DISABLING TRANS: POLITICAL IMPLICATIONS AND POSSIBILITIES OF CONSTRUCTIONS OF TRANS AS A DISABILITY

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Abstract

Within the trans community, trans activists and authors have discussed the construction of trans (trans/transgender/transsexual/two-spirit/genderqueer) to identify as a disability at length. There are a number of important reasons this issue has been taken up, from theoretical issues about identity construction to access to anti-discrimination protection and medical interventions. This is an ardently debated issue which is often acknowledged as being interlocked with class. With few exceptions, people who identify as disabled in addition to being trans are largely erased from this discourse. This paper examines the historical and contemporary construction of trans as a disability. Further, drawing on the writing of trans authors and my own experiences in the trans community, I discuss the current debate within the trans community about this issue and examine some non-disablist possibilities for ways for the trans community to move forward in solidarity with disabled people and communities.
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Introduction

Within the trans community, there has been an ongoing debate about the psychiatrization of trans people and our construction as disabled. This paper examines the ways that medical and legal discourses construct trans as a disability and what trans people’s responses to this construction are. From an interlocking analysis of oppression and based in the radical model of disability, I will analyze trans people’s responses and offer possibilities for moving forward in anti-oppressive ways.

I began this project because I have often felt that this debate renders me and people like me – people who identify as disabled and trans – invisible. Within the trans community, there is a common opinion, that trans people are not disabled. Consequently, people like me who are trans and disabled are discursively non-existent. This project, however, is not one of insertion: adding disabled trans people into the discussion. This project is an attempt at radical transformation: putting forward new ideas about trans and disability (including trans as a disability) that are built upon the understanding of oppression as interlocked and ideas of mutual solidarity and liberation.

My identity also encompasses a number of other things which deeply inform the way I experience being a disabled trans person. Indeed, I am a particular kind of disabled trans person, one who experiences these things through my whiteness, my poverty, my (recent) experiences of male privilege, my experiences of sexism and gender based

1 While I have yet to hit the poverty line in my adult life, for the last year I have been a grad student which affords me a great deal of privilege and cultural capital, including the ‘promise’ of future class privilege.
violence, my residence as a settler in the Global North, and my queerness. While I experience subordination, I also have privilege and both of these experiences inform my perspective on the construction of trans as a disability as they do all of my perspectives.

I bring all of these things with me to and through this project. There is no doubt that I am ‘close’ to this material. I am invested in it and I think that this investment, rather than devaluing it, makes it stronger. This paper is part of a broader ongoing political project to make trans movements accountable to their disabled members and to work with disability movements for social justice.

Language

Words are not simply composed of letters - ink on paper, they are laden with political and social meaning. According to Barnes, Mercer and Shakespeare (1999), “the language and concepts we use influence and reflect our understanding of the social world” (p. 11). Language choices are political choices and, as such, require not only definition but also political contextualization.

Trans is a term used to encompass people who are transgendered, transsexual, (some) two-spirit, genderqueer and transitioned (Bauer, Hammond, Travers, Kaay, Matthias' Hohenadel, Karin M., & Boyce, 2009). Trans is used to be inclusive of these groups and those individuals who may identify as both transsexual and transgender. Some authors use trans* in order indicate the potential for the word to include a suffix (see: Cadwallader, 2009; Trans PULSE, n.d.; Zachs, n.d.). I intend for it to be used in this way in addition to an identity in and of itself without a suffix.

There can be deep divisions between transsexual people and transgendered
people. Before I began taking hormones or seeking sex reassignment surgery, as someone who identifies as both trans and genderqueer, I felt like my identity was delegitimized by many transsexual identified people. I also experienced the refusal to respect my pronoun by a number of transsexual people, people who themselves have had to fight to have their own pronouns respected. I have found this division deeply hurtful, problematic and counterproductive.

Similarly, I am also deeply troubled by transgendered identified individuals who condemn transsexual identified people. Some transgender people have argued that transsexualism is problematic because transsexuals accept the pathologization of trans identities and collaborate with the medical industrial complex (see, for instance, Mackenzie, 1994). These divisions, too, are deeply hurtful, problematic and counterproductive. My use of the word trans is also an attempt to reject these divisions as well as the sex/gender binary.

Transsexual, unlike a number of other words in the trans lexicon, has a generally agreed upon definition. The term refers to an individual whose assigned sex does not conform with the sex that person identifies being and involves the pursuit of, desire for and/or use of hormones and/or surgeries to change of primary and/or secondary sex characteristics (APA, 1980; Gapka & Raj, 2003; Hausman, 1995; 2006; Hird, 2000; Irving, 2005; Lawrence, 2008; Mackenzie, 1994; Matza, 2009; Meyer et al., 2001; Nanda, 2008; T. Smith, 2011; Spade, 2007-2008; Stryker, 2006; Stryker, 2008).

Transgender is an umbrella term which can encompass transsexuality but does not necessarily do so (Califia, 1997; 2003; Gapka & Raj, 2003; Gapka & Raj, 2003;
Lawrence, 2008; Nanda, 2008; Stryker, 2008; Valentine, 2007). Trans activist and scholar Susan Stryker reports “the term implies a movement away from an initially assigned gender position” (Stryker, 2008, p. 19).

Some people who identify as a transsexual find the application of the word transgender onto them to be offensive. For instance, Margaret Deirdre O’Hartigan has said using transgender to describe her “co-opts my life, denies my experience, violates my very soul. I changed my sex. ... I took cold steel to myself and proved that anatomy is not destiny” (as quoted in Califia, 1997, p. 261). While transgender and transsexual are used synonymously at times, some people find it is not applicable and/or is offensive.

Two-spirit individuals may or may not also identify as transsexual or transgender. Two-spirit is an Indigenous identity that refers to cultural gender practices and identities that exist outside of Western notions of the binary gender system. The term was coined at the Third Native American First Nations gay and lesbian conference in 1990 and was adopted as, according to Michelle Cameron (2005), a two-spirit person, “an Aboriginal-specific term of resistance to colonization and [is] non-transferable to other cultures” (p. 125). Cameron asserts that the concept of two-spirit is “based on gender orientation” (2005, p. 124). However, Brian Joseph Gilley (2011) argues that focusing on gender with respect to two-spirit identity has come at the expense of sexuality. Beth Brant (2011) maintains that two-spirit is both a historic term and a contemporary term in which “Native people who are continuing and/or reclaiming these roles within their communities” (p. 4). While two-spirit is a pan-Indigenous identity, it is important to note that there are specific traditions and customs within nations and I want to caution against
universalizing cultural specific understandings of gender. In sum, two-spirit cannot be equated with trans; however, some two-spirit people may identify as trans or temporarily adopt a trans label in order to pursue hormones, surgery, or other medical interventions.

The ideas of transsexuality and transgenderism are specific to white, Western binary understandings of gender (Gapka & Raj, 2003; Stryker, 2006). Gender ambiguity, transition and/or cross-gender behavior have existed in many cultures throughout history (Feinberg, 2006/1992; R. Green, 1975/1969; Mackenzie, 1994; Nanda, 2008; Stryker, 2006; Whittle, 2006; Wilchins, 1997; Zucker, 2008). However, transsexuality and transgender are specific to recent Western ideas of gender subversion/crossing (Stryker, 2006). Transgender is, however, “currently being exported for Third World consumption” (Stryker, 2006, p. 1). Thus, the progressive notion of challenging/usurping/crossing the gender binary in settler culture in Canada and the United States poses the threat of imposing itself on and displacing Indigenous models of gender organization and contestation here and around the world.

I also use the word genderqueer in this paper. Genderqueer, according to Gherovici (2010), means to live outside of or beyond the gender binary, as opposed to transitioning. However, Stryker (2008) points out that it can be the case that one identifies as genderqueer and transitions fully or partially.

When it was coined in 1910 by Magnus Hirschfield, the word transvestite was used to describe a plethora of gender diversity, similarly to how transgender is employed today (Stryker, 2008). According to Stryker (2008), “to the extent that it has not fallen entirely out of favor, it refers primarily to people who wear gender-atypical clothing but do not
engage in other kinds of body modification” (p. 17). I refer to these terms when
discussing it as a specific diagnoses but, in keeping with the common linguistic choices
of the trans community (Stryker, 2008), I use the word cross-dresser otherwise.

I also use the term cis to describe non trans people. From my observations, cis is
not commonly used in published trans writing as authors tend to use cissexual and, to a
lesser extent cisgender(ed). Cissexuals are defined by Julia Serano (2007) as “people who
are not transsexual and who have only ever experienced their subconscious and physical
sexes as being aligned” (p. 12). Cadwallader (2009) asserts that the term was developed
“as a way of drawing attention to the unmarked norm” (p. 17n3). I use cis because to use
cissexual or cisgender would work to reify the sex/gender binary and, possibly, privilege
sex over gender or vice versa.

I also choose to use the term disabled people in this paper rather than ‘people with
disabilities.’ What is commonly known as ‘people first language’ is often used
paternalistically (Oliver, 1990). Disabled people, on the other hand, implies an identity
that is socially constructed and politically imposed on people (Oliver, 1990; Oliver,
1996).

As trans people are often constructed as disabled it would be problematic for me to
make a distinction between disabled people and trans people. Whether or not one agrees
with this construction, semantically (as I will demonstrate below), trans people are
disabled. Further, the distinction between trans people and disabled people is problematic
because it implies that trans and disability are separate and distinct, erasing those people
who are otherwise-disabled. As Ballan, Romanelli, & Harper (2011) say, trans and
disability are “neither interchangeable nor separable” (p. 262). Consequently, I have elected to use the phrase otherwise-disabled trans people to discuss those of us who identify as (or are identified as) disabled independently of the construction of trans as a disability. Sometimes the term trans-disabled is also used to refer to this group (Ballan et al., 2011). I chose not to use this, however, because it could imply that other trans people are not disabled.

**Radical Model of Disability and Interlocking Oppression**

This work is grounded in what I call the radical model of disability (Withers, 2012). Much of disability studies is invested in the social model of disability which was developed in the 1970s (Oliver, 1996; Thomas, 2004b; Withers, 2012). While the social model of disability has made significant contributions to disability studies, the disability movement and the lives of disabled people, this model is, as I have argued elsewhere, deeply flawed and outdated (Withers, 2012).

The social model of disability has been critiqued extensively for failing to be inclusive of many marginalized disabled people, including people who are not physically disabled (see: Dossa, 2009; Morris, 1991; Thomas, 1999; Thomas, 2004a; Withers, 2012). This, according to Peter Beresford (2004), has led to there not being “a strong sense of shared ownership of the social model” (p. 209). The social model of disability’s inability to engage with interlocking oppression means that it erases the majority of disabled people’s experiences while working to affect change for those disabled people with the most privilege.

The social model of disability’s primary theoretical contribution is that disability is
socially constructed: disability is the oppression disabled people experiences while impairment is “lacking all or part of a limb, or having a defective limb, organism or mechanism of the body” (in Oliver, 1996, p. 22) which is inherent to the individual. Revolutionary at the time, feminist scholars (see, for instance, J. Butler, 1990; Hubbard & Wald, 1993) have since thoroughly critiqued the notion that biology is not also socially constructed.

The radical model of disability re-embeds disability with impairment, arguing that the division is more harmful than useful and that disability (including impairment) is socially constructed (Withers, 2012). Disability under this framework is understood as a political label imposed on certain kinds of deviant people and used to control disabled people and the population as a whole. It calls for an in-depth understanding of interlocking oppression and for marginalized people to unite against systems of subordination and domination. It also demands the creation of radical ideas of accessibility (building on an analysis of interlocking oppression) that aren’t simply about ramps, but also interdependence, inclusion and justice.

Interlocking politics, although they have been articulated as such since at least the 1970s, are rarely done in a meaningful, non-tokenistic way. Disability is often just tacked onto the list of oppressions – if mentioned at all. In the trans community, otherwise-disabled trans people are frequently erased. As an otherwise-disabled trans

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2 Tones Smith (2011) quotes the Combahee River Collective, 1977 calling for “the development of integrated analysis and practice based upon the fact that the major systems of oppression are interlocking” (p. 4)
person, I have been deeply impacted, frustrated and hurt by the erasure and rejection of otherwise-disabled trans people within what is supposed to be our own community

At conferences that have had workshops on disability (usually one, possibly two, sometimes none) they also have workshops on topics like ‘how to pass’ and SRS which impose normative (white, middle-class, non-disabled and often straight) views of masculinity and femininity onto trans people. In my experience, even when there has been some inclusion of disability issues about accessibility and awareness in trans spaces for and about disabled people, the dominant threads throughout these conferences were ones of the erasure of disabled (and other marginalized) people.

Trans discourse has been controlled by cis people, especially cis doctors, until recently (Irving, 2005; Ware, 2010). Over the past two decades, however, trans voices have emerged much more (Irving, 2005; Stryker, 2006). The perspectives of otherwise-disabled trans people and other marginalized people, however, remain peripheral within this discourse. Overwhelmingly, trans literature is written by nondisabled white people (Stryker, 2006). I find it deeply troubling that a group that has fought very hard to wrestle control of its own discourse and been successful in this only relatively recently (although this struggle, particularly with medical experts, persists) continues to marginalize its members of subordinated groups.

