transness as debility: rethinking intersections between trans and disabled embodiments

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abstract

Some authors in disability studies have identified limits of both the medical and social models of disability. They have developed an alternