to theory (Rembis, 2010; Schildrick, 2009; Shakespeare, 2000). Queer theory is used in this discourse to expand the rigid sex and gender roles, as well as heteronormative assumptions that are often placed on the sexuality of disabled people (Golfus, 1997; Tepper, 2000; Wilkerson, 2002). The result has been a deconstruction of binaries, an expansion of

normative ideas around what does and does not constitute sex, and a challenge to past silences as and imposed ideas around disabled sexuality (Kaufman, Silverberg, & Odette, 2003; Rembis, 2010).

The social model of disability, rooted in resistance to the medical and individual model of disability is directly related to other disciplines rooted in social justice and activism. Monaghan (1998) describes these connections,

> The new, humanities-oriented approach to disability studies borrows from…cultural studies, area studies, feminism, race-and-ethnic studies, and gay-and-lesbian studies. It is extensively informed by literary and cultural criticism, particularly of the post-structuralist variety, insofar as it pulls apart concepts about disability to see what cultural attitudes, antagonisms, and insecurities went into shaping them. (Monaghan, 1998, ¶ 13)

These connections provide an important base for an intersectional approach to disability within other disciplines, and social justice movements.

The critique of the social model of disability has been summed up by Shakespeare and Watson (2001) as, "a modernist theory of disability—seeking to provide an overarching meta-analysis covering all dimensions of every disabled person's experience" that "is not a useful or attainable concept" (p. 19). Backlash and critique of the social model has been quite common and underscores the need for a revision of theory and thinking in disability scholarship. Gabel & Peter (2004), argue for the need to "provide ways of theorizing disability more suited to current contexts and more responsive to emerging world trends" (p. 586) and propose the use of resistance theory to achieve this aim. It is argued that resistance is a natural progression of disability theory since resistance is already a key component to the social model of disability in that it was created in resistance to the medical model, and is based in resistance to oppression,

stigmatization, economic and social marginalization, political exclusion, and ableism. One form

of resistance may be in the use of imagery in the media that challenges beliefs and stereotypes

around disability, it might take place in terms of a struggle, or through writing and art that these

aims are achieved. Gabel & Peter (2004) have a more nuanced and complicated understanding of

resistance:

> Thinking of resistance in this way, as operating in all directions of the social sphere
>
> across paradigmatic boundaries, helps one to understand the push and pull of the
>
> conversation of resistance. Resistance functions as a way for disabled people to push
>
> against dominance while also attempting to pull society into disabled people's way of
>
> seeing . . . Disabled people and their political partners are in critical de/re/constructive
>
> conversations with those who actively or passively participate in disablement. Various
>
> forms of resistance fold, unfold, and fold back into one another while variegated new
>
> forms of social relations emerge. (Gabel & Peter, 2004, p. 594-595)

Resistance theory emphasizes the use of multiple voices containing a variety of experiences as a

way to enlarge the understanding of everyone and to overcome disagreements and move beyond

singular interests thereby incorporating "resistance within social movements as a tool for

transforming the target of their resistance- the larger society" (Gabel & Peter, 2004, p. 593).

Gabel (2005) sees resistance as mutually engaging, dialectic and capable of transformative

change:

> In addition to interpreting resistance as engagement in dichotomous processes, resistance
>
> theory also connotes an open-ended negotiation of meaning, a fluid dialectic movement
>
> without the constraints of time or space. It addresses the critics of the strong social
>
> model by opening up possibilities and blurring boundaries while it also avoids the

theoretical tendency to construct abstract or rigid models from which action and social

change cannot emerge. (p. 8)

While the rejection of the medical model of disability is still prevalent in most disability

theory, there has been some reconceptualization, particularly within the context of resistance

theory, that incorporate the usefulness of the medical model in the lives of some disabled people.

This includes the benefits of some medications and technologies that improve functioning (Gabel

& Peters, 2004). Despite this, there is still caution against using the medical model in the social

context of disability because of the ways in which the medical-industrial complex may continue

to oppress disabled people if this happens. This may include the pathologizing of distress caused

by societal discrimination and treatment of internalized oppression with medications.

Additionally, adherence to the medical model may continue the stigmatization of people based

on medical and diagnostic categories and cures that border on cultural genocide in their attempts

to cure or fix disabilities, such as a cure for deafness which would erase deaf culture, or a cure

for dwarfism, thereby eliminating Little People (Gabel, 2005; Ricker, 1995; Tucker, 1998).

Like studies of race, class, gender and sexuality, disability studies give voice to those

who have been ignored by wealthy, educated, able bodied, white society and history, and

disability is now largely understood as a cultural construction, much in the same way race,

gender, sex and sexuality are (Jones, 1996; Rapley, 2004; Swain, French, & Cameron, 2003;

Wendell, 1996). Falling outside the norm, groups which have been historically othered challenge

cultural constructions of normality by pushing boundaries and exposing the false notion of a

mythic norm, white heterosexual able bodied and male, as the natural (Lourde, 1984). Post-

modern and social constructionist theory have been crucial in turning the gaze from the "other"

onto the self, thereby pressing all people to rethink natural or normal concepts of sex, gender,

race, sexuality, and the study of disability and disability theory calls into question assumptions and norms for bodies, functioning and beauty (Terry & Urla, 1995). McRuer (2002) notes:

> Contemporary cultures function according to models (of ability, productivity, efficiency, flexibility) that privilege nondisabled (and docile) bodies and identities . . . and the concomitant revaluation of a range of corporealities currently sustains vibrant activist and intellectual communities concerned with the development of alternative disability identities and cultures. (p. 224)

Disability studies, while shaping an identity and community for disabled people, has also problematized the able-bodied and disabled binary, arguing that this system maintains power over the privileged and dominant without accurately describing the reality of human experience. These categories are false, in that every human has a diverse and complicated range of bodily experiences. Disability activists and theorists have critiqued the medical model of disability and provided a complex understanding of the ways in which able bodied stereotypes and ideas of normalcy maintain systems of power and oppression.

Queering and Cripping

At the root of queer theory is the practice of queering, that is, to question what is normal or normative, and to ask critical questions about who is being excluded and what is being assumed. Queering, or to queer (when queer is used as a verb) is used as a way to upset the norms and heteronormativity of society.

> If the term queer is to be a site of collective contestations, the point of departure for a set of historical reflections and futural imaginings, it will have to remain that which is, in the present, never fully owned, but always and only redeployed, twisted, queered from a

prior usage in the direction of urgent and expanding political purposed. (Butler, 1993, p.

228)

In the quote above, Judith Butler asserts that queer can be used as method to engage in a process

that inquires, expands current knowledge and understanding. "Queerness constitutes not just a

resistance to social norms or a negation of established values but a positive and creative

construction of different ways of life" (Halperin, 1995, p. 81). Queering is a primary mode of

queer critique, a "critical perversion that continuously forges unexpected alliances and gives

voice to identities our heteronormative culture would like to, and cannot, silence" (McRuer,

1997, p. 5). Queering is political; it resists universalizing and continues to change in response to

social and cultural climates (Ramlow, 2009). The goal, as Michael Warner (1991) puts it, is "to

make theory queer, and not just to have a theory about queers" (p. 18). Queering has been used

across disciplines from the queering of literature, film and plays, to sports and science, religion

and ecology, sociology and geography, to marriage and politics. Queering, in this way, means to

question and complicate, to challenge and play, to propose and subvert, and to push continually

toward complexity.

Cripping emerged out of disability theory and activism as a mode of critiquing and

subverting the representations, practices and exclusionary effects of able bodied assumptions.

"Similar to the queering of queer, cripping reframes, reinterprets and resignifies multiple

representations of disability in the service of urgent and emerging social and political contexts"

(Ramlow, 2009, p. 136). Cripping, has its roots in queer theory. As McRuer (2006) notes:

In queer studies it is a well-established critical practice to remark on heterosexuality's

supposed invisibility . . . an important body of feminist and antiracist work considers how

compulsory heterosexuality reinforces or naturalizes dominant ideologies of gender and

race . . .Able-bodiness, even more than heterosexuality, still masquerades as a

nonidentity, as the natural order of things. (p. 1)

Cripping values deviance, highlights the ways in which disability is excluded,

stereotyped, and marginalized, and offers a place of resistance to these modes of normalcy.

Cripping is a method of inquiry that challenges normative ways of being and seeing calling into

question cultural assumptions around beauty, bodies, health and functionality.

Cripping allows the "capacity for recognizing and withstanding the vicissitudes of compulsory

ablebodiness" (McRuer, 2005, p. 591). McRuer (2006) sees cripping as directly related to queer

theory:

> I argue that critical queerness and severe disability are about collectively transforming (in
>
> ways that cannot necessarily be predicted in advance)- about cripping- the substantive,
>
> material uses to which queer/disabled existence has been put by a system of compulsory
>
> able-bodiness, about insisting that such a system is never as good as it gets, and about
>
> imagining bodies and desires otherwise. (p. 32)

Queering and cripping act as tools of inquiry and critique to notice, question, reclaim and reform,

acting to recognize that "another world can exist in which an incredible variety of bodies and

minds are valued and identities are shaped, where crips and queers have effectively (because

repeatedly) displaced the able-bodied/disabled binary" (McRuer & Wilkerson, 2003, p. 14). As

is shown in the next section of this paper, queerness and disability in many ways are inextricably

linked and co-created in the service of compulsory heterosexuality and ablebodiness.

Queering Disability and Disabling Queers

Disability theory and queer theory share many similarities. Both arose out of civil rights

movements, and have deep commitments and roots in radical activism. Both queer and disabled

communities have deep histories of oppression. Both have been demonized by religion, discriminated against in employment, housing and education, and isolated socially. Queer and disabled communities are vastly diverse in their memberships, with queer and/or disabled people representing a vast array of class, race, gender, sexuality, religion, and political affiliation. Notably, both queer and disability theories have ardent stances against concepts of normality, whether through gender, sexuality, mental, bodily, social or cultural. That does not mean that queer theory and disability are one and the same, or that one is a subset of the other, "Theory has to understand that different identity environments, or alternatively of other new social movements, often differ in important ways- even when they are intermingled in experience (Warner, 1991, p. xxvii).   As noted in the previous section of this paper, disability theory has built upon the identity-based theories of queer theory in order to develop a theoretical base from which to talk about disability. This thesis asserts that queer theory may find as much usefulness in disability theory as disability theory has found in queer theory.

Of particular interest when considering the intersections of queer theory and disability theory is the role that psychiatry and the medical and mental health fields have played in oppressing both queer and disabled bodies and experiences. This has been done by pitting one pathology against the other, by using disability to justify the exclusion and pathology of queer people and by using queerness to other, exclude and pathologize disability (McRuer, 2006; Sherry, 2004). Homosexuality and disability are both seen as pathological conditions, and homosexuality is often seen as a kind of disability, while disabled people are often seen as asexual or undesirable as sexual partners. This paper will now consider the ways in which queerness has been constructed through disability and the ways in which disability has been constructed as queer in the medical-industrial complex.

Important to the understanding of the ways in which queerness has been used in the construction of disability is the recognition that a lesbian or gay identity does not need to be ascribed to disability in order to use queerness as pathology in disability. The ways in which disability has been queered can be seen most notably in the pathology of bodily difference. Physical difference in bodies has been ascribed as "freakish" as evidenced by the history of the circus sideshow, as well as in the history of medical photography of not only disabled but also intersexed bodies. Garland-Thomson (2001) writes extensively about the power dynamics and structure that a culture of staring creates,

> As anyone with a visible disability knows, being looked at is one of the universal social experiences of being disabled . . . The dominant mode of looking at disability in this culture is staring . . . staring is an intense form of being looking that enacts a spectator and spectacle between two people . . . and manifests the power relations between subject positions of 'disabled' and 'able-bodied' . . . Constituting the starer as normal, and the object of the stare as different, it creates disability as a state of absolute difference, rather then as one more variation in human form. (p. 346-347)

Indeed, all oppressed and marginalized people are in some ways constructed as "perverts" by heteronormative culture, creating classes of people who are sexually deviant in opposition to those who need protection from them. McRuer & Wilkerson (2003) describe this at length:

> The drama of perverts, victims, and protectors is played out in countless arenas, from honest (read: white-middle class) taxpayers cheated by sexually and reproductively out-of-control welfare mothers (read: African American women) to innocent (read: heterosexual) youth in need of protection from the corrupting influences of sexual, especially queer, content (a notion of corruption also inflected with class issues) on the

Internet. Thus social relations of race, class, age, and other modes of oppression that are

not always reducible to conflicts of gender and sexuality are nonetheless continually

played out in sexual terms- mediated by the bodily terms that disability activists and

scholars have recognized. (p. 8)

Here one can see the ways in which sexual representations and identities are co-constructed. In

many ways, the restriction and regulation of any sexual expression can be viewed as a form of

political and social repression. Much in the same way that many queer people are stereotyped as

sexual predators who may corrupt or turn innocent people into queers, physical difference and

disability have been queered by ascribing and inferring asexuality, vulnerability, infertility,

exoticism, and perversion to people with disabilities. People with cognitive disabilities have also

been queered through the ascription of uncontrollable sexuality that needs to be protected and/or

contained. This is done in an effort to justify the exclusion of queer and/or disabled people from

issues of access and basic rights, and to construct a medical model of "normalcy" in bodies.

"Deviant" sexualities are often used in the construction of the other, and as this paper has noted,

deviant sexuality has also been ascribed to disabled people as well.

Theorist McRuer has noted the ways in which compulsory able bodiness and compulsory

heterosexuality are interwoven in that these systems work together to continually remake the

able body and heterosexuality (McRuer, 2006). Indeed, heterosexuality is about health,

reproduction, strength, power and stamina. Queerness as sick and deviant therefore lies in a

contested body of weakness, unable to procreate. Health is directly related and reproduced in

compulsory heterosexuality, and compulsory able bodiness is abound with notions of straight

heterosexuality. They mythic norm, is not only white and straight then, but also able bodied.

Baynton (2001), a disability theorist, has demonstrated through much of his writing the ways in which disability has functioned historically to justify the inequality of other minority groups. He asserts, "Not only has it been considered justifiable to treat disabled people unequally, but the *concept* of disability has been used to justify discrimination of other groups by attributing disability to them" (p. 33). He demonstrates the ways in which disability has been applied to gender, race and immigration status as a way to question citizenship and desirability. Given Baynton's argument, it is a logical step to then consider the ways in which disability has also been attributed to queerness as justification for pathology and exclusion. One only has to look to the history of queer diagnoses to see the ways in which disability has been used in the construction of queer. Historically, the medical model has labeled homosexuality as a psychiatric disability and sexual deviance as pathology and neurosis. Homosexuality was not removed from the DSM until 1973, and the argument can be made that the diagnosis has remained throughout time, with just a change in name. Diagnoses of queerness and sexuality still exist in the DSM, most notably in the pathology of trans identities within the diagnosis of Gender Identity Disorder. The construction of queerness as a disability continues actively today; it is not uncommon for there still to be language and discourse around "treatment" for LGBT people and the search for (or discovery of) a "gay gene" or worse still, a "cure". Additionally, disabled people were often seen as "unanalyzable by the psychoanalytic community and a history of pathologized narcissism has often been imposed on the identity politics of both LGBTQ people and people with disabilities" (Siebers, 2008). The queering of disabled people as justification for pathology and exclusion by the medical and mental health community shows the ways in which heterosexual normativity is threatened, not only by sexuality and LGBTQ people, but by the physical difference and disability as well.

Following this rationale, it seems important to consider the implications of the Americans with Disabilities Act (ADA), a federal law designed specifically to give equal access and protections to people who were previously discriminated against and excluded based on ability. The ADA applies to every aspect of employment including recruitment, hiring, promotion, demotion, layoff and return from layoff, compensation, job assignments, job classifications, paid or unpaid leave, fringe benefits, training, and employer-sponsored activities, including recreational or social programs. The ADA, by providing people with federal legal protections, was specifically designed to begin to transform the ways in which disability has been used as justification for exclusion. Rothman (2003) describes the historical impact of the ADA:

> The Americans with Disabilities Act . . . demonstrated a clear shift in theoretical position. The ADA views disability as more of a social construction than as a moral failure and placed on society the responsibility for ensuring that disabled people have access, rights, and opportunities similar to those of nondisabled people. (p. 246)

Laws have a huge implication outside of just the legal realm and effect the creation of medical, sexual, and physical norms (Frug, 1992). Through the work of community members, activists and theorists in the disability community, the passage of the ADA is a direct example of laws being used to shift sociocultural norms around health and normality.

Despite the fact that trans and/or gender nonconforming identities are contained within the DSM, and are therefore considered by the APA as mental disorders, trans and gender nonconforming people are specifically excluded from the American with Disabilities Act. In fact the ADA specifically excludes "sexual behavior disorders" and "gender identity disorders" from its definition of a protected disability (Americans with Disabilities Act, 1991). The ADA also excludes homosexuality and bisexuality from coverage because they "are not impairments and as

such are not disabilities" but contrarily also excludes disorders specifically named in the DSM such as "transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders" (Americans with Disabilities Act, 1991). Although the APA recognizes these specifically as mental disorders by their inclusion in the DSM, the ADA specifically excludes them from the federal law. *All* other DSM diagnoses are covered under the ADA. Why then specifically exclude the queer diagnoses? This is a clear example of the ways in which queerness and disability have not only been co-constructed, but also the ways in which disability and queerness have been used against each other. The American Psychological Association insists that "queer diagnoses" are indicative of disorders, therefore labeling queer people as impaired and disabled. The APA uses disability as a way to exclude and marginalize queer people. The American with Disabilities Act on the other hand, specifically uses queerness as justification for exclusion.

This is a clear example of the ways in which sexual behavior and transgressive gender identity are used to reify the socially moral grid that underscores all law.

Rather then changing the ethical significance of all disabilities, the Act carves out a new class of untouchables defined by sexuality and sex behaviors. Because the ADA is the most extensive civil rights law to address bodily norms, the exclusion of sex-and gender-related conditions has tremendous expressive importance. By leaving open a space of permissive employer discrimination, the Act identifies the sexual 'deviant' as the new pariah, using the legal machinery of the state to mark as outsiders those whose noncompliant body renders them unfit for full integration into a working community . . . By categorically repudiating persons whose sexual behavior transgresses social norms,

the Act denies the sexually nonconforming legal protections that are guaranteed to all

citizens in a democratic state. (Hiegel, 1994, p. 2)

It has been noted in the literature that the specific exclusion of transsexuals, gender identity

disorder, and other queer diagnosis from the ADA was a result of a compromise to address the

concerns of conservative members of congress, notably Jessie Helms, who saw the ADA as

supporting or favoring individuals whose lifestyles they did not approve of, thereby making it

impossible to utilize religiously motivated reasons for non-hire (Hebert, 2009; Levi & Klein,

2006). While some may argue for the exclusion of gender related identities from the

classification of disability because they do not want to pathologize individual experience, this

was certainly not the motivation of Congress. Bias, bigotry, hatred and oppression of trans and

gender nonconforming people exists at the heart of this exclusion.

A number of different approaches have been used to gain legal protections against

discrimination in employment for trans and gender nonconforming individuals. Some argue that

gender non conformity is a medical condition to pursue protection under disability law, but this

has been unsuccessful at the federal level (due in large part to the ADA), and has had mixed

results on the state level (Levi & Klein, 2006; Herbert, 2009). Some jurisdictions provide

protections for trans and gender nonconforming people by including gender identity and/or

gender expression in their anti-discrimination statutes, in an attempt to protect trans and gender

nonconforming people as a class, but this has also been unsuccessful on a federal level and while

it has occurred in a number of states, it is still a significant minority of states (Herbert, 2009;

Levi & Klein, 2006).