To provide one brief example, I will use the Transgender Studies Reader, a 750 page text edited by Susan Stryker and Stephen Whittle (2006). In her introductory chapter Stryker (2006) recognizes that “anti-transgender violence can be linked to other systemic forms of violence such as poverty and racism” (p. 10). However, she acknowledges that
she and co-editor Stephen Whittle made choices that “admittedly limited the range of
cultural and ethnic diversity of work included” (p. 15). Ware (2010) asserts: “trans people
of colour who search for home and reflexivity in this book will not find it” (p. 32).
Similarly none of the 50 chapters are specifically about disability or class and only one
chapter discusses disability in any detail. In the one article in the *Transgender Studies
Reader* that does engage with disability, Singer (2006) only uses photographs of
otherwise-disabled trans people who are disabled in typically represented ways. While he
notes this, he does not provide diverse imagery of disabled people. Stryker does not
acknowledge the erasure disability or class in this text. About two-thirds of the book’s
cover is comprised of the image of the torso of a white normative (thin, nondisabled)
person, working to reinforce specific ideas about what it means and looks like to be trans
and negating other ideas about who is trans.

When disability is acknowledged, there is often a failure to be able to count
higher than two. Trans and disability may be acknowledged *or* race and trans *or* class and
trans *or* queerness and trans, etc. There seems almost to never be space to acknowledge
let alone embrace multiplicity. For instance, at one conference, I facilitated a workshop
called “Trans as a disability?” This workshop (the only workshop scheduled in its time
slot) was held at the same time as the people of colour caucus. Thus, the organizers were
implicitly saying that one was either disabled (or concerned with disability issues) or a
person of colour, erasing the interlocking nature of the two identities and disabled people
of colour. Here, even though disability and race had a slot on the schedule, disabled
people of colour were erased.
In conducting an analysis of trans people’s opinions about the construction of trans as a disability drawing publicly available accounts by trans people, the existing exclusion of marginalized trans people is also replicated in this paper. This is deeply problematic. Thus, this paper is not so much a canvass of trans people’s opinions on the construction of trans as a disability as it is an analysis of the attitudes of those people who are allowed space within the trans community to publically express their opinions.

Methodology

I employ textual analysis in this paper to examine when and how trans has been constructed as a disability and what the response of this construction has been by the trans community. Content analysis is a methodology used “in order to try and obtain a sense of the ways in which, in particular cultures at particular times, people make sense of the world around them” (Mckee, 2003, p. 1). This project pursues three related lines of inquiry into constructions of trans as disability in medical and legal contexts, and in trans communities. While this paper focuses on constructions of trans as a disability in Canada, I draw on American medical discourse and trans discourse because the American discourses influence Canadian medical, legal and political discourses.

It would be almost, if not totally, impossible to separate Canadian and American trans medical discourse. The American Psychiatric Association has Canadian members and permits them to hold leadership positions (American Psychiatric Association, n.d.a). Additionally, the DSM-5 Sexual and Gender Disorders Work Group was chaired by a Canadian and four of its original fourteen members were based at Canadian universities (APA, n.d.b). Similarly, while there are some important differences between Canadian
and American trans discourse, there is also a great deal of overlap. Every trans conference I have ever attended had people from both countries present. There is an active sharing of information and support across the border. I rely solely on Canadian jurisprudence, however, as it has an independent set of decisions.

For the medical portion of this paper, I conducted a general review of the literature and a focused analysis of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (American Psychological Association [APA], 1952; 1968; 1980; 1987; 1994; 2000; 2013a). I analyzed these texts for when and how disability is defined as well as the diagnostic criteria for transvestism, transvestic fetishism, transsexuality, gender identity disorder (not otherwise specified) and (other specified/unspecified) gender dysphoria.

I used a similar methodology for the legal analysis. I engaged in a search of all reported cases in Canada, using both the Canadian Legal Information Institute (CanLII) and Quicklaw for all cases that contain the terms: “transsexual,” “transgender,” “gender identity disorder,” “gender dysphoria,” “transvestite,” or “genderqueer.” This search yielded 974 ‘hits’ (many of which were repeating cases). I examined these cases for those that were directly relevant and did not contain the search terms incidentally. I recorded the relevant information for all human rights cases brought forward by trans individuals and determined the grounds for each of these cases. In cases also containing the word

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3 A number of cases have been filed in Canada specifically because the healthcare system is publicly funded which creates a discrete set of prescience in Canada. As I will discuss later, this has a significant impact on some Canadian activist’s approaches to the classification of trans as a mental disorder.
“disability” or “disabled,” I examined the text for discussions about trans as a disability and then analyzed these cases.

Because the search was done using English search terms, there is a possibility that French language cases that have not been translated have not been found through this search. In order to reduce the number of cases that were overlooked, I made a note of all French language cases that were cited in other judicial decisions, of which there are none that I am aware that are pertinent.4

In order to analyze trans content, I had to first establish the parameters of what would be considered trans texts. I primarily relied on trans people to self-identify as trans in the text that I was analyzing. Where an individual did not identify in the text as trans, I relied on my own knowledge of the author from my experience in the trans community and/or examined other texts by that author, including individual’s web pages. All of those individuals who are included as otherwise-disabled trans individuals self-identify as such in this or other texts.

I made the decision to include texts by multiple authors in which only one author is trans. This could mean that ‘trans responses’ include opinions that are not held by trans people or in which trans people were tacked on tokenistically in order to provide legitimacy to the work. Not including texts with multiple authors who are not all trans, however,

4 findlay, Lafrenboise, Brady, Burnham and Skolney-Elverson (1996) mentioned La Commission des Droits de la Person du Quebec v. Anita Anglsberger in their report. Anglsberger pursued their case on the grounds of civil status (a ground that does not exist outside of Quebec) and was successful. This case is not available on CanLII or Quicklaw.
could work to further marginalize trans authors. Although, “there are more and more of us with the same fancy titles and letters after our names” (Ryan, 2009, p. 7), trans people experience systemic discrimination. Consequently, trans people may be less likely to hold tenured positions and more likely to be listed as secondary authors.

**Medical Discourse and the Construction of Trans as a Disability**

**The Medical Model and the Pathologization of Trans**

The medical model is a way of understanding disability in individuals as a form of biological malfunction which necessitates medical intervention (Elliott & Dreer, 2007; S. R. Smith, 2005; Vellacott, 2011; Withers, 2012). It is through the medical model that disability is primarily understood in Canadian society, making medical discourse central to disability discourse (Vellacott, 2011; Withers, 2012). Trans people have been medicalized and constructed as disabled through medical discourse, as I will show. This has significant implications for the lives of trans people.

Trans began being medicalized in Western cultures in the nineteenth century, generally under the rubric of homosexuality (Hausman, 1995; 2006; Lothstein, 1983; Mackenzie, 1994; Smith, 2011; Stryker, 2008; Wilchins, 1997). It was not until the post-War era, however, that (particularly) transsexuality became the focus of significant public attention. In 1952, an American, Christine Jorgensen made international news when she had sex reassignment surgery in Denmark (Califia, 1997; 2003; Ekins & King, 2006; Feinberg, 2006/1992; Lawrence, 2008; Mackenzie, 1994; Meyerowitz, 2004/2002; T. Smith, 2011; Stryker, 2008). Jorgensen’s doctors, Hamburger, Stürup and Dahl-Iversen (1953) called Jorgensen’s being trans an “all-dominant problem” (p. 395) and justified
her surgery on eugenic grounds. In addressing concerns about groups of homosexual men pursuing castration, they asserted: “from a eugenic point of view it would do no harm if a number of sexually abnormal men were castrated and thus deprived of their sexual libido” and, thus, not reproducing (p. 395). Classification as eugenic unfitness was a predecessor to the contemporary construction of disability (Davis, 2002; Withers, 2012).

The term transsexual however, was not coined until Harry Benjamin, who has been called “the founding father of contemporary western transsexualism” (Ekins, 2005, p. 306), did so in the 1960s. Benjamin (1966) popularized the idea that trans people are “‘trapped’ in the wrong bodies” (p. 9) and frequently used ‘handicap’ to refer trans people’s experiences. Stryker (2008) asserts that Benjamin work marked the beginning of the “Big Science” era in trans research which continued until the late 1970s (p. 93).

**Trans in the DSM**

A number of authors have discussed the pathologization of trans through the DSM (see: Califia, 1997; 2003; Drescher, 2010; Mackenzie, 1994; T. Smith, 2011; Stryker, 2008). Certain forms of trans identities and behaviours have been constructed as a disability through the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) from its onset while others were added later and, still others are marginally pathologized. The DSM is the diagnostic guide used by psychiatrists and other mental health practitioners in Canada and the United States. I argue that the DSM is used as a tool for disablement of trans populations and the shifts in language used throughout the DSM are demonstrative of changes in social norms.

The DSM is frequently called the psychiatrists bible by supporters and critics
alike (see: Anand & Mahli, 2011; Caplan, 1995; Frances & First, 2000/1998; Kutchins & Kirk, 1997; T. Smith, 2011; Weitz, n.d.). Psychiatric survivor Don Weitz calls it “a catalogue of negative moral judgments which psychiatrists use to medicalize, target and stigmatize dissidents and alternative ways of perceiving, interpreting or being in the world” (1988: 159). While its legitimacy is questioned, its influence, however, is widely accepted and is even described as hegemonic (see: Anand & Mahli, 2011; Schwartz & Wiggins, 2002).

The DSM was first published in 1952 (APA) and it has changed significantly over its five full editions and two revisions. The DSM was developed out of the perceived need to have a common language for practitioners as, up to that point, different institutions and practitioners had different names for diagnoses and diagnostic criteria (APA, 1952). Following the Second World War, the first edition of the DSM was released. At 132 pages, it was composed of lists and disorder names with little explanation. The DSM-II was slightly shorter (119 pages) and followed the same basic design. It was not until the DSM-III that the text ballooned to 494 pages, included the multi-axis system and shifted towards a more descriptive tool. The next four editions: DSM-III-R, DSM-IV, DSM-IV-TR and DSM-5 followed the same basic principles as the DSM-III however the diagnostic language and criteria shifted over these editions and the multi-axis system was eliminated in DSM-5 (APA, 2013a).

Certain forms of trans subjectivity have been pathologized in each edition of the DSM; however, they have been constructed as a disability differently over the years (or, sometimes, not at all). The first edition of the DSM was released the year before
Hamburger, Stürup and Dahl-Iversen’s (1953) publication discussing Christine Jorgensen’s sex reassignment surgery. The DSM was also developed before the term transsexual had been coined. During the years preceding DSM-I, it was rarely discussed and when it was it was couched within understandings of homosexuality (Califa, 1997; 2003; Hausman, 1995; 2006; Hird, 2000; Lawrence, 2008; Mackenzie, 1994; Meyerowitz, 2004/2002; Stryker, 2008). It was not until after homosexuality was removed from the DSM that transsexualism first appeared in the DSM (APA, 1980). Transvestism/transvestic fetishism/transvestic disorder, however, has consistently been listed as a mental disorder in each edition and revision of the DSM (APA, 1952; 1968; 1980; 1978; 1994; 2000; 2013a). In this section, I will discuss how different trans identities have been pathologized in the DSM and then examine the ways it has been constructed as an impairment (see Appendix B, C, D and E for outlines of specific diagnostic changes for each diagnosis).

**Transvestism:**

Transvestism has been constructed quite differently over the years. The name was then changed from Transvestism (APA, 1952; 1968) to transvestic fetishism (APA, 1987; 1994; 2000) and, most recently, transvestic disorder (APA, 2013a). One key consistency is that it has always been classified as a “sexual deviation” (APA, 1952; 1968) or “paraphilia” (1980; 1987; 1994; 2000; 2013a) rather than a “gender disorder” even though appropriately gendered attire is the central concern. DSMs II, III and III-R (APA, 1968; 1980; 1987) require some form of sexual arousal or excitement in the criteria (DSM-I does not provide criteria). In 1994, however, the DSM-IV added the word
“behaviors” to the criteria, broadening it to potentially include any heterosexual male cross-dresser who did so over a period of 6 months and experienced ‘impairment’ (APA, 1994; 2000). Revised again, the DSM-5 clearly requires sexual arousal involving cross-dressing (APA, 2013a).

Another important component of this diagnosis is that it was restricted to heterosexual men in the DSM-III (APA, 1980). This criterion remained intact until 2013 when the gender and sexuality specifies were removed (APA, 2013a). The condition is considered to be “rare in males and extremely rare in females” (p. 703). Cross-dressing, generally involving sexual arousal and sometimes restricted to men, has been considered a mental disorder as long as the DSM has existed.

**Homosexuality (Transgender/Transsexualism):**

The shift between the DSM II and the DSM III was a significant one, with changes in the layout of the text, inclusion of diagnostic criteria and, for the first time, the inclusion of transsexualism. Homosexuality was considered a mental disorder in the DSM I and DSM II (APA, 1952; 1968). Trans people were often included in this category (Lothstein, 1983; Mackenzie, 1994; Stryker, 2008; Wilchins, 1997). In 1973, the American Psychiatric Association removed homosexuality from the DSM and issued a statement, which was drafted by Dr. Robert Spitzer. It claimed: “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” (APA, 1973, p. 3). While the APA no longer pathologized homosexuality it made it clear that it continued to devalue it.
Homosexuality was replaced, through this 1973 position statement, with “sexual orientation disturbance (homosexuality).” The 1980 DSM replaced sexual orientation disturbance with ego-dystonic homosexuality. This new diagnosis required an absence of and desire for heterosexual arousal in combination with “a sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress” (APA, 1980, p. 282). Homosexuality was pathologized in the DSM until the most recent edition of the DSM through the diagnosis: sexual disorder not otherwise specified - for individuals who would have been classified as having ego-dystonic homosexuality (APA, 1987; 1994; 2000).

The first edition of the DSM following the removal of homosexuality, DSM-III (APA, 1980), contained gender identity disorder in children and transsexualism (adults). Consequently, a “widespread claim that GID was introduced into the DSM-III in 1980 as a kind of ‘backdoor maneuver’ to replace homosexuality” began taking hold (Zucker, 2006, p. 546). Zucker and Spitzer (2005), prominent APA members argue, however, these were unrelated. They maintain GID was introduced into the DSM because: [i]t became apparent that psychiatrists and other mental-health professionals had become increasingly aware of the phenomenon, that is, of adult patients reporting substantial distress about their gender identity and seeking treatment for it, typically hormonal and surgical sex-reassignment (p. 37). They argue that the connection made between the psychiatric diagnoses is false because, among other things, ego-dystonic homosexuality was in the DSM already and “several clinicians and scientists who argued in favor of delisting homosexuality from the DSM-II… were members of the DSM-III subcommittee
on psychosexual disorders that recommended the inclusion of the GIDC diagnosis in DSM-III” (p. 35).

Zucker and Spitzer refer to the position that there is a causal relationship between the removal of homosexuality from and the insertion of gender dysphoria in the DSM as “revisionist arguments about the putative origin of the inclusion of the GIDC diagnosis in the DSM-III” (p. 38). Nevertheless, many trans activists and allies continue to believe that the inclusion of transsexuality in the DSM is not coincidental (Gherovici, 2010).

**Gender Identity Disorder/Gender Dysphoria in Children:**

Gender identity disorder of childhood (GIDC) was added to the DSM-III (APA, 1980) and was the first overt criteria for pathologizing gender nonconforming children. The criteria for GIDC, notably, has always been specifically gendered criteria, unlike the criteria for adults and post-pubescent adolescents (see Appendix C and D). These criteria rely on gender stereotyping; one of the criteria for diagnosis is wearing stereotypical clothes of the ‘opposite’ sex and/or engaging in stereotypical activities (or toys) of the ‘opposite’ sex (APA, 1980; 1987; 1994; 2000; 2013a). The only exception to this is the DSM III which does not have an express criteria based on gender stereotypes for girls.

**Transsexualism/Gender Identity Disorder/Gender Dysphoria in Adults and Adolescents:**

The inclusion of GIDC and transsexualism in 1980 was, according to Drescher (2010), a consequence of a larger trend in psychiatry to “abandon the psychodynamic theories” and embraced “descriptive, symptom-based framework drawing upon contemporary research findings” (p. 112). Transsexualism later became gender identity disorder (GID) in adolescents or adults (APA, 1980; 1994; 2000) and then gender
dysphoria (GD) in adolescents and adults (APA, 2013a). With respect to gender dysphoria in adults and post-pubescent adolescents, the criteria have also changed through the various revisions of the DSMs (see Appendix D). Until the most recent DSM (APA, 2013a), the criteria have always been based on feelings of “discomfort” and “inappropriateness” with one’s assigned sex, a criteria related to the engendered physicality of the individual and a criteria setting a minimum length of time that the person must have experienced these criteria in order to be diagnosed (APA, 1980, p. 263; 1987, p. 76; 1994, p. 537; 2000, p. 581). Each edition of the DSM also required a specification of the subject’s sexuality. The new criteria have a specification for people who are posttransition and no longer requires specified sexual orientation (APA, 2013a). DSM-5 allowed for intersex people (those with “disorders of sex development”) to be classified as gender dysphoric, unlike previous versions of the DSM (with the exception of DSM-III-R). The APA views gender dysphoria as “a multicategory concept rather than a dichotomy” (APA, 2013b, p. 14). Thus, someone with GD is placed on a spectrum of intensity or severity.

**Gender Identity Disorder/Gender Dysphoria Not Otherwise Specified**

Beginning with the DSM-III, there have been gender disorders that can be applied to any number of gender variant individuals. While specific criteria have changed with time, these diagnoses are vague (see, APA, 1980; 1987; 1994; 2000; 2013a). Rachlin, Dhejne and Brown (2010) argue:

> GID NOS is intentionally constructed to encompass a wide range of individual experiences and presented in clinical practice. However, it may be described as an
“orphan diagnosis.” An orphan diagnosis is one that exists formally but is either rarely used or rarely studied. We believe that in this case, the GIDNOS diagnosis is used but rarely studied. (p. 89)

Montreal General Hospital’s head of the psychiatric Human Sexuality Unit, Doctor Pierre Assalian, held that transgender people could be diagnosed with GIDNOS (*Montreuil v. Canada [Canadian Forces], 2009*). The preamble for the diagnostic criteria of the DSM-5, however, defines transgender as “the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender” (APA, 2013a, p. 451).

The DSM-5 contains two catchall categories: other specified gender dysphoria and unspecified gender dysphoria (APA, 2013a). These categories require “significant distress or impairment” but could involve meeting none of the criteria for gender dysphoria (APA, 2013a, p. 459). Thus persistent transgender individuals who experience substantial distress and/or impairment could be diagnosed with gender dysphoria while those who experience it intermittently could be given one of these diagnoses. The DSM-5 notes that gender dysphoria is different than “simple nonconformity to stereotypical gender role behavior by the strong desire to be of another gender than the assigned one and by the extent and pervasiveness of gender-variant activities and interests” (p. 458). The DSM-5 also asserts that individuals must experience distress or impairment in order to be diagnosed. However, because, as I will show in the next section, impairment is so vague, this category could be used to pathologize many people who are gender nonconforming.
Are Mental Disorders Disabilities?

While gender nonconformity has clearly been medicalized, it is important to interrogate whether or not it has been constructed as a disability through the DSM. Throughout the various editions and revisions of the DSM, disability has been used differently and has often been undefined. There is no set consensus on the medical definition of disability (Withers, 2012). The APA, however, does provide some indications of how it defines the word in the various texts. In the DSM-I (APA, 1952), it appears to use the term synonymously with functional incapacity and impairment. In the DSM-III through DSM-IV-TR, the Association asserts that disability is “impairment in one or more important areas of functioning” (APA, 1980, p. 6; 1987, p. xxii; 1994, p. xxi; 2000, p. xxi). The DSM-5 makes a similar assertion that disability is: “impairment in social, occupational, or other important areas of functioning” (APA, 2013a, p. 21).

William Narrow, who sat on the DSM-5 Impairment and Disability Study Group and co-author Emily Kuhl (2011) also equate activity limitation and disability. They also assert: “[t]he terms impairment, functioning, disability, and distress are used by U.S. mental health professionals in ways that are more often than not ill defined and confusing” (p. 158).

Mental disorders are also undefined. I think it is important to note that in the 60 years and 7 versions of the Diagnostic and Statistical Manual of Mental Disorders it remains unable to fully define mental disorders. However, each edition and revision since 1980 asserts that mental disorders usually involve “distress” or “disability” (APA, 1980, p. 6; 1987, p. xxii; 1994, p. xxi; 2000, p. xxi, 2013a, p. 21). Thus, it appears that most
mental disorders are constructed as either distressing or disabling. With respect to the trans diagnoses specifically, the DSM-5 requires either distress or impairment (disability). Therefore, the DSM constructs as trans distressing or a disability but not necessarily both.

Some DSM critics have pointed out that the DSM transforms discrimination into pathology because impairment can be the consequence of discrimination (Ehrbar, Winters, & Gorton, 2010). Langer and Martin (2004) argue that “individuals could be pathologized for reacting against oppressive social or political forces” (p. 2). Thus all trans people who experience discrimination in (undefined) ‘an important area of functioning’ (love, school, going to the grocery store, work, going to the bathroom, etc.) can be brought into the DSM nosology and considered disabled.

**Legal Discourse – Broadening Medical Constructions of Disability**

While medical discourse often, but not always, constructs trans as a disability, that medical discourse gets taken up in law and commonly interpreted as a disability. Legal discourse is significant because, like medical discourse, it can have substantial implications in society more broadly. Indeed, law professor Paul Butler (2004) asserts: “[c]ulture shapes the law, and law is a product of culture” (p. 987). Legal constructions of trans as a disability also have significant implications for trans people with respect to legal rights and recognition, access to space and services, etc.

Generally, trans people have been deemed to be disabled when the issue has arisen in human rights cases. In Canada, each province and territory has human rights act. And along with the federal statute, there are fourteen different human rights acts. Of these,
eight specifically define disability as including a mental disorder (Alberta, New Brunswick, North West Territories, Nova Scotia, Ontario, Saskatchewan, and Yukon). Four other jurisdictions define disability as including a “mental disability” (British Columbia, Canada, Manitoba, and Nunavut) while two jurisdictions (Quebec, Prince Edward Island) do not define disability (see Appendix G for list of legislation). As gender dysphoria (formerly GID) is included in the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2013a) and is, therefore, categorized as a mental disorder by the leading psychiatric text in Canada, it would automatically be categorized as a disability in the eight provinces that define disability as including a mental disorder.

The Courts have consistently found that transsexuality and transgenderism are disabilities under human rights law. In *Sheridan v. Sanctuary Investments Ltd.* (1999), the British Columbia Human Rights Tribunal found that “discrimination against a transsexual constitutes discrimination because of ‘physical or mental disability’” (para. 97). The same Tribunal held that transsexualism and transgenderism⁶ are considered a physical disability (*Ferris v. Office and Technical Employees Union, Local 15, 1999*). In Ontario, the Provincial government has conceded that trans is a disability in two cases (*XY v. Ontario* (Minister of Government and Consumer Services, 2012; *Hogan v. Ontario* (Health and Long-Term Care), 2006). The Ontario Human Rights Tribunal also found that “transgenderism is a disability and the disability is transgenderism” (*Hogan v.

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⁵ In Quebec, the word used in the legislation is handicap rather than disability.

⁶ Transsexual and transgender are used interchangeably. The Tribunal ruled specifically that transsexual is a disability but uses the term synonymously with transgender.
Ontario, 2006, para. 128). Hogan (2006) also used the terms GID, transsexual and transgender interchangeably, thus the classification of disability could be applied to all three. The Canadian Human Rights Tribunal has, similarly, found that transsexualism is a disability (Montreuil v. Canada (Attorney General), 2009, para. 44).7 Indeed, in every reported human rights case in Canada in which a transgender or transsexual person has pursued the case on the grounds of disability the Court or Tribunal has found transgender or transsexualism to be a disability.

Canada’s Charter of Rights and Freedoms (1982) also protects individuals from discrimination on the grounds of “mental or physical disability” (s. 15 (1)). Disability is not defined in the Charter. There is only one reported Charter case with respect to the protection of trans people’s rights on the grounds of disability. The Federal Court in this case, Tewnion v. Canada (2003), summarily dismissed Tewnion’s Charter claim. Tewnion sought protection on the grounds that transvestitism was a disability when he was terminated from the Canadian Armed Forces. He had publicly worn women’s clothes and was dismissed. He pursued a wrongful dismissal case against the Armed Forces in which the Court ruled:

In fact, the evidence, such as it is, does not show that the plaintiff was released from the Forces because he was thought to belong to any particular group but rather because he was found to have indulged in conduct in public which was properly considered to be wholly inappropriate from a member of the Canadian Armed Forces. To put that another way, he was not released because of who or

7 See previous note.
what he was, but because of what he had done. (para. 7)

Thus, the court found (prior to trial and hearing full evidence) that gender non-conformity is “inappropriate,” a choice and is discrete from one’s identity or membership in “any particular group” (para. 7). It is problematic, however, to make a distinction between the activity of gender non-conformity and the identity of gender non-conformity. While action and identity can be independent of one another (one could cross-dress without being a cross-dresser) they are also interlocked.

As I have argued elsewhere (Withers, 2012), definitions of disability tend to become more restrictive as the amount of resources attached to that definition increase. Thus, a trans person could be classified as disabled under human rights law, but not disabled under social assistance or disability benefits law.

In a workers’ compensation case, however, the Board implied transvestism (with the possibility of “developing transsexualism” [para. 52]) was a disability and consequently withheld benefits. The Workers’ Compensation Board found that a worker could not be rehabilitated because she had GID. The Board implied that transvestism and GID are disabilities. This decision was overturned on appeal, as she was deemed capable of being rehabilitated (Decision No. 716/92, 1993) when that definition is beneficial to the trans person.

Other cases relating to disability benefits, however, have not necessarily found that trans is a disability. In Stephens v. Services de santé du Québec (1994) a transsexual person was denied disability benefits because the law required one to be unable to
perform “any remunerative occupation for which she was trained” (para. 9)\(^8\) which was the insurance benefit policy’s definition of disability. Transsexualism was found not to be a disability under this definition. Thus, while Stephens would be classified as disabled under human rights law, they were not considered disabled when they attempted to obtain ongoing income support.

In Ontario, the *Ontario Disability Support Program Act* (1997) also has a narrow definition of disability. Recipients are required to have “a substantial physical or mental impairment” that will last at least a year and have a “substantial restriction” “to attend to his or her personal care, function in the community and function in a workplace” (s. 4). There are two reported cases of individuals with GID/GD in conjunction with other medical diagnoses who have received disability benefits through this scheme (1203-02560 (Re), 2012; 1205-06928 (Re), 2013). There are, however, no reported cases of individuals obtaining disability social assistance with a diagnosis of GID/GD alone.

Subsequently, while the province has conceded that trans is a disability under human rights law, trans people are not necessarily considered disabled under social assistance law.