Despite the fact that transition related health care is accepted by health care providers to

be medically necessary (Brown, 2001; Gordon, 1991; Meyer et al., 2001; Pfallin & Junge, 1998),

no state has a regulation that explicitly provides Medicaid coverage for transition related

treatment (Gehi & Arkles, 2007). In fact 24 states explicitly exclude transition related

treatments, and for those that do not, whether procedures are or are not covered are frequently

determined through agency and court decisions (Gehi & Arkles, 2007). Gehi & Arkles (2007)

describe this situation as a double bind for trans and gender nonconforming people with huge

class and racial implications:

> The courts often defer to medical evidence with regard to transgender people in a wide
>
> variety of contexts but then often disregard or implausibly explain away the
>
> overwhelming weight of medical evidence when considering the necessity of transgender
>
> health care. The state often requires transgender people to have been evaluated and
>
> treated by transgender health experts or to have received specific forms of transition
>
> related health care before giving them access to gender-matched ID, appropriate sex-
>
> segregated systems, or remedies for discrimination. At the same time, the state often
>
> denies access to transition related health care to Medicaid recipients and people in state
>
> custody. This double bind assaults the dignity of transgender people and has a profound
>
> impact on trans communities, with disproportionate effects on those who face other forms
>
> of marginalization, such as racism and poverty. State systems that deny coverage for
>
> transition related health care while requiring this care in other contexts thereby create a
>
> hierarchy of race and class in which rich, predominately White trans people- because they
>
> do not need to rely on the state for health care- are the only transgender individuals able
>
> to gain access to a wide variety of basic services and opportunities on anything
>
> approaching an equal basis with non-transgender people. (p. 23)

All of this not only continues to point to the co-creation and construction of disability and queerness and the justification for exclusion, but also further complicates the debates around GID in the DSM.

Nowhere do the implications for the relevance of disability theory in the consideration of LGBT people come to the surface more prominently then in the current and past debates around, "queer diagnoses" in the medical and mental health community, specifically Gender Identity Disorder (GID).   The debate around GID has been quite active in recent years due to the upcoming publication of the DSM-V and the creation of a working group to specifically examine the diagnosis of GID and its criteria. Obviously, the biggest argument for the removal of GID in the DSM is that many activists and/or members of the trans community object to the diagnosis on the basis of it being a mental disorder. They argue that this continues to extend the cognitive authority over trans bodies and experience and continues to reflect social and cultural assumptions, stereotypes, maintain hierarchies and systems of power and oppression, deny the complexities of trans experience, and remove the power of the person to self identify (Ault & Brzuzy, 2009; Ehrbar, Winters & Gorton, 2009; Langer & Martin, 2004; Lev, 2005; Sennott, 2011; Serano, Ryan, & Winters, 2009).

Some of the discussion around GID argues for its usefulness in a legal setting and has begun to acknowledge the benefits around the use of diagnosis and the medical model of transsexuality as well as disability in legal proceedings in order to expand access, services, and the rights of transgender people on a state level (Levasseur, 2009; Thaler, 2009). It has been suggested that there need not be a DSM diagnosis for an individual to be covered by law, because it is enough that trans and gender nonconforming people may be seen as having an impairment acknowledged as a health condition to pursue protections (Levi & Klein, 2006).

Others suggest that for vulnerable populations, such as those who are confined to the prison industrial complex, pursuit of gender affirming treatments through a medical model is absolutely necessary, justified and compelled by the specific context of prison (Lee, 2008). It is argued, that the removal of the medical model would make it much more difficult for people to gain access to services since prisons would not support gender affirming treatments such as hormones. Gorton (2005) argues:

> Loss of the DSM diagnostic category for GID will endanger the access to care, psychological well being, and in some cases, *the very life* of countless disenfranchised transgender people who are dependent on the medical and psychiatric justification for access to care. (p. 9)

Other people within the transgender community such as those dependent on shelters, group homes and other sex segregated facilities, as well as those who utilize public health care systems, will also be negatively affected if they are unable to pursue protections through a medical model of transsexuality. For those individuals who are the most vulnerable in the trans and gender nonconforming community (i.e. trans people in prisons, poor trans people and trans people of color) legal suits against medical and insurance systems are lengthy, inaccessible, problematic and increasingly stigmatizing. One needs access to gender affirming and socially just legal professionals, something that is usually only found in major metropolitan areas, and that dependence on court trials and cases is a tenuous way to secure services.

Gorton (2005), argues that the call for the removal of GID in order to de-stigmatize trans and gender nonconforming people undermines the fight to destigmatize all mental illness, therefore pitting marginalized groups against one another. Shannon Sennott (2011) posits that Gorton's view is an essentialist argument that "would only be feasible if the DSM contained a

diagnosis for all variations of gender identity, including those that conform to the socially enforced gender/sex/sexuality categories" (p.29). Sennott (2011) states:

> Focus on the de-stigmatization of all mental illness instead of fighting for the removal of GID runs the risk of essentializing the argument to a point where the movement to end gender oppression is so diluted it can no longer be legitimately connected to its feminist tradition and roots . . . The arguments that call for the removal of GID from the DSM based on de-stigmatization are founded on the feminist principles that in a socially-just world, gender of any kind will not be pathologized. (p. 99)

Other arguments suggest that a continued pursuit of legal protections through disability law may be the best way to secure state level protections for trans and gender nonconforming people (Levi & Klein, 2006). While rejection of trans and gender non-conformity as a disability in many ways may be the result of negative attitudes and feelings towards people with disabilities in the trans and gender nonconforming community, the biggest argument still is in protest to GID as a mental illness, rather than a disability. This question circles back to the ADA itself and the specific exclusion of trans and gender nonconforming people from federal legal protections. Whether trans and/or gender nonconforming people protest the pursuit of legal protections under disability law, or disability activists hedged to allow the exclusion of trans and gender nonconforming people in the ADA due to right wing pressure does much to demonstrate,

> Not only the contradictory nature of identity, but also the ways in which the division of 'us' and 'them', in all of its manifestations is institutionalized. Contemporary systems of power are structured to shore up –or immunize- dominant fictions of identity and to secure thereby the privileges that accrue to those not stigmatized by queerness, deviance, or pathology. (McRuer, 2002, p. 223)

That is to say, the institutionalization of power has positioned itself in such a way to secure the compulsory heterosexuality and compulsory able bodiness as positions that are linked and bound together granting privileges to those that fall within its normalized boundaries.