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\(^8\) The original defines disability as: “une incapacité totale et continue résultant d'accident, de maladie ou d'une complication grave d'une grossesse, nécessitant des soins médicaux et qui empêche l'assuré d'exercer toute occupation rémunératrice ou de faire un travail pouvant lui rapporter un profit ou un salaire et pour lequel son éducation, son expérience et son entraînement l'ont raisonnablement préparé” (para. 2).
The courts frequently construct trans as a disability. With respect to human rights legislation, trans people have consistently been found to be disabled. Here, the DSM is filtered through law which, like writing the DSM itself, is a social process through which trans people emerge disabled. There have been no cases involving a cross-dresser that have found transvestic disorder to be a disability. However, it seems clear that, should a cross-dresser who has been or could be diagnosed with transvestic disorder pursue a human rights claim, particularly in those jurisdictions that disability is defined as or includes ‘mental disorder,’ it would be found to be a disability.

**Trans Responses**

There is no shortage of literature on the construction of trans as a mental disorder/disability. Most people opposed to the disablement of trans argue that it is oppressive and/or stigmatizing and must be discontinued. Those who favor its continued classification argue that psychiatric disability is negative so the diagnosis should be reformed or reclassified as a physical disability/disorder in order to reduce stigmatization. These criticisms all start with the premise that disability is negative, with some people arguing that it is not a disability while others argue that disability is negative but needs to be considered a disability in order to access resources.

Undoubtedly, the most common opinion that I have come across with respect to the construction of trans as a disability within the trans community is the rejection of this premise.

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9 The Court also found that depression coupled with gender dysphoria was a mental disability in a family law matter (*Forrester v. Saliba*, 2000). It is unclear if the Court would have found that gender dysphoria on its own constituted a disability.
construction, generally, and the inclusion of trans in the DSM, specifically. A number of trans activists and scholars have written extensively about this, condemning the association of trans with mental illness, mental disorder and/or disability. Indeed, Stephen Whittle (2006), one of the editors of *The Transgender Studies Reader* asserts that an underpinning ideology in transgender studies is “the premise that to be trans was not to have a mental or medical disorder” (p. xii).

There is, however, some disagreement within the supporters of this discourse about why trans is not a disability. One of the primary objections to the classification of trans as a disability and its categorization as a mental disorder is that doing so works to uphold a false gender binary. For instance, trans activist and author Gordene Olga MacKenzie (1994) is unwaveringly opposed to the medical model of trans and argues that sex reassignment is socially coerced. She asserts that “it seems easier to 'fix' individuals than the culture” (p. 167) but that society should change rather than trans people (including sex reassignment).

Dean Spade is a trans activist, lawyer and author who is also critical of how the pathologization of trans people is used “to maintain normative gender performance” (Spade, 2006 a, p. 319). Spade critiques “disciplinary projects of medicalization, legal recognition, and punishment that work to recuperate trans subjects and make them stable and legible for binary gender systems” (Spade, 2009-2010, p. 449). He argues that while “[a] model premised on a disability – or disease-based understanding of deviant behavior is believed by many to be the best strategy for achieving tolerance by norm-adherent people for those not adhering to norms… the costs of such an approach... is too high”
(Spade, 2006b, p. 329). He also argues:

If we want to end oppression on the basis of gender identity and expression for all people, we need to examine how the rigid regulation of binary gender is a core element of participation in our capitalist economy, how the hyperregulation of poor people’s gender and sexuality has propped up that system, and how this has resulted in disproportionate poverty and incarceration for poor, gender-transgressive people. Starting from that analysis, we can undertake strategies to combat these problems and make sure that our activism does not further entrench this regulation by relying on pathologization and medicalization to articulate gender rights. (Spade, 2006, p. 232)

He maintains that it is an “immediate error and danger of the medical model of transsexuality is its separation of gender from cultural forces” (Spade, 2003, p. 25). Spade (2003) maintains that the “goal for trans law and policy remains demedicalization and an end to practices that coerce people into expressing gender identity through a narrowly defined binary” (p. 29).

Similarly Riki Wilchins (1997), who has been involved in organizing protests against the APA and the psychiatric classification of trans and calls for “the end of gender” (title) is opposed to the medical model of trans. She does not believe that justice can be won for trans people while it remains classified as a mental disorder. She writes: “I intend to fight for my political freedom. I will not be told that I am mentally ill. I will not be told that I am disabled. I will not live within the confines of a mental diagnosis which is a lie” (as quoted in Lev, 2009/2004, p. 319).
Similarly, a respondent on a public trans chat room asserts: “There's a reason people are trying to get the APA to continually review how they look at gender dysphoria. Viewing it as a disability gives credence to cisgendered privilege [sic] that something is 'wrong' if one doesn't fit within an inherently binary system” (Need info..., 2013, n.p.).

Another frequent argument against the conceptualization of trans as a disability is that trans is a “natural human variation, and not disease or mental illness” (Dickey, James, & Askini, 2009, n.p.). Or, as Julia Serano (2007) puts it, “[h]uman beings show a large range of gender and sexual diversity, so there is no legitimate reason for any form of cross-gender behaviour or identity to be categorized as a mental disorder” (p. 160).

Another common reason that trans people resist disabled identities is that disability and mental illness carry stigma with them that trans people wish to avoid. Frequently cited, Anne Bolin (1988) is an early promoter of the idea of delisting trans from the DSM because of stigma. She promotes a minority approach to trans people rather than a medical one. Similarly, another trans person asserts: “I don't want more negative connotations attached to further the social stigma.”

A report prepared for the Vancouver transgender outreach organization High Risk Project Society, the authors reject the construction of trans as a disability for several reasons. The report argues that "proceeding on the ground of disability forces transgendered people to accept a self-definition as disabled either mentally or physically in order to make a claim that they deserve to have human rights" (findlay et al., 1996, p. 23). This, they argue, "it is inconsistent with a political strategy that demands the society
change its ideas of normal and healthy and non-disabled to include transgendered people, rather than to continue to treat them as aberrations, which in turn reinforces the mistreatment they receive" (p. 23). They also argue that "Psychiatric problems" are frequently caused by "rejection, discrimination and humiliation, and not from the basic transgendered condition" (p. 24).

Kelly Winters calls for major changes to the classification of trans in the DSM and for some trans diagnoses (transvestism and post-transition GID) to be removed while others have major reforms. She argues that the psychiatrization of trans people as having “mental disorder has worsened the stigma that transgender people suffer” (2005, p. 78). She maintains that the DSM creates a “false stereotype” (2012, n.p.) that “stigmatizes [trans people] unconditionally as mentally deficient” (Winters & GID Reform Advocates, 2010, n.p.). Winters (2005) also argues that delisting GID could “reduce[e] stigma and fear” that trans people experience (p. 86) and that trans should not be in the DSM *per se*; rather, “chronic distress” from gender dissonance should be (p. 73). She suggests that once someone has transitioned, that they should no longer be classified as having a mental disorder, what she calls a “clear exit clause” (p. 82).

Often, however, many trans people who are responding to the construction of trans

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10 They also argue that this protection is not extended to all trans people: “Transvestites, for example, may not seek or require medical intervention, so unless they are considered in need of psychiatric help they may not be considered disabled” (p. 23). Given more recent changes in human rights codes and court interpretations, however, I do not believe that this argument holds today.
as a disability do not explain why, they simply assert that trans is not a disability. Some call this inclusion offensive without explanation (see, for instance, Macdonald v. Downtown Health Club for Women, 2009; Need info..., 2013). The complainant in XY v. Ontario (Minister of Government and Consumer Services) (2012) reported that she was, according to the decision, “reluctant to claim disability” because she did “not regard her gender identity as a ‘disability’” (para. 5). Similarly, at a workshop that I presented in 2008, called Trans as a Disability? One participant said: “I’m not disabled, there’s nothing wrong with me. I can walk. I’m not disabled.” On The Transgender Board, during a heated discussion about whether or not GID is disability, one member asserted: “I do not agree that it is a disability. I understand the criteria may actually fit in some ways” (Need info..., 2013, n.p.). This individual’s belief that trans people are not disabled is based, at least in part, on the presumption that trans people can be economically productive. Another board poster asserted that GID is a disorder, not a disability (Need info..., 2013).

The grounds that trans human rights claimants pursue their cases on are also demonstrative of how trans people relate to their construction as disabled people. Of the 34 distinct human rights cases filed by trans people that I was able to locate, the vast majority did not pursue their case on the grounds of disability. Half of all complainants (50%) filed on the grounds of sex/gender alone and 85% listed sex or gender as one of the grounds of the complaint. Excluding those cases in which the grounds for unknown, the number of cases that involve alleged sex discrimination totals 94%. Conversely, no complainants filed on the grounds of disability alone while slightly less than a quarter
(23%) listed disability as one of the grounds for the basis of the complaint (see Appendix 
G for table of cases, Appendix H for chart of grounds of discrimination).

Although in most of these cases the reason that the trans individual chose the 
grounds which they did is not discussed, one can elicit some information about how trans 
people view themselves through their decisions about which grounds they file human 
rights complaints on the basis of. The fact that there’s not a single case in reported 
Canadian jurisprudence in which a trans person has filed on the basis of disability alone 
and there are so few cases in which the grounds of disability are employed at all is 
demonstrative of a reluctance or refusal to identify as disabled. As a discussed earlier, 
individuals who have been or could be diagnosed with gender identity disorder or gender 
 dysphoria are clearly delineated as disabled under human rights law in eight jurisdictions 
and likely classified as disabled under human rights legislation and in every Canadian 
jurisdiction.

**Class, Income and Access**

One of the most common critiques of the argument to not apply a medical model to 
tans is that it would restrict sex reassignment to those with the funds to pay for it 
privately. This can be a substantial expense. Surgeries can be thousands, even tens of 
thousands of dollars. While hormones are much less expensive in the short term, they can 
still be prohibitively expensive. The cumulative cost of my testosterone, should I live to 
75 years old and take it until then, will be more than $100,000. Most people who I have 
cited who call for the demedicalization of trans do not address this issue. Some of these 
people, particularly MacKenzie (1994), do not think people should access surgeries or
hormones, making this issue irrelevant to them.

There are exceptions to this; however, as some of trans people who condemn the idea that trans is a disability do address class. Irving (2005), who is critical of the medical model of trans argues that campaigns to (re)list SRS conceal “the realities of poverty, homelessness, stringent welfare criteria, unemployment, immigration issues, disease and substance use faced by many impoverished trans people” (p. 337). This argument, however, is not particularly strong as it borders on a ‘race to the bottom’ mentality. Fighting for a raise in social assistance rates may obscure the problems with housing including lack of physical and financial access and power imbalances between owners and tenants but that does not mean there shouldn’t be such a raise. Although, I agree with Irving that a failure to recognize those issues and also work to remedy them on the part of more privileged trans people is deeply problematic.

Soshoux (2006), who is opposed to GID in the DSM, asserts that if medical benefits are lost: “Good riddance. What we'll get instead is so much better and will fill whatever void is left by the passing of a moribund theory that no one will notice anyway” (p. 6). Similarly, James (2004) argues that most transgender people do not access medical supports in transitioning and “Subsidized healthcare is not a fair trade for human dignity” (n.p.). She goes on to argue:

There are some trans people, especially older trans people, who argue that disease models validate their identities and allow treatment. They want GID to stay because they fear trans health services will become less available. Some also wish GID to remain because they consider themselves disabled because of GID and
collect government benefits based on this alleged disability. Their self-interests should not affect the scientific debate at hand. (n.p.)

Indeed, there is an anti-welfare/anti-poor sentiment in comments like James’. This sentiment is also present in on-line responses to the inquiries of someone about their ability to access disability social assistance with a GID diagnosis. One person replied: “GID is not a disability. Get a fucking job, you bum!” a comment which was supported by several discussion participants (Need info..., 2013, n.p.). While another responded: “I think most of these bums need to get off their asses and get a f$%^in job” (n.p.).

Some trans people opposed to the conceptualization of trans as a disability and its inclusion in the DSM, however, do sincerely deal with class issues. Stryker (2008) argues that the exclusion of insurance coverage for sex reassignment brings up “important questions about the U.S. healthcare industry more generally” (p. 15). Winters (2011) calls for changes to the GID diagnosis, in part because “[i]n the US, access to surgical transition care is most often limited to the most financially privileged” and others should have access to it (n.p.). Spade (2011) also discusses the unavailability of healthcare for poor and working class people.

**Physical, Not Mental**

A number of trans authors and activists argue that, rather than being classified as a mental disorder, trans (or certain trans) statuses should be considered physical disorders. This argument is significant as it attempts to reconcile the need for medical care, specifically public or private insurance coverage for transitioning expenses, while seeking to avoid the stigma of classification of mental disorders. Nicholas Teich (2012),
for instance, argues that trans is “a medical, not a mental, issue” (p. 93). He articulates this distinction because he notes the need for medical care while wanting to avoid the stigma of mental disorders. He argues that medical doctors (i.e. endocrinologists) should care for trans people rather than mental health workers professionals.\footnote{This argument is semantically problematic as Psychiatrists are medical doctors and consider the DSM “a medical classification of disorders” (APA, 2013, p. 10).}

Julia Serano (2007) maintains that trans people can never achieve “true equality” (p. 160) while a diagnostic category for gender nonconformity remains in the DSM. She is, however, opposed to “completely demedicalizing transsexuality” (p. 160) in the absence of systems to ensure that trans people can access to medical transitioning regardless of class. Serano says the proposal to create a non-psychiatric medical diagnosis “makes sense, being that most transsexuals feel that our problem lies not with our minds, but with our bodies” (p. 160). She also supports a consumer choice model for sex reassignment.

Numerous other trans people have publicly supported a categorical shift from a mental to a physical condition. Michaela Lamb (2004) maintains that trans is a physical issue but advocates for GID to remain in the DSM until that is scientifically proven. Claudine Griggs (1999/1998) asserts that “Transsexuals feel that they were born with a physical disorder that they have no power to eliminate psychologically” (p. 31). Similarly, Gapka and Raj (2003) categorized GD/GID as a physical health issue and indicated their political disagreement with the classification of GID as a mental disorder by inserting “[sic]” after the term “gender identity disorder” (p. 8). Evin Taylor (2010)
also implies that trans is a physical rather than mental health issue, asking rhetorically: How many mental illnesses can be put into total remission through medical surgeries?” (p. 270). C. Jacob Hale, a well-known trans author also supports the reconceptualization of trans as a physical diagnosis (J. Butler, 2006). Eli Clare (Clare, 2007; 2010) has also observed a number of trans people referring to themselves to be physically rather than psychologically disabled, even as having a ‘birth defect.’

**Through a Radical Disability Lens**

From a radical disability perspective, the opposition put forward by trans people to understanding trans as a disability is quite problematic. There are four key tenets of the radical model: "the necessity of recognizing and relating to [interlocking oppression], that disability is a social construction, that the disability label is imposed as a tactic to retain power and social control and that we have to create space for each other both in terms of acknowledging our lived experiences and ensuring accessibility" (Withers, 2012, p. 119). Using this model as a lens, I will critique the common themes amongst trans people who fully reject the notion that trans is not or should not be considered a disability (disorder).

Firstly, it is commonplace to erase otherwise-disabled trans people through trans discussions about disability. Statements like "transsexuals are not disabled individuals” (Would you say..., n.d., n.p.) or trans author’s statement that trans people argue "they are not disabled" (Nanji, 2012, n.p.) construct trans people as necessarily not disabled. The “We Are Trans* Not Sick!” petition to the World Health Organization and the thousands of people who have signed it (Zachs, n.d., n.p.) also construct sick people, people with other diagnoses, as necessarily not. Petition author, Max Zacks told the *Huffington Post*
“[t]he whole point is we are perfectly healthy, there is nothing wrong with us, and we don’t need to be treated like nutters or pitied as physically afflicted” (Morse, 2012, n.p.). Similarly, James (2012) argues that one way to spot a fake trans person online is if they say they are disabled. Here, again, psychiatrized and physically disabled people are excluded from the category of trans. These attitudes erase otherwise-disabled trans people and the interlocutory nature of oppression.

Some trans people who are against GID in the DSM do however acknowledge the existence of otherwise-disabled trans people. Irving (2005) states “Gender variance is not an illness... Nevertheless, when making these arguments one must be aware of the consequences they have on trans people who do have a mental illness” (p. 339). Irving is also critical about how “not a lot of consideration is given to how disability intersects with trans identities” (p. 350) in this debate. However, he uses problematic language to describe psychiatrized people, saying they are “suffering” (p. 339) which imposes a universal and negative view of psychiatrized people’s experiences and he rarely talks about disabled people substantively.

Conversely, Tones Smith (2011), who also claims to use an interlocking analysis, engages with disability meaningfully, extensively and consistently in his Master of Social Work thesis Pathology, Bias and Queer Diagnoses: A Crip Queer Consciousness. Smith provides a comprehensive account of the ways that psychiatry has used psychiatric diagnoses to subordinate women, people of colour, queers and trans people. Inexplicably, however, he only extends his demand to “stop the unethical practice of including diagnosis based on perceived cultural norms and values” (p. 125) to trans people, calling
for trans diagnoses to be delisted as mental disorders. He argues that “[t]rans people are not impaired in their functioning” (p. 73), implying that otherwise-disabled people are. Smith argues that “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” (p. 126). However, he fails to apply this to his own politics around the DSM, focusing on trans diagnoses and abandoning everyone else (including many trans people).

An interlocking analysis also requires a reflexive understanding of who is benefitted by certain political positions. In this case, those individuals with class privilege will not be harmed by sex reassignment surgeries being made less financially accessible but poor and working class people are harmed by this position, especially in jurisdictions with publicly funded SRS. The almost complete absence of discussion about financial accessibility to SRS by people against understanding trans as a disability when it exists is deeply problematic. Some of the discourse employed by these trans critics is openly classist, particularly towards people on social assistance. Others suggest that the cost of accepting disability or a mental illness label is not worth the reward of saving the price of sex reassignment. That is not a decision that everyone has the privilege to make. Soshoux (2006), for instance, says "Good riddance" (p. 6) to publicly funded sex reassignment. Soshoux is a lawyer and it would be easy for her to fund a transition but that is not the case for many trans people.

Race is also largely erased in this debate. Applying an interlocking analysis to these trans responses also means recognizing that racialized people are disproportionately poor
(Raphael, 2007) and that this likely means that racialized trans people are more likely to be poor than white trans people. Racialized people are also more likely to be disabled. They also experience the medical industrial complex differently, and much more negatively than white people do (Browne & Fiske, 2001; Browne, 2005; Nestel, 2012). Critiques of the construction of trans as a disability that are classist and/or disablist are more likely to have detrimental implications for people of colour.

I also want to draw attention to another of Debra Soshoux’s (2006) comments. She refers to accepting a mental illness label as accepting a “slave ideology” (Soshoux, 2006, p. 6). She does this making an analogy with the Israelites escaping Egypt. This comparison is profoundly problematic as it equates actual enslavement with identity constraint. It is anti-Semitic and racist and diminishes the violent and genocidal consequences of slavery which have profound continuing legacies in racialized communities. Similarly, in her argument against the categorization of trans as a mental disorder, Joelle Ruby Ryan (2009) calls trans people “a colonized people” (p. 3). The use of colonization as a metaphor, when talking about people categorized as disabled, is deeply problematic as it equates two very different experiences (Sherry, 2007). Equating being trans with being enslaved or colonized erases the experiences of Indigenous and racialized trans people who continue to be impacted by these systems. It also works to exalt white trans people in North America, erasing their continued benefit from the

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12 In Canada, racial data is rarely collected with relation to disability. However, rates of disability are known to be disproportionately high amongst Indigenous people and poor people (who are disproportionately people of colour) (Stienstra, 2002).
exploitation, enslavement, colonialism and genocide of Indigenous and racialized people and their responsibility to work for justice in solidarity with these groups.

While the position that trans is a physical disorder or disability rather than a mental one addresses some of the class issues around transitioning, it remains problematic, even oppressive. Like the rejection of disability generally, the rejection of mental disability seeks to bypass stigma rather than diminish or eliminate it. Consequently, otherwise-psychiatrized trans people are both rendered invisible and abandoned to stigma by the rest of the trans community. Those who advocate the reclassification of trans as a physical rather than mental issue are essentially saying that the stigma and oppression experienced by psychiatrized people is warranted and/or acceptable but it is inappropriate to subject trans people who are not otherwise psychiatrized to this stigma and oppression.\(^\text{13}\)

This issue is particularly significant because trans people are much more likely to be classified as having a mental disorder in addition to their trans diagnosis than cis people (APA, 2013a; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005; Lawrence, 2008; Rotondi et al., 2011; Zucker & Cohen-Kettenis, 2008). Whatever the reason for the higher incidents of psychiatric diagnoses in trans people (oppressive views of psychiatrists, increased scrutiny through the medical gaze, reactions to oppression, etc.) psychiatrized people are more prevalent in trans communities than in the general population.\(^\text{13}\) Gapka and Raj (2003) while they stress that trans is a physical health rather than mental health issue, do discuss a number of mental health issues among trans people.
population yet many trans activists and authors actively work to marginalize and stigmatize otherwise-psychiatrized trans people.

Another key component of a radical disability lens entails understanding disability as a social construction (Withers, 2012). Spade's (2003) suggestion, an “immediate error and danger of the medical model of transsexuality is its separation of gender from cultural forces” (p. 25), erases the fact that medicine and disability are created through cultural forces. Many trans people who oppose understanding trans as a disability work to reinforce the idea that disability is a phenomenon that is inherent to the individual that operates independently of social forces. This reification can work to bolster the oppression of disabled people (including disabled trans people).

When trans people only organize to delist GD from the DSM what are they saying about the remaining diagnoses? There are a number of psychiatric conditions that specifically target women in the DSM 5. These include histrionic personality disorder which has been critiqued by feminists for pathologizing women’s behavior (Worell & Remer, 2003). People with this diagnosis, according to the APA (2013a) “often act out a role (e.g., “victim” or “princess”)” and are considered to have “pervasive and excessive emotionality” (p. 668). Similarly, premenstrual dysphoric disorder has been argued to potentially apply to all women who menstruate (Caplan, 1995) and, I would add, many genderqueers and trans men. It lists a number of physical symptoms that, Caplan (1995) argues “are extremely common not only among women just before their menstrual periods begin but among women and men at any time. These include bloating, changes in appetite, and sleep disturbances” (p. 79). Borderline personality disorder is another
diagnosis that could be (trans)gendered. Its diagnostic criteria include “identity disturbance,” “intense anger,” suicidal or mutilating behaviour, impulsiveness (sex, drugs, food, spending, etc), instability because of mood, and feeling empty among other things. Similarly, women are the vast majority of those diagnosed with borderline personality disorder (75%) (APA, 2013a). It also encompasses many of the experiences of trans people (Bauer et al., 2012; Gapka & Raj, 2003). Surely, a trans critique of the pathologization of gender variance would include some, if not all of these diagnoses would it not?

Picking and choosing diagnoses, however, fails to look at the big picture. Paula Caplan (1995) argues “[e]very category of mental disorder in the DSM is a construct, just as much as ‘normality’ and ‘mental disorder’ are constructs. (p. 56). She reports that these determinations “about who is normal begin with at most a few dozen people – mostly male, mostly white, mostly wealthy, mostly American psychiatrists” (p. 31).

Critiques of the pathologization of abnormally can also be applied to physical disabilities like obesity and idiopathic short stature and dwarfism (Withers, 2012). While some physical diagnoses can be painful or harmful and present in the body, this does not mean that they are not also socially constructed. Poverty leads to a significant number of health disparities (Raphael, 2007). War leads to a great deal of disablement, particularly of racialized people in the Global South. The chronic pain disease fibromyalgia is linked to surviving trauma and violence (Cohen et al., 2002; Walker et al., 1997). Even things like cancer cannot be said not to be socially constructed. I got kidney cancer at 24 years old. Was this related to growing up near a gas plant or pesticides on my food or was it
simply a genetic anomaly? There is a clear link between residence near certain kinds of industries and cancer and other serious health conditions which is deeply social and firmly interlocked with race and class (Ash et al., 2009; Dhillon & Young, 2010).

When trans people and allies argue that only the trans sections of the DSM are social constructions or judgments, they reinforce the idea that other psychiatric and physical diagnoses are neutral biological realities.

According to the radical model of disability, disability is an identity that is imposed on people as a tool for social control. Of particular relevance to this principle are the arguments revolving around trans people not wanting the stigma of disability. This desire is irrelevant. Trans people are already constructed as disabled and already have that stigma. Wanting not to be considered part of a subordinated group does not make someone not be a part of a subordinated group (Withers, 2012).

This argument also applies to those trans people who say that considering trans a disability is offensive. There is, however, more going on with respect to these claims. These people are saying something significant about disability when it is assumed to be common knowledge or not in need of explanation that being classified as disabled is offensive. They are taking for granted that everyone knows that being disabled is bad, is negative and they negate all other possible experiences of disability.

A number of trans authors have critiqued the pathologization of gender variance without critiquing systems of pathologization generally. There is a long history of pathologization and the construction of certain kinds of people as disabled being used for social control (Baynton, 2001; Ehrenreich & English, 1973; T. Smith, 2011; Withers,
As I have previously argued (Withers, 2012), when Winters (2005) writes: “Difference is not a disease, nonconformity is not a pathology, and uniqueness is not an illness” (n.p.) I fully agree with her. My concern, however, is that she applies this to trans people and not to other people who have been pathologized. Indeed, enforcing normality onto people and punishing those who are deemed abnormal is incredibly problematic. This applies to all human variance, not only gender variance. It also begs to question if, when trans people point to trans as a “natural human variation” (Dickey et al., 2009, n.p.) they are suggesting that disability is not natural and/or if they are questioning the humanity of disabled people.

The last piece of a radical disability lens is about creating space for all of us, developing radical accessibility. This involves both ensuring that there is room to talk about the struggles people have with their identities, bodies and minds and that master narratives do not preclude other trans narratives. It also involves building space for more than the most privileged trans people and ensuring that the experiences of racialized people, otherwise-disabled people, poor and working class people, migrants, women, queer people and youth and older people are honoured.

Radical accessibility involves thinking about inclusivity in a number of ways, including how language can work to exclude, marginalize and oppress people (Withers, 2012). Suggesting that people who could be diagnosed with a condition in the DSM makes them "mentally deficient" (Winters & GID Reform Advocates, 2010) or without “human dignity” (James, 2004, n.p.) or calling a disabled person seeking social assistance a “bum” (Need info...., 2013, n.p.) creates a vacuum that sucks out space for disabled
people within trans organizing and trans communities. Gesler (1999) asserts that “language helps environment to emerge” (p. 14). Using language about disability that demeans disabled people makes spaces inaccessible to many trans people as well as disabled people generally. Similarly, using language that is sexist, homophobic, classist, racist and/or ageist works to exclude many trans people.