> Members of marginalized communities in effect identify an even more marginalized group in order to resist the stigma imposed by a dominant culture: gay men and lesbians insist that homosexuality is not "really" a mental disorder, feminists insist that female bodies are not "really" biologically inferior, as so forth . . . disability of some sort is invariably identified as the "real" aberrancy . . . methodological distancing takes place within disability communities as well, most obviously as people with physical disabilities distance themselves from those with cognitive disabilities. I would extend the complication further, however, suggesting that queerness or 'perversion' also function, within processes of methodological distancing as the 'real' aberrancy. People with physical and mental disabilities who are *perceived* as a bit queer can demonstrate that such a difference is texturally produced by distancing themselves from the 'real' queerness or perversion (embodied by those who are not straight). (McRuer, 2002, p. 225)

While disability theory has used queer theory to critically think about the heteronormative assumptions of disabled experience, and has used the basic tenets of queer theory to question binaries and expand theory, queer theorists have not followed suit. What is lacking from this discourse between queer and disability theory is a critical analysis of the important implications that current disability theory can have for queer people, as well as the ableist assumptions of most discussions around queer identity, politics and theory. Since the construction of queer in the medical and mental health community has always been done within a framework of disability

it seems logical that these connections would be explored. That queer theory has not attempted to see the connections and relevance of contemporary disability theory on the lives, experiences and rights of LGBT people, despite the obvious connections between the two, points to a fear of aligning queer people with disabled people. Is this neglect the result of ableism? Similarly, despite the obvious construction of queerness as a disability, trans and gender nonconforming people are explicitly excluded from the benefits of the ADA. Is this the result of homophobia? The historical neglect of these intersections may be the result of the ways in which disability has been ascribed to queer people as well as the ways in which disabled people have been ascribed queerness, as justification for the exclusion and othering of both groups. It seems as though in many ways, queer people and disabled people have been pitted against each other. Each group pushes away either queerness or disability as a way to gain some small amount of cultural leverage or privilege. Each group, fearing further isolation, victimization and discrimination pushes the other further away from themselves, reenacting the structures of power and oppression that have been so deftly constructed.

A major landmark of disability theory is the move from the individual model of disability to disability as a social construction, no longer the fault of the individual, but produced by society. GID may do well with a similar revisioning, one where the impairment one feels is due to the social stigma and oppression that is experienced by trans and gender nonconforming people through violence, discrimination, transphobia and denial of access to rights and services. Theorists and activists involved in the debates around removal and revision of GID have much to learn from modern disability theory and disabled people. McRuer's argument and call for critical investments and alliance of AIDS activist and disability activists exemplifies this. To

make these connections, GID has been inserted in brackets where AIDS was used to show the similarities and parallels in these movements.

> I call in this essay for critical investments- an investment in disability theory on the part of cultural workers concerned with [GID], an investment in [GID] and queer theory on the part of disability activists . . . 'Critical Investments', is thus not meant to invoke simply the economic investment of capitalism, where a single-minded focus on individual returns invariably obscures collective interests . . . the critical investments I advocate for in this essay would entail continually focusing on a queer/disabled collectivity, surrounding [GID] theorists with a larger disability community and vice versa . . . I am in fact critical of investments made according to the individualistic terms of an economic system that has served neither people with [GID] nor people with disabilities well; I seek instead to theorize critical practices that move beyond the limits of queer/disabled bodies-critical practices, that is, that refuse methodological distancing in order to further systemic critique and coalition-building. (McRuer, 2002, p. 225-226)

This paper attempts to bridge the intersections of queer theory and disability theory in a discussion of queer diagnoses in the DSM, to align causes in common, and to deconstruct the ways in which homophobia, transphobia and ableism work hand in hand to oppress all queer and disabled people. The hope will be for social work to start the process of undoing some of the ways in which psychiatry and the medical-industrial complex has systemically marginalized and oppressed all queer and disabled people, by acknowledging these intersections and moving forward within a model of social justice. It is about moving beyond single-issue politics; it's about understanding the complexities of identities and lived experience. It is the understanding that fighting for racial justice *is* queer; fighting for disability justice *is* queer.

CHAPTER FIVE

DISCUSSION

Previously in this paper, we have looked at the ways in which the medical-industrial complex and psychiatry have shamefully used gender to diagnose and categorize women's mental health. In many ways psychiatric medicine has policed gender in women by diagnosing physical and psychic responses to oppression associating mental illness with femininity (Langer & Martin, 2004; Lev, 2005; Manners, 2009; Ussher, 1991). Similarly, gender non-conformity has been conflated with mental illness contemporarily and historically in the medical-industrial complex (McHugh, 1992; Socarides, 1969; Siomopolous, 1974). Some scholars note "that there is an intrinsic link between the century long oppression of women's mental wellbeing within the psycho-medical-industrial complex and the pathologization of gender non-conformity through the psychiatric classification and treatment of GID" (Sennott, 2011, p. 94). The connection between the policing of femininity and the policing of gender non-conformity are indeed parallel as the assumed normative non-disordered gender identity is the masculine natal male, making all other gender identities subject to scrutiny, misunderstanding and abuse by the medical-industrial complex. Similarly, this argument can be extended to include the ways in which the long oppression of disabled people by the medical-industrial complex is intrinsically linked to the psychiatric classification and treatment of GID.

This paper has examined the ways in which the medical-industrial complex has sought to cure and fix disability by creating a false binary between able bodied and disabled, much in the same ways they have rigidly upheld the gender binaries of man and woman, and sexuality binaries of heterosexual and homosexual. The medical model of transsexuality is rooted in this

binary construction of gender, and a pathology of bodily difference rooted in ableism and the construction of queer through disability. As Sennott & Smith (2011) note:

> The awareness that the gender binary is a sociopolitical construct is founded on the decoding of gender roles and expressions by feminist principles and traditions. However, this decoding of identities, roles, and expressions was still founded on an essentialist perspective that conflates designated sex, gender identity, gender expression, and sexual orientation . . . Essentializing a client's gender identity can be just as dangerous as resorting to biological essentialism. This is the identity narrative that a gender-nonconforming person is forced to adopt in order to be seen as legitimate in the eyes of physical and mental health providers. Similarly, with this binary constrain to one's identity narrative, a gender nonconforming person is immediately compromised by a pathologizing discourse and rhetoric that does not allow for the development of more subtle, complex, and individualized expressions of gender identity. (p. 226)

The medical-industrial complex is notorious for its attempts to fit people into culturally constructed boxes and to attempt to fix those that do not, the most obvious example being in the diagnostic criteria for GID. This disallows for a variety of gender and trans experiences. Bodies that do not conform to culturally normative experiences of gender are seen as pathological, inferior, disabled, and a rigid outline for the fixing of these bodies policed and controlled by the medical-industrial complex and dependent on a diagnosis of GID is outlined in the Standards of Care, a widely used document in the mental health field. Similarly, both queerness and disability have been used against each other not only in the creation of both disability and queerness, but also in the justifications for exclusion. That is non-normative bodies and gender expressions are often stigmatized and policed removing autonomy and self-expression. It is the policing of

difference and more specifically, in this context, gender identities, which is problematic. Non-normative sexualities, gender and bodies need not be stigmatized and pathologized by the ever-widening medical-industrial complex.