**Continued Classification/Trans is a Mental Disability**

While it appears that the rejection of the classification of trans as a disability is the dominant paradigm within trans communities, there are a number of trans activists who have called for, at a minimum, the continued classification of GID/GD in the DSM. Prominent author Kate Bornstein (1995) asserts: “[t]he desire to be free from the stigma of having been diagnosed with a mental disorder is understandable” but she is concerned about retaining medical grounds to conduct sex reassignment (p. 268). Bornstein is highly critical of those trans activists who call for the removal of GID (now GD) from the DSM, saying “[t]his may be one instance in which transactivists have taken their ideology to the point of logical absurdity and left the majority of their own community in the lurch” (p. 268).

Similarly, Miqqi Gilbert (2008) calls gender dysphoria a “legitimate psychological malady” and a “mental illness” (p. 7). Gilbert supports the classification of GID/GD as a mental disorder and want to see all provinces that cover surgeries to continue to cover them. Another well-known trans author, Jay Prosser (1998) argues that “the current campaign to remove gender identity disorder entirely from DSM does not consider that, for some, transsexuals, gender identity disorder may be experienced
precisely as a disorder, a physically embodied dis-ease or dys-phoria” (p. 203).

Nick Gorton is a trans doctor who advocates for a (reformed) version of GID to remain in the DSM. He argues that GID is a disease for which “the true treatment of transgenderism/GID is not necessarily in changing transgender individuals beyond their chosen medical/surgical interventions, but rather in changing society” (Gorton, n.d., n.p.). Further, Gorton asserts: “when talking about the stigma and negative consequences for people with disabilities we must refrain from using language that itself perpetuates the stigma for the broader community of people with illness and disabilities” (Ehrbar et al., 2010, p. 3-4). At a minimum, for Gorton, we need to not reinforce disablism while trying to better the lives of non-otherwise-disabled trans people.

Randall Ehrbar is a trans psychologist. He is also one of the authors of the WPATH Standards of Care (Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... & Zucker, K., 2012). He reports that there is “[a]n argument made by some advocates for retention of a diagnosis is that efforts to eliminate the diagnosis are reflective of ableist assumptions about mental disorders” (Ehrbar, 2010, p. 67). He argues that “[w]hile it is true that there is a stigma associated with being diagnosed with a mental disorder, this stigma in and of itself does not justify the removal

\[14\] For this opinion, Gorton and those who support the position that trans is a disability are accused of “play[ing] right into the hands of Zucker and others who can seize Gorton’s membership in the trans community to try to legitimize their projects of transphobic oppression” (Ryan, 2009, p. 41 n24).
of the diagnosis. The additional question of whether being diagnosed serves the people so diagnosed also needs to be asked” (Ehrbar, 2010, p. 67).

Most of those trans people who support the continued classification of (certain) trans identities as mentally disordered do so out of concerns for access to healthcare rather than disability solidarity, specifically, the ability for poor and working class people to afford surgeries should GID/GD be delisted from the DSM. These issues manifest quite differently in Canada and the United States as there is national health care insurance in Canada. In Canada the argument is often made that middle-class people can afford to access surgeries while poor and working class people have to rely on the public insurance program (Namaste, 2000).¹⁵ In the United States, some trans people make the argument that the continued pathologization of GID/GD is a middle-class issue for those who have access to good private insurance (Ehrbar, 2010; Namaste, 2000). Others, however, argue that the delisting of GID/GD would be detrimental to poor people in the United States (Lamb, 2004).

Namaste (2000) critiques the argument that GID/GD should be delisted from the DSM as a position that emphasizes a consumerist approach to healthcare. She maintains: “This position does not concentrate on issues of healthcare. Classifying SRS as a cosmetic procedure would not challenge the institutional relations that determine how

¹⁵ Irving (2005), however, argues that the demand for continued classification of GID/GD in the DSM in order to permit surgeries is a middle class one. He does not explain why he suggests this but it may be because his thesis was authored during a time period when SRS as not publicly funded in Ontario.
transsexuals experience health care” (p. 232). Some trans people also emphasize the importance of keeping GID/GD in the DSM to highly marginalized people, including sex workers and incarcerated/institutionalized people (Lamb, 2004; Namaste, 2000).

A small number of non-otherwise-disabled trans people even openly embrace the label of disability. One trans person maintains that “Being Trans is not a disability, although needing to transition is” (as quoted in Gapka & Raj, 2003, p. 48). Further, Margaret Deirdre O’Hartigan is renowned for her vocal support of the construction of trans as a disability. She argues that “[p]eople's middle-class sensibilities are offended by having the label 'disordered' placed on them.” She continues: "it's not having a disorder that is stigmatizing. It's people's prejudice” (as quoted in Gallagher, 1996, p. 51). O’Hartigan recalls: “we insisted that the state civil rights agency enforce existing law prohibiting discrimination on the basis of disability” (O'Hartigan, 1999, n.p.). “Rather than condemning such a stigmatization… GID opponents reinforce it by attacking the diagnosis rather than the prejudice” she argues (as quoted in Scott-Dixon, 2006, p. 201 n10).

Trans lawyer Jennifer Levi, with cis lawyer Bennett Klein (2006) argue “[s]tigma is not a principled reason to avoid using the law for protection. The answer to this objection is to address the stigma, not to enhance it by avoiding the law” (p. 82). They argue that the argument made by trans people that disability is somehow not a social construction “is tenuous at best” (p. 82). They embrace the use of disability as grounds for, among other things, human rights claims. These not otherwise-disabled people who support the medical model of (certain) trans generally do so out of interest in access for the trans
community – access to sex reassignment or legal rights.

Much of the trans discourse about the disablement of trans as problematic, disablist and, occasionally, hateful. Nevertheless, some non-otherwise-disabled people demonstrate important examples of engaging in trans rights and/or liberation struggles in solidarity with (other) disabled people. Indeed, Nick Gorton’s call not to stigmatize or “tacitly approve of the stigmatization of those other communities by others” (in Ehrbar et al., 2010, p. 3) is, in my opinion, both promising and essential.

**Responses by Otherwise-Disabled Trans People**

There are almost no written discussions about the construction of trans as a disability by otherwise-disabled trans people. Indeed, I could only find a few brief discussions on the topic, one of which was my own. This is both a problematic erasure and an unfortunate loss. I have argued elsewhere that disabled people have useful and important knowledges because of their experiences with disability can offer (Withers, 2012). The erasure of otherwise-disabled trans people from this conversation precludes our important experiential knowledge of trans and disability.

The first otherwise-disabled trans person’s response does not engage the issue from a disability perspective, it seems to have just happened to be written by someone who identifies as disabled and trans. Patrick Califia. Califia (1997; 2003) is also critical of the inclusion of gender identity disorder in the DSM in his book *Sex Changes*. He asserts that “transactivists have long deplored the notion of transsexuality as a mental disorder” (Califia, 2003, p. xxxv). Califia (1997/2003) maintains that the pathologization of GID is damaging and stigmatizing.
At the same time, he calls for the expenses of SRS to be publicly funded for poor and disabled people. However, while disabled, he largely ignores the issue of disability in both editions of this text. At one point, Califia (1997; 2003) proclaims “Transgendered men are not content to seek pity or the sort of charitable assistance one would render a disabled person. They want allies and partners who find them attractive, as they are, who will validate their male identities” (p. 209). Here, then, he casts disabled people as separate and distinct from trans men, as unattractive, pitiful and content with charity. This is particularly unfortunate as Califia is disabled and gives workshops on sex and disability (Allison, 2009; Califia, 2006/2001). Califia’s contemporary approach to sex and disability, he says, is not “objectifying and condescending” (quoted in Allison, 2009, n.p.). There is a substantial incongruence between these two statements.

Similarly, a trans person named Eileen (Need info..., 2013, n.p.) posted on The Transgender Gender Boards that, like many non-otherwise-disabled people, she too does not think that that trans is a disability. She argues:

I hope financial challenges with this can be solved without it being classified as something that stigmatizes people. I would hope the answer lies in broader global acceptance and recognizing that it is a type of physical impairment that needs correcting and that insurance needs to allow for coverage. (n.p.)

She particularly expresses concern about the institutionalization of people because they’re trans.

Another account is by otherwise-disabled trans person who uses the pen name Static Nonsense (SN) (2010). This author, posting to the popular Questioning
Transphobia blog, reported withdrawing from the trans community when they began identifying as mentally disabled and, particularly, when they began telling people about it. For them, “my disabilities are a major factor in why I identify as trans” (n.p.). SN argues that “Transgenderism isn’t a disorder and shouldn’t be treated as such in society – it’s an identity” (n.p.). However, they also argue that trans people’s rejection of the ‘crazy’ or ‘disability’ label leads to “a whole mess of problems a la ableism, psychophobia and a combination of misunderstanding and misinformation” (n.p.).

SN argues that this reaction “isolates trans people with mental illness” and argues it is problematic to assert that when one gender identifies in a particular way that is not a “true and appropriate identity” if it is the result of a “mental illness” (n.p.). SN asks: “Why exactly is an identity shaped without the influence of mental illness more valid than one that is influenced by them?” (n.p.).

In an audio track posted to YouTube, one disabled trans person discusses how they relate to their body and privilege (Riley, 2012). Being disabled and having been through a number of surgeries, they believe:

is one of the reasons why I have no physical dysphoria. I will always look like trash regardless of gender. We as disabled people don’t start privileged. Being trans is not a huge leap for us. The able-bodied person is privileged and so being trans will hit them harder. (n.p.)

This person, although they have an unfavourable view of their own body, articulates an experience in which disability has made being trans easier. Here, disability is not wholly negative; rather, it has brought important insight and experience to being trans. The
discussions around the construction of trans as a disability by SN and Riley are much more nuanced than the bulk of the discourse on this issue by non-otherwise-disabled people.

Syrus Marcus Ware (Ejiogu & Ware, 2008) writes about his experiences as a trans person who is a psychiatric survivor. Ware describes a psychiatric system in which “race, sexuality, gender and class were interwoven to create a make-shift explanation of [his] ‘problem’” (p. 7). Ware, who is trans, and Ejiogu, who is cis, are critical of the system of medicalization of trans people and, because they address trans from an interlocking analysis, it cannot be separated from disability. In his Master’s thesis, Ware (2010) writes:

I am troubled by the disavowal of trans-as-disability present in much critique of the medicalization of transsexuality. This disavowal re-inscribes disability as bad or unwanted and risks further marginalizing trans people who identify as disabled, whether through the labeling of gender identity disorder or another disability altogether. (p. 22 n13)

Because Ware has an interlocking anti-oppression politic, he critiques attempts at liberation by (certain) trans people at the expense of otherwise-disabled people. In this short footnote, Ware (2010) addresses the importance of ensuring there is space for otherwise-disabled trans people and not perpetuating their marginalization.

Eli Clare, another disabled trans author, is deeply critical of those people who claim the label of ‘birth defect’ both because of the offensiveness of the word defect and why some trans people embrace it. Clare recounts how people claim this word “say, ‘I should
have easy access to good, respectful healthcare, just as other disabled people do”” (2010, p. 459). Clare replies to this assertion: “I could only wish disability assured decent health care. Instead disabled people deal with doctors who trivialize and patronize us, who believe some of the worst ableist stereotypes, and sometimes even think we’d be better off dead” (2007, n.p).

Clare is also deeply critical of the calls of those trans people who identify as physically disabled or having a ‘birth defect’ for a cure, like disability:

disability equaling the need for cure—is drenched in some of the very stereotypes that disabled people struggle against every day. It takes for granted that disability is an individual medical problem curable, or at least treatable, by doctors. It runs counter to the work of disability rights activists who frame disability as an issue of social justice, not of medical condition (2007, n.p.).

Clare argues this position is not only problematic for otherwise-disabled trans people, but also all trans people because it “leaves us as trans people wide open to shame” (2010, p. 459-460).

At the same time, Clare asserts: “I respect the people who frame their trans-ness” as a disability (2010, p. 459). Further, while Clare also argues that “trans-ness not as pathology but as human variation” (2010, p. 463), he does so as someone who is deeply critical of the medical model and pathological views of disability generally (see: Clare, 1999).

Clare also raises an important point about the articulation of trans people being imprisoned in the ‘wrong body.’ This concept was popularized by Doctor Harry
Benjamin (1966) who wrote about transsexuals as people who “feel that their minds and their souls are ‘trapped’ in the wrong bodies” (p. 9). The depiction of trans bodies as wrong bodies has become the primary cultural understanding of the trans experience (Bailey & Triea, 2007). Wrong body discourse remains dominant in the understanding of trans experiences (Bailey & Triea, 2007; Gamson, 1998; Irving, 2005; Spade, 2006a; Stryker, 2008).

Many trans people promote the understanding that (certain) trans people are ‘trapped in the wrong body.’ For instance, trans author Jay Prosser (1998) writes: “being trapped in the wrong body is simply what transsexuality feels like.” Prosser acknowledges that “the standardization [of trans narratives] renders some stories unintelligible, delimiting transsexual subjectivity, censoring the number of possible legitimate transsexual tales” (p. 107).

Clare (2010), however, asks “what leads us to the belief that our bodies are defective in the first place?” (p. 460-461). When offered imaginary cures for his disability, Clare refuses, saying “I simply don't know my body any other way” (p. 459). Wrong body discourse is also alluded to by Riley (2012) who says “I have no physical dysphoria” (n.p.).

I am also one of those people who Prosser might call an unintelligible trans person. My narrative is not one of being trapped in the wrong body and this narrative exists, at least in part, because I am disabled. I use hormones. I have had top surgery. I sometimes use a cane, wrist braces, painkillers. These are all technologies that I use to help me get by in a world that is hostile to people like me and to help me be more comfortable in my
body. I have been diagnosed with gender identity disorder (as transsexual). However, if a wrong body narrative is inherent to transsexuality, I cannot be transsexual, I cannot have GID. I am impossible. Alternatively, the erasure of otherwise-disabled trans people has also erased important understandings – understandings that don’t only tell us something about each of us, but about what trans can be.¹⁶

As I have shown, the construction of trans as a disorder/disability is widely discussed within the trans community. However, otherwise-disabled trans people are almost entirely excluded from this discussion. This is not only problematic because it is indicative of the marginalization of a particular community within the trans community but also because we know a great deal about the intersection of trans and disability and that knowledge is erased from this discussion. Certainly, when I write about disability, I do not assume that it is wholly negative as my own experiences of disability have taught me otherwise. However, rooted in nearly every position by a not otherwise-disabled trans person is the supposition that disability is negative and should be avoided.

While otherwise-disabled trans people do not all agree about the construction of trans as a disability, there is a great deal of nuance and insight that is added to this debate through otherwise-disabled trans people’s engagement with the topic. For us, disability is a part of who we are. We exist and we should have a meaningful place in the trans community and, particularly, this debate.

¹⁶ This is not to suggest that otherwise-disabled people’s bodies are the only sites where wrong body discourse does not make sense.
Conclusion: Solidarity and Social Change

Non-otherwise-disabled and otherwise-disabled trans people alike fall across the spectrum in accepting or rejecting the construction of trans as a disability. The vast majority of non-otherwise-disabled trans texts that I analyzed, however, are adamant that trans is not a disability. These texts frequently employ problematic stereotypes about disabled people, including implications that no disabled people are trans and they often work to reinforce the oppression of disabled people.

otherwise-disabled trans people’s opinions are rarely present in this debate which is not only exclusionary but also leads to the loss of important perspectives about trans, disability and trans as a disability. Eliciting the perspectives of otherwise-disabled trans people about the construction of trans as a disability, their experiences within the trans community given the importance of this debate and their ideas about building solidarity between disability and trans movements is an important area for future research. Without having a richer understanding of the experiences of otherwise-disabled trans people, inclusion of this population within the broader trans and disability movements cannot be meaningful.

Seeking justice for trans people that is founded on the oppression of disabled people will not lead to justice for all trans people, especially because so many trans people are otherwise disabled. Dan Irving (2005) discusses what he calls a politics of “scarcity of liberation” (p. 309). He argues “[s]ince the state has made drastic cuts to social programs and clawed back many gains won through popular struggles, many activists believe that gains for one oppressed group will be won at the expense of
another” (p. 235). This scarcity mentality leads to competition between groups rather than a united front.

A scarcity mentality is at play when trans activists accept the premise that fighting the stigmatization of all psychiatrized people “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” (Sennott, 2010, p. 99). For cis ‘ally’ Sennott and trans author Smith (2011) who presumably accepts this argument, disability justice appears to not only be counter to trans justice but also to feminism. However, as many disabled feminists have argued (see: Garland-Thompson, 2005; C. Green, 1995; Morris, 1991; Wendell, 1997; Withers, 2009; Withers, 2012), feminism must engage with disability and vice versa.

Some trans activists argue that trans people cannot access equality or social change if they are classified as disabled (findlay et al., 1996; Wilchins, 1997). Trans people, at least some trans people, will always be classified as disabled – at least as long as the power to pathologize deviance and abnormally exists. If they believe that disabled people can never win justice or equality they are simply demonstrating their own ignorance about disability and the victories that disability organizing have already accomplished (see: Barnartt, 2008; Fleischer & Zames, 2001; Longmore, 2003; Lord, 2010; Shapiro, 1993; Vanhala, 2011). While we disabled people have a long way to go, there is no evidence to suggest that social justice is not possible for disabled people – for everyone.

Rather than employ scarcity of liberation politics, trans people could be more
effective engaging in a unity politic. This would involve, at a minimum, trans people asking what they are saying about other marginalized groups when they talk about trans issues and if such a position strengthens solidarity or is divisive and/or marginalizing in and of itself. Gorton argues:

As a social justice movement it is imperative that we do not, in seeking to remove stigma from our community, either overtly stigmatize other communities ourselves or tacitly approve of the stigmatization of those other communities by others…. the very discrimination that we believe may be erroneously be applied to the transgender community. (in Ehrbar, Winters & Gorton, 2010, p. 3-4)

This is a minimum standard. I believe, though, that we can do better. Acknowledging that struggles are interlocked and working towards social justice for everyone is an achievable possibility. So, too, is winning.

Susan Stryker (Stryker, 1994) says: “I live daily with the consequences of medicine’s definition of my identity as an emotional disorder. Through the filter of this official pathologization, the sounds that come out of my mouth can be summarily dismissed as the confused ranting of a diseased mind” (p. 244). What if that weren’t true for anyone? What would happen if all trans people and disabled people came together to demand that people be respected regardless of their pathologization? What would happen if everyone received respectful, accessible, free medical care that did not rely on individualistic and problematic ideas about normalcy and deviancy – medical care without the medical model? What would people’s lives be like if interdependency was both recognized and celebrated and accessibility was viewed as a necessary starting
point? These are just a few questions that looking out from the intersection of trans and disability bring forward. I, for one, cannot wait to find the answers.
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Appendix A: List of Acronyms Used

APA – American Psychiatric Association

DSM – *Diagnostic and Statistical Manual of Mental Disorders*

GD – gender dysphoria

GID – gender identity disorder

GIDC – gender identity disorder of childhood

GIDNOS – gender identity disorder not otherwise specified
Appendix B: Transvestism/Transvestic Fetishism/Transvestic Disorder

Criteria:
- A period of at least 6 months in a heterosexual feminine cross-dresser
- Transvestism
- Transvestic Fetishism
- Transvestic Disorder
- Personality Disorders
- Sexual Disorders
- Psychosocial Disorders
- Non-Probabilistic Mental Disorders
- Certain Other Disorders
Appendix D: Transsexualism/GID/Gender Dysphoria (Adolescents or Adults)

1987

Disorders

1980

Disorders

1972-1986

Disorders

1994

Disorders

2000

Disorders

- Gender Identity Disorder
  - Transsexualism
  - Gender Dysphoria
  - Sexual Dysphoria
Appendix E: Unspecified/Non-Transsexual/NOS
Appendix G: Table of Human Rights Legislation


Appendix H Grounds of Human Rights Cases Brought Forward by Trans People

<table>
<thead>
<tr>
<th>Grounds of Discrimination</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability and Sex</td>
<td>8</td>
</tr>
<tr>
<td>Sex</td>
<td>17</td>
</tr>
<tr>
<td>Sex and Sexual Orientation</td>
<td>4</td>
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<tr>
<td>Sexual Orientation</td>
<td>2</td>
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<tr>
<td>Disability</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
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### Appendix I: Table of Human Rights Cases

<table>
<thead>
<tr>
<th>Case</th>
<th>Grounds</th>
<th>Issue</th>
<th>Trans = disability?</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. v. B.C. (Ministry of Health), 2012 BCHRT 47</td>
<td>sex</td>
<td>access to healthcare (SRS)</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Canada (Attorney General) v. Canada (Canadian Human Rights Commission), [2003] F.C.J. No. 117 (appeal of Kavanagh v. Canada (Attorney General))</strong></td>
<td>disability, sex</td>
<td>access to women's prison, access to SRS</td>
<td>yes</td>
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<tr>
<td>Dawson v. Atira Women's Resource Society, 2012 BCHRT 166</td>
<td>sex, sexual orientation</td>
<td>housing</td>
<td>n/a</td>
</tr>
<tr>
<td>Dawson v. Khan, 2012 BCHRT 169</td>
<td>sex, sexual orientation</td>
<td>housing</td>
<td>n/a</td>
</tr>
<tr>
<td>Finan v. Cosmetic Surgicentre (Toronto), 2008 HRTO 47</td>
<td>sex</td>
<td>refusal of service</td>
<td>n/a</td>
</tr>
<tr>
<td>Forrester v. Peel (Regional Municipality) Police Services Board et al, 2006 HRTO 13</td>
<td>sex</td>
<td>ill treatment - police</td>
<td>n/a</td>
</tr>
<tr>
<td>Hartford v. Progress Place Rehabilitation Centre, 2009 HRTO 196</td>
<td>sex</td>
<td>refusal of service</td>
<td>n/a</td>
</tr>
<tr>
<td>Hogan v. Ontario (Minister of Health and Long-Term Care), 2006 HRTO 32</td>
<td>disability, sex</td>
<td>healthcare (financial coverage of SRS)</td>
<td>yes</td>
</tr>
<tr>
<td>Hosseini v. Interstyle Ceramic and Glass, 2009 BCHRT 55</td>
<td>sexual orientation</td>
<td>employment discrimination</td>
<td>n/a</td>
</tr>
<tr>
<td>K.M. v. Sunnybrook Health Sciences Centre, 2012 HRTO 1505</td>
<td>disability, sex (and new ground gender identity)</td>
<td>access to healthcare</td>
<td>n/a</td>
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<tr>
<td>Case</td>
<td>Issue(s)</td>
<td>Decision/Outcome</td>
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<tr>
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<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
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<tr>
<td>Kavanagh v. Canada (Attorney General), [2001] C.H.R.D. No. 21</td>
<td>(see Canada (Attorney General)...)</td>
<td>(see Canada (Attorney General)...) yes</td>
<td></td>
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<tr>
<td>Kelly v. Insurance Corp. of British Columbia, 2007 BCHRT 382</td>
<td>sex (and place of origin)</td>
<td>sex designation on identification n/a</td>
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<tr>
<td>LaLonde v. Toronto East General Hospital, 2012 HRTO 2153</td>
<td>unknown (original case settled, decision with respect to TEGH meeting conditions of settlement)</td>
<td>access to healthcare n/a</td>
<td></td>
</tr>
<tr>
<td>MacDonald v. Downtown Health Club for Women, 2009 HRTO 1043</td>
<td>sex</td>
<td>refusal of service possibly</td>
<td></td>
</tr>
<tr>
<td>Magnone v. British Columbia Ferry Services and others (No. 3), 2008 BCHRT 191</td>
<td>sex</td>
<td>employment discrimination, wrongful dismissal n/a</td>
<td></td>
</tr>
<tr>
<td>May v. Ontario (Health and Long Term Care), 2012 HRTO 733</td>
<td>unknown (ruling that Hogan applies to complainants)</td>
<td>access to healthcare (SRS) n/a</td>
<td></td>
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<tr>
<td>McIntosh v. Ontario (Minister of Government Services), [2010] O.H.R.T.D. No. 2359</td>
<td>disability, sex</td>
<td>sex designation on identification n/a</td>
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</tr>
<tr>
<td>Montreuil v. Canada (Canadian Forces), 2009 CHRT 28</td>
<td>disability, sex</td>
<td>employment discrimination, wrongful dismissal yes</td>
<td></td>
</tr>
<tr>
<td>Case Study</td>
<td>Relevant Issues</td>
<td>Outcome</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>----------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Sautereau-Fife v. Canada Safeway, 2011 BCHRT 274</td>
<td>sex, sexual orientation</td>
<td>employment discrimination, wrongful dismissal</td>
<td>n/a</td>
</tr>
<tr>
<td>Schleppe v. The Paparazzi Club and others, 2009 BCHRT 146</td>
<td>sex</td>
<td>employment discrimination</td>
<td>n/a</td>
</tr>
<tr>
<td>Sheridan v. Sanctuary Investments Ltd. (c.o.b. B.J.’s Lounge), [1999] B.C.H.R.T.D. No. 43</td>
<td>disability, sex</td>
<td>access to washroom, ill treatment</td>
<td>yes</td>
</tr>
<tr>
<td>Silveira v. Ontario (Minister of Government Services), 2011 HRTD 249</td>
<td>unknown (interim decision)</td>
<td>sex designation on identification</td>
<td>yes</td>
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<tr>
<td>Skeffington v. Alberta (Human Rights and Citizenship Commission), 2006 ABQB 776</td>
<td>sex, sexual orientation</td>
<td>employment discrimination</td>
<td>n/a</td>
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<tr>
<td>Vancouver Rape Relief Society v. Nixon, 2005 BCCA 601</td>
<td>sex</td>
<td>employment discrimination (volunteer)</td>
<td>n/a</td>
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<tr>
<td>Vanderputten v. Seydaco Packaging Corp., 2012 HRTO 1977</td>
<td>sex</td>
<td>employment discrimination, wrongful dismissal</td>
<td>n/a</td>
</tr>
<tr>
<td>XY v. Ontario (Minister of Government and Consumer Services), 2012 HRTO 726</td>
<td>disability, sex</td>
<td>sex designation on identification</td>
<td>yes</td>
</tr>
</tbody>
</table>
Appendix J: Plain Language Summary

This paper is about the ways that trans people are viewed as disabled and how trans people respond to it. I am trans and disabled and I feel we are made invisible when trans people talk about how we are viewed as disabled. I wanted to look at ways of uniting trans people and disabled people to win social justice.