The legacy of the medical model of transsexuality has constructed itself to police the autonomy and decisions of trans and gender nonconforming people. Through this model, a construction of diagnosis and cognitive authority has been created forcing trans and gender nonconforming people to utilize the medical-industrial complex in order to receive access to not only gender affirming treatments, but other important legal implications such as access to basic civil rights and the change of gender markers on legal documents. This has made it such that a majority of trans and/or gender nonconforming people seek therapy in the pursuit of a letter, with a stamp of GID that is a "validation" from the medical-industrial complex of their known identity in order to be granted access to these things. This creates problematic power structures and a potential for the abuse of cognitive authority as gatekeepers decide who is "trans enough".

What is of critical importance for both trans people and all mental health providers to understand, is that one does *not* need the SOC, a diagnosis of GID, or a letter from an "expert" in order to receive gender affirming treatments. The SOC and the "letter" are in fact a false gate that have been built into real existence by the medical-industrial complex who see trans people as unreliable and mentally ill, unable to make informed choices and decisions about their bodies. The Standards of Care (SOC) are "recommended requirements", *not necessary a legally binding framework.* In fact, some agencies such as The Callen-Lourde Community Health Center in New York City, Fenway Community Health Center in Boston, MA, the Holyoke Health Center in Holyoke MA, The Castro-Mission Health Center in San Francisco, and others, use a model of informed consent that allows people to access hormones without utilizing the SOC and a

diagnosis of GID. More and more PCP's (primary care physicians) prescribe gender-affirming hormones to people under this model of informed consent (Douglas, 2009; Meininger, 2009). Additionally, there are a few surgeons who will perform gender-affirming surgeries without a letter.

It seems necessary that in the future, health agencies who utilize a model of informed consent will exist across the country, not just in major cities, and that more doctors will recognize their roles as activists and allies for their clients and prescribe hormones using a model of informed consent within a social justice framework that recognizes the inherent limitation and contradictions within the medical- industrial complex, while providing affirming and transparent care within this context. It is the job of mental health providers to understand their role in this movement and to act as allies and activists for their clients. If letters must be written, due to limited access to medical practitioners who do utilize an informed consent model, then it is the job of the therapist to co-author responsible and transparent letters that do not utilize the SOC, but are rooted in the therapeutic relationship in an allyship and affirming model.

Gender Identity Disorder as a diagnosis in the DSM represents a highly controversial issue within and around the transgender community with roots in the medical model of transsexuality. As agents of social control, patriarchal psychomedical institutions have diagnosed gender differences to ensure sociopolitical homeostasis and maintain disciplinary authority (Butler, 2004). Arguments against GID arise out of this shared understanding of how social and political gender policing has contributed to bias, violence, and abuse by psychiatric and mental health professionals, forced institutionalization and continued oppression of individuals based on their gender. Yet GID remains a complicated and controversial issue due to

the double bind that it places many people into. Butler (2004) describes the contradiction as such:

> The debate is a very complex one, and that, in a way, those who want to keep the diagnosis want to do so because it helps them achieve their aims and, in that sense, realize their autonomy. And those who want to do away with the diagnosis want to do so because it might make for a world in which they may be regarded and treated in non-pathological ways. I think we see here the concrete limits to any notion of autonomy that establishes the individual as alone, free of social conditions, without dependency on social instruments of various kinds. Autonomy is a social conditioned way of living in the world. Those instruments, such as the diagnosis, can be enabling, but they can also be restrictive and often they can function as both at the same time. (p. 77)

On the one hand diagnosis is often necessary in conjunction with other requirements for medical and mental health services, as well as modification of name and gender on legal documents, and many argue that the diagnosis of GID is necessary for legal protections and access to medical and mental health services (Meyer et al., 2001; Pauly, 1992). At the same time, in many cases the diagnosis of GID as a mental disorder undermines the need for medical treatment and provides justification for insurance companies to deny coverage for gender affirming treatment (Winters, 2005, 2008a, 2008b). In this paradox, systems often deny coverage for transition related health care while requiring this care in other contexts, creating a double bind, and a horribly demeaning and unjust situation for the many people who seek access to treatments through the utilization of the medical-industrial complex.

The lived experiences of gender nonconforming individuals are complex and multifaceted reflecting an infinite number of circumstances influenced by social, cultural,

political and biological conditions. GID may hinder autonomy by eliminating the space for

persons who do not feel distress or impairment due to their gender identification, do not wish to

transition from one gender to another, or do not fit the trans narrative necessary to access a

diagnosis in the first place. GID, in effect, creates experience and narrative, and serves to

continue to propagate stereotypes and misunderstandings about the diversity and complex

multifaceted experiences present within the trans and gender nonconforming community.

Pathology, diagnosis and the medical model accommodate only some identities and experiences

thereby limiting autonomy by restricting forward movement of identities, narratives and

experience. It seems then that this inclusion versus removal debate should be challenged to

imagine other more inventive, expansive and just ways of experiencing identity and community.

Sennott and Smith (2011), argue for a transfeminist approach to working with gender

variant clients. "The transfeminist approach is an alternative therapeutic re-conceptualization of

feminist therapy based on the weaving of feminist thought, social justice frameworks, and

principles of allyship" (Sennott, 2011, p. 102). The transfeminist approach assumes that gender

identity is co-constructed in accordance with what feels authentic, ego syntonic and sincere as

one relates to the world and others within social and cultural constraints (Sennott & Smith,

2011). A therapist who adopts the transfeminist approach works to,

> Disassemble the essentialist assumption of the normativity of the sex/gender congruence
>
> and acknowledges that those who do not fit neatly into on sex/gender/gender expression
>
> category or another can still feel as though they belong inside a gender identity and
>
> expression continuum that is not confined within the binary. (Sennott, 2011, p. 103)

That is to say, non-normative bodies and identities are valid conceptions of self and represent the

wide diversity of gender and gender expression in humanity. Additionally, the transfeminist

approach outlines four fundamental therapeutic approaches to working with trans and gender nonconforming people:

1. A hierarchy of authentic, lived experience for women does not exist.

2. To privilege one *type* of womanhood or femaleness over another is inherently anti-feminist.

3. No one individual, group, or type of woman can define what it means to *be* a woman.

4. Most trans and/or gender – nonconforming individuals have lived experience as a girl or a woman and have suffered the direct repercussions of socially condoned misogyny and systemic gender-based oppression. (Sennott & Smith, 2011, p. 225)

This approach is clearly based in feminist principles, and Sennott & Smith (2011) are well aware of the early mistakes of first and second wave feminism. They identify the problems of early feminism and suggest tools and implications for moving forward with transfeminism:

We encourage clinicians to be careful not to make assumptions, similar to those made by early waves of feminism and, in so doing, neglect the important differences that exist in our gendered selves. Feminism began as a movement for white women with class and economic privilege. Differences concerning class and race were ignored, leaving entire communities of women without a place in feminism. The history of feminism has taught us that there are as many ways to be a woman as there are women. Furthermore, trans rights are women's rights, which are also reproductive justice rights. This is evident in trans people's fight for fair and affirming medical and mental health treatment and the basic right for control and autonomy over their bodies, including access to gender-affirming hormones, surgery, and other gender-affirming treatment. We advocate a transfeminist approach to gender justice that does not privilege the experience of one type

of woman over another and that similarly recognizes that there are as many different

ways to express gender as there are people. The vast difference in the makeup of our

intersecting identities is a critical component of the conversation around gender and the

gender justice movement. (Sennott & Smith, 2011, p. 224-225)

This acknowledgment of the early limitations of feminism, are often ignored, and the

intersections of trans rights with reproductive justice, and women's rights, is an important piece

of just practice with trans and gender nonconforming people. To deepen this conversation it is

critically important to acknowledge the legacy of ableism in the feminist and LGBTQ movement

and the intersections of disability justice with gender justice. The end of this chapter will

suggest some possible ways in which modern disability theory can continue to expand feminist

thinking and work with trans and gender nonconforming people.

The transfeminist approach realizes that the role of gender expert in working with trans

and gender nonconforming clients has a strong footing in much scholarship and discussion

around working with trans and gender nonconforming clients, creating much fear and

apprehension by those who do not feel competent enough to engage in this work. Sennott and

Smith (2011) through their work with the non profit organization Translate Gender have

conducted trainings and workshops in which they ask therapists and doctors to speak openly and

candidly about their countertransference, prejudices, assumptions, phobias and fears when

working with trans and gender nonconforming people. They summarize clinician's fears as

such:

The greatest fear that clinicians have in working with differently gendered clients is that

they are not properly educated or trained to work with a differently gendered population.

This includes therapist's concerns about 'blind spots' in treatment, fear of saying the

wrong thing' or 'messing up a person's pronouns', 'overthinking' instead of being

present and mindful with a client, and not having enough resources and knowledge to

effectively advocate for a client. If a therapist feels this way . . . it is critical they begin

the process of self education and self awareness . . . This action can include, but is not

limited to, taking responsibility for continuing ones education through research and

study, trainings and workshops, and accessing online resources. . . supervision with a

peer group or a therapist knowledgeable in the areas of gender and sexuality to allow for

the exploration of one's own assumptions, stereotypes, and countertransference in

working with differently gendered clients. (Sennott & Smith, 2011, p. 228)

There is no mention of expert, or expertise in this approach. The client remains the

expert on themselves and their own gender and identity. One does not need to be an expert in

order to work with trans and/or gender nonconforming people. In fact, it seems as though the

creation of gender or transgender experts in the mental health field contributes to the problematic

power relationships already present in the policing of trans bodies and experiences. Sennott &

Smith (2011) offer this advice to clinicians:

No one can tell another person what his or her gender is; only an individual can know

this. We advise clinicians to consistently recognize that when clients state their gender

identity there should be no argument, no question, and no doubt as to whether or not this

is the person's 'real' gender identity. It is the responsibility and obligation of mental

health providers to realize this and recognize that they *do not* hold the responsibility of

deciding a person's gender identity. That is for the person to decide and the therapist to

mirror and affirm. It is a personal identification, not something that can be assigned,

diagnosed or pathologized. (p. 222)

Any culturally competent therapist with an understanding of the separate and distinct continuums of sex, gender, gender expression and sexuality, that is rooted in a social justice model that acknowledges the intersection of other identities such as race, class and ability, is capable of working with trans and gender nonconforming clients and providing them with the services they need want and deserve. This means, continually educating oneself by attending workshops and conferences and by reading scholarship and research written and conducted by trans and gender nonconforming people, by exploring one's own gender identity and expression, and seeking out the support and supervision of like minded therapists. The work lies in the therapist's ability to understand their own bias, stereotypes, and the ways in which their own gender identity and expression may or may not fit socially constructed roles. There is no better tool then self-awareness. This approach in many ways overturns the cognitive authority held by many professionals in the field. Instead of assuming the therapist knows what is best, the transfeminist model requires that clinicians educate themselves, examine their own belief systems around gender, and utilize a social justice framework, placing the needs and experiences of the client in the forefront of therapeutic work. "Another common concern of therapists is that they will unconsciously perpetuate the systems of oppression within the therapeutic relationship" (Sennott & Smith, 2011, p. 228), thereby recreating exclusion and stigmatization in the therapeutic relationship. It is vital for a socially just therapist to consider the ways in which different aspect of identities affect sex, gender identity, gender expression/impression and sexuality. Sennott & Smith recognize that,

> Race, class, size, ability, national origin, religion, first language and citizenship all play
>
> roles in how we may or may not express our gender, how we have come to understand

ourselves and our gender roles, and the ways in which our genders are perceived by communities and society. (p. 224)

By doing so, conversations are able to form around how individuals are affected by both privilege and oppression, and the ways in which individuals have been socialized to maintain both these privileges and oppressions. It is important to acknowledge that mistakes may happen, but it is critical to acknowledge and name these mistakes, apologize, hold themselves accountable and move forward. Feelings of guilt around mistakes are never useful to the client (Sennott & Smith, 2011).

One of the most important aspects of the transfeminist approach is the acknowledgment of the myriad of mistreatment, abuse and pathologization that trans and gender nonconforming people have experienced at the hands of the medical-industrial complex throughout the course of history. "Historically, the medical establishment has supported both physical and psychological trauma to trans and gender-nonconforming people . . . it is important to acknowledge the collective multigenerational trauma that has been experienced by the trans community (Sennott & Smith, 2011, p. 228). Rarely within the "helping professions" does one practitioners willing and able to recognize and speak to some of the more disturbing and unhelpful aspects of the medical-industrial complex. As we will see in the quote below, the transfeminist approach not only acknowledges this trauma and history of abuse but also incorporates it into a deeper understanding of clients experience in the therapeutic alliance.