I am also white, queer and poor. Also, I am a grad student which means that I have access to a lot of things other people don’t have. I live in Canada which is built on stolen First Nation’s land. In Canada, lots of our money comes from taking advantage of poor people around the world. These things, plus being disabled and trans impact how I understand the world and this project.

Important Words:

a) **Trans**: Trans people are people who society says are one gender (men or women) who feel differently than that. I use the word trans to include transgender people, transsexual people and people who don’t choose between the two.

b) **Transsexual**: This group is made up of people who have or want to have surgery or take hormones to change their bodies from men to women or women to men.

c) **Transgender**: These are people who identify in a way that is different than the sex or gender they have been told they are. They can be people who don’t identify as men or women or people who go back and forth between the two. Some transsexuals call themselves transgender but some transsexuals find being called transgender hurtful.
d) **Cis**: This is a word that means the opposite of trans. Cis describes people who have gender identities that match their bodies and how society views their genders.

e) **Two-spirit**: Two-spirit is a First Nations word that includes people who are not straight and/or not cis. Two-spirit people also sometimes call themselves trans, transgender or transsexual but sometimes they don’t.

f) **Transvestite**: is a medical word that means people who cross-dress. Lots of people find this word out dated and hurtful and use cross-dresser instead.

g) **Genderqueer**: These are people who identify as something outer than men or women.

h) **Otherwise-disabled**: All trans people are seen as disabled. So, I use the word otherwise-disabled to talk about trans people who are seen as disabled in addition to being trans. Otherwise –disabled trans people includes trans people who have intellectual disabilities, physical disabilities and/or psychiatric disabilities.

**Radical Model of Disability and Interlocking Oppression**

Models are ways of understanding things. I wrote about what the radical model of disability is in my book *Disability Politics and Theory*. There are four key parts of this model.

1. Disability is a label that is put onto people. It is not about people’s bodies and minds being ‘different.’ Instead, it is about social values that get put on people who are thought of as abnormal. Disability is about society not biology.
2. People are called disabled for political reasons. We tend to make less money or we are seen as too needy. But if our society was set up in different ways, our experiences would be different.

3. Interlocking oppression. This phrase has two parts. The first part, interlocking, means that things can’t be separated – they are locked together. The second part, oppression, means when power is used over people. It includes discrimination, prejudice, unfairness and injustice. Oppression is done to groups of people like women, people of colour, disabled people, queer and trans people, and poor or working class people. Oppressions are interlocked, among other things, because there is cross-over between groups. For example, many women are people of colour. That means that there can’t be justice for women unless there is justice for people of colour and vice versa. All oppressed groups have to have justice for any one group to have it.

Using the term interlocking is a way of talking about how oppression is complicated. It is also used to go against the trend to separate different kinds of oppression based on individual groups rather than looking at they are linked.

4. When we talk about accessibility, we need to talk about it accessibility for lots of different kinds of people. This is called radical access. It is about more than ramps and elevators. It includes working to make sure that lots of different kinds of people are included. It includes things like making events free, having child care and not allowing people to discriminate against other people because of how they look, their background or identity.
Lots of the time, when trans people write about how trans gets viewed as a disability, the fact that many trans people are disabled gets overlooked. This erases otherwise-disabled people. Lots of other groups of people are often left out when trans people write about this issue. This paper is mostly made up of research from things that trans people have written, especially published things. That means that it is looking at the attitudes of those people who have space in the trans community to publically express their opinions rather than trans people in general.

**Methodology**

Methodology means the method that I used to reach my conclusions. To understand how trans gets viewed as a disability, I also looked at medical writing, including the American Psychiatric Association’s main book: *Diagnostic and Statistical Manual of Mental Disorders*. In order to understand how trans people get viewed as disabled legally, I looked at court decisions and human rights laws. Mostly, I focus on Canada, but there is a lot of cross-over with the United States. To understand what trans people think about this issue, I looked at what trans people wrote, mostly in books and magazines but also on websites.

**Medicine and How Trans is Viewed as a Disability**

The medical model is another way of understanding trans. It is the most common model of disability in Canada. This means that doctors have a lot of power over disabled and trans people’s lives. Trans was not always considered a medical issue. During the 1800s, doctors took interest in trans people and homosexuality, or queerness. In 1952 an
American woman had sex change surgery in Denmark. Her sex change became famous around the world. After that, doctors paid attention to trans people more. One of these doctors was Harry Benjamin who started writing a lot about trans people.

The American Psychiatric Association published its first *Diagnostic and Statistical Manual of Mental Disorders* in 1952. Most people call it the DSM for short. This book lists all of the conditions that psychiatrists call mental illnesses. Transvestism and homosexuality were both in this book. With these two conditions (most trans folks were thought of as a form of homosexual), trans people officially became mentally ill.

Some people think the DSM is bad. Psychiatric survivor activist Don Weitz (1988) says it is used to control people who are different or have different ways of understanding the world. It doesn’t matter if you like it or not lots of people use it. Since it first came out, there have been a number of new editions and changes to the DSM in 1952, 1968, 1980, 1987, 1994, 2000 and 2013.

Transvestism, or certain kinds of transvestism, have always been in the DSM. The names they call it, who qualifies and what is considered transvestism has changed though.

Homosexuality was in the DSM until 1973 when the writers of the book decided it wasn’t a mental disorder anymore. This decision was made after of years of protests against putting homosexuality in the DSM. Once homosexuality was removed, it was a mental disorder to be homosexual and really unhappy or distressed about it. You couldn’t be straight and have this mental disorder.

Also, 1980 was the first time that gender identity disorder (kids) and transsexualism
(adults) was put in the DSM. This was also the first edition of the DSM to come out after homosexuality was removed. Lots of people believed that there was a connection between removing homosexuality and inserting transsexuality. The American Psychiatric Association denied this. The definitions of gender identity disorder and transsexualism have changed over the years. The names have changed too. Now, it is called gender dysphoria. Dysphoria basically means extreme unhappiness. If people don’t meet all of the parts on the checklist for gender dysphoria, they can be diagnosed with gender dysphoria unspecified.

The DSM isn’t totally clear if gender dysphoria is thought of as a disability. The word disability is sometimes used differently depending on the edition of the DSM but is never clearly defined. Disability usually means impairment.

The term mental disorder also doesn’t have a full definition. This is the case even though it is the book of mental disorders. The trans conditions have to involve distress or impairment. That means that a lot of the time trans is thought of as a disability.

**Trans in the Law**

The law is important because it has a lot of impact because it controls legal rights and can sway society. Generally, because trans is a mental disorder in the DSM, trans people are considered disabled under human rights law. But, the only case that addresses rights for transvestites found that it isn’t a disability. There are some other kinds of law that might not view trans as a disability (like social assistance).

**Trans Responses**

Different trans people have different ideas about whether or not trans should be
thought about as a disability. The most common attitude that I found is that trans shouldn’t be thought about as a disability. Some people argue that sex changes hold up the wrongheaded idea that there are only two sexes, male and female, and they are separate. Likewise, some people argue that it works to hold up ideas of what are normal. They say that these ideas are oppressive. Some trans people say that trans is natural, not a disability or a disease.

A few protests have been organized against trans people being put in the DSM. And some trans people say we can never have justice if we are called disabled. Lots of trans people say disabled people are treated badly. This is why they think trans people shouldn’t be called disabled.

I looked at all of the human rights cases in Canada that were put forward by trans people. Only one quarter of those people said they were disabled. This shows that a lot of trans people don’t want to be thought of as disabled.

**Class, Income and Access**

Other trans people say that it is important to have trans considered a disability in order for trans people to get sex changes. Hormones and sex change surgery can cost a lot, sometimes over $100,000. Lots of trans people don’t have the money to pay for sex changes without insurance or the government paying. In Canada, there are a lot of trans people who want all of the provinces to put sex changes on the list of operations that are covered by health care. But, there are some trans people who think it isn’t worth it to be thought of as disabled or having a disorder in order to get medical care paid for.

Some trans people thing that surgeries should be paid for but that trans should be
thought of as a physical disability not a mental disability. They say that they don’t want to be treated like people with mental illnesses. They want to be treated better than that. So, they say trans is a physical issue not a mental one.

Others think that trans surgeries should be treated the same way as nose jobs or face lifts. They say if you have the money and you want it you should be able to get it. This way, trans is about money, not disability.

**Looking at it Through the Radical Model of Disability**

A lot of the things that trans people say about disability don’t work to change things for everyone, just some trans people. When people assume that trans people are not disabled, they leave out all the people who are otherwise-disabled. They leave out people who are labelled as intellectually or physically disabled and people who are thought of as to having other mental illnesses. When people say that trans is natural they make it seem like disability isn’t natural – it can be.

Looking at intersecting oppression means looking at how we have to fight for disability justice in order to get trans justice. It also means that people shouldn’t have to have lots of money to get what they need from doctors. We have to work together so everyone has what they need, not only rich white trans people.

Some people who say gender is social not biological so trans isn’t a disability. But this erases how disability is a political label. Disability, like gender, is always social. Lots of disabilities are caused by war, trauma and poverty – these are social. But even things like cancer have a social part. If you are exposed to toxic chemicals in the air or on your food and get cancer it is because we, as a society, decided that those chemicals were
worth the cost. Who gets labeled disabled comes down to what bodies and brains we decide as a society what is normal and the rest gets called disabled. The label of disability has been used to control lots of groups of people who are thought of as weird or not normal. That is how the label is still used.

When trans people only try to have trans people taken out of the DSM, it is important to ask who gets left behind. Lots of people who aren’t trans are considered mentally ill because they are defiant, don’t fit their gender role or are weird. When we choose only a couple of diagnoses in the DSM to fight, we don’t look at how the whole book is messed up. When trans people say trans is physical not mental because they don’t want to be treated bad, they are suggesting it is o.k. to treat people labeled mentally ill bad. Lots of trans people are labelled mentally ill other than being trans. This means that they get left out. And, of course, not wanting to be treated bad for being labelled mentally ill or mentally disordered doesn’t actually make people treat you well.

Lastly, the radical model calls for radical accessibility – creating space for all of us. When people talk about accessibility, they are often talking about ramps, interpreters, etc. and leaving it there. Radical accessibility means thinking about access in lots of ways, not only ramps, etc. This is about making sure that people feel comfortable talking about the troubles we have with our minds, bodies and identities. It also means that we have to make sure people can tell their stories of what it is like to be trans even if those stories are different than the stories we are used to hearing. It also means thinking lots about ways of different kinds of people including people. This means working to eliminate discrimination and oppression for everyone. It also means making things free
and having things like childcare.

**Trans is a Disability**

Some trans people argue that trans is a disability and should stay that way. Most of the time this is to keep access to healthcare. Others, however, simply see it as a disorder or disability. Others, including me, question what trans people are saying about disabled people when they argue that disability is bad and trans people aren’t disabled. Some trans people think it is useful to call ourselves disabled in order to get human rights protection.

**What Do Otherwise-Disabled Trans People Say About This?**

There are very few otherwise-disabled trans people who have written about this issue that I have found. Like other trans people, otherwise-disabled trans people have lots of different ideas about this issue. Pat Califia (1997/2003) supports the protests against having trans people be included in the DSM. He thinks that being in the DSM is damaging and leads to being treated badly. But, he thinks that sex changes should be publicly paid for. Eileen is worried that it could lead to trans people being put in institutions. Someone online who goes by the name of Static Nonsense (2010) says that trans isn’t a disorder or disability. They say that trans people shouldn’t try to separate themselves from disabled people too much though. Static Nonsense says disabled people should be included in the trans community.

Riley (2012) says that being trans was easier and they didn’t feel unhappy with their body because they are disabled. For Riley and Static Nonsense, it isn’t a black and white issue. Disability is more complicated for them for many non-otherwise-disabled trans people.
Syrus Marcus Ware (Ejiogu & Ware, 2008) writes about his experiences as a trans person of colour who is a psychiatric survivor. He says that it is important to look at how oppressions are interlocked. Ware (2010) also says he doesn’t like how some trans people talk about disabled people when they say they aren’t disabled. He says otherwise-disabled people shouldn’t be erased or treated badly in this conversation.

Eli Clare (2010; 2007) mostly writes about how some trans people say they are physically disabled, not mentally disabled. Clare says this erases the oppression of physically disabled people. This is especially true when they use the word ‘birth defect’ which lots of disabled people find hurtful and incorrect. Clare says that being trans isn’t about being sick (medical model) but about diversity. He is very critical of the medical model generally.

Clare talks about the shame trans people face about their bodies. A lot of trans people and doctors say trans people are “trapped in the wrong bodies” (Bnjamin, 1966, p. 9). This being in the wrong body is now the broad social view of what it is like to be trans. While it is true for some trans people, it isn’t true for all of us. This means that lots of people get left out or have to fit a view of trans that isn’t how they feel – including me.

While otherwise-disabled trans people do not all say the same things about trans being a disability, there is a great deal of detail and personal experience that we add. For us, disability is a part of who we are. We exist and we should have a meaningful place in the trans community and this debate.

**Conclusion: Solidarity and Social Change**

When trans people try to get rights or justice by being oppressive to disabled
people, nobody wins. Instead of thinking about groups competing, we need to think about all of us working together. Disabled people can offer a lot to the trans movement if we are given a chance. Likewise, trans people can offer a lot to the disability movement if we are given a chance. Together, and with other oppressed groups, we can make the world a better place.