While it is highly likely that trans and gender-nonconforming people have lived through some form of maltreatment by medical and mental health professionals, those who have not are often aware of the history that the medical-industrial complex has played in the lives of other trans community members . . . The Internet allows access to others' lived

experiences, and often it is through remote connections that community members inform one another of injustices and particularly triggering or traumatizing experiences with health care providers. As a result, it is highly likely that a gender-nonconforming person sitting in the office of a mental health professional may be wary and guarded due to either lived experienced or vicarious experience of collective trauma. For this reason, trans and gender-nonconforming people may not enter treatment with the same mutuality, trust and helping relationship of other clients. They may be guarded and worried, hypervigilant, and reluctant . . . Concerns and fears should be acknowledged, validated, and normalized through recognition of the harms that the medical establishment has perpetrated against members of the trans and gender-nonconforming community. (Sennott & Smith, 2011, p. 229)

Sennott & Smith (2011) also outline other fears and concerns a trans or gender nonconforming client may have. These fears may include, having all concerns brought into therapy connected to one's gender by the therapist, assumptions about gender identity stemming from abuse, identity being seen as a "phase", having to educate the therapist around basic issues, not being believed or validated in assertions of gender identity, being forced to fit into binary gender roles, and not being "trans enough" to access letters, legal documentation and gender affirming treatments (Sennott & Smith, 2011). As one can see, many clients report fears that are directly related to the medicalization of trans bodies and experience and their experiences of trauma directly or vicariously within the medical-industrial complex. The transfeminist approach encourages clinicians to mirror and affirm language and identities, not to conceptualize every issue as relating to gender identity, ask questions from a place of exploring a client's feelings rather then from a desire for self-education. Also, it is important for therapists to decide on a policy for letter

writing before meeting with individual clients and to be aware of resources within communities

that do not require a letter but rely on informed consent in order to create a space where both

client and clinician are free to explore other aspects of the therapeutic relationship (Sennott &

Smith, 2011).

Through the major advances of the social model of disability one can see the ways in

which society actually causes disability in individuals. Similarly, "The DSM does not account

for the difference between distress or impairment that is inherent to the psychology of an

individual and that which is a result of oppressive sociocultural structures" (Sennott, 2011, p.

95). This is to say, too often distress in the lives of trans and gender nonconforming people is

blamed and placed on the individual, much in the same way that individuals are often assumed

responsible for their disabilities. Instead, disability theory has taught us that much of disability is

a result of societal oppressions and barriers, stereotyping and discrimination. It seems, then,

following in the footsteps of disability theory, that at the very start of this debate should be the

move away from the individual model of GID to the societal model of GID.

"Instead of recognizing that the moral failure lies in society's unwillingness to embrace

different gender identities and expressions, society blames transgender and gender

nonconforming people for bringing discrimination and violence on themselves" (Grant, Mottett,

& Tanis, 2010). It is time for professionals to start unpacking some of these complications in

work with trans and gender nonconforming people and it is time for the APA to stop the

unethical practice of including diagnosis based on perceived cultural norms and values. In 2010 a

study of 6,450 trans and gender nonconforming individuals reported that, "Health outcomes for

all categories of respondents show the appalling effects of social and economic marginalization,

including much higher rates of HIV infection, smoking, drug and alcohol use and suicide

attempts than the general population" (Grant, Mottett, & Tanis, 2010). The negative effects of transphobia and transgender oppression from mental health and other health care professionals has disastrous implications for the kinds of treatment, services and care trans and gender nonconforming people receive (or don't) from their providers. The transfeminist model, rooted in activism and social justice with an awareness around the interconnectedness of the construction and pathology of queer and/or disabled people may be the best way to start to transform the harm that has been done, and continues to be perpetrated in the medical-industrial complex towards all queer and/or disabled people.

While moving towards an understanding of impairment as caused by social conditions of oppression, one must also remember the critiques of the social model of disability. Clare (2001) reminds individuals to:

> pay attention to our bodies- our stolen bodies and our reclaimed bodies. To the wisdom that tells us the causes of the injustice we face lie outside of our bodies, and also to the profound relationship our bodies have to that injustice, to the ways our identities are inextricably linked to our bodies. (p. 364)

The advancement of disability theory is critical but it must continue to pay particular attention to the critiques of a social model that argue this model may be as narrow and rigid in defining experience as earlier models. Resistance theory emphasizes the use of multiple voices containing a variety of experiences as a way to enlarge the understanding of everyone and to overcome disagreements and move beyond singular interests thereby incorporating "resistance within social movements as a tool for transforming the target of their resistance- the larger society" (Gabel & Peter, 2004, p. 593).

Similarly, those who work for disability justice and continue to write disability theory should do so with a crip queer consciousness and explore the connections between GID and the pathology of disability to forge new understandings of the hope as well as the limitations of pursuing disability rights for the treatment and consideration of trans and gender nonconforming people. For as it stands now, trans and gender nonconforming people seem to live in a double bind, that is they are at once dependent on the medical model of transsexuality for access to services, and yet denied access to services, as well as denied basic legal protections due to their gender identities. It seems as though demanding services for queers highlights,

> The tension between transgression and inclusion, dissidence and accession to the
> dominant legal and political order. Claims to full citizenship based on equal rights or
> recognition run the risk that the responsibilities imposed on sexual minorities as the
> "trade-off" in these circumstances will amount to an extension of disciplinary power,
> thereby compromising the transgressive potential of alternative sexualities and sexual
> practices. (Grabham, 2007, p. 37)

That is to say both queer and/or disabled communities, activists, theorists and academics must at once weigh both the risks and benefits of inclusion, equal rights, in continuing to follow in a model controlled by the medical-industrial complex. It seems necessary, that the debate around GID remain decidedly queer, and that the community will continue to push the problematic relationship of cognitive authority, challenge the problematic construction of equal rights and remain an active public dissent to dominant systems.

> The concept of sexual dissent . . . forges a connection among sexual expressions,
> oppositional politics, and claims public space. Because sexual representations construct
> identities (they do not merely reflect preexisting ones), restriction and regulation of

sexual expression aimed at sexual minorities and gender nonconformists . . . What the

right wing wishes to eliminate is our power to invent and represent ourselves and to

redefine our politics. They know our public sexual expression is political, and that is

how we must defend it. Rather then invoking fixed, natural identities and asking only for

privacy or an end to discrimination, we must expand our right to public sexual dissent.

This is the path of access to public discourse and political representation. (Duggan &

Hunter, 1995, p. 5)

This dissent must be enacted as complete resistance to compulsory ablebodiness and compulsory

heterosexuality, "crips and queers should insist on teaching straight culture the lessons they have

learned from dissent and on understanding dissent as a central component of progressive political

agency" (McRuer & Wilkerson, 2003, p. 10). Through the examination of these oppressive

structures and systems, both historically and contemporarily an understanding will occur that

centers on justice and, "a recognition that another world can exist in which an incredible variety

of bodies and minds are valued and identities shaped, where crips and queers have effectively

(because repeatedly) displaced the able-bodies/disabled binary" (McRuer and Wilkerson, 2003,

p. 14). Disability and queerness are at the center in the movement for social justice, and with a

crip queer consciousness, another world is possible.

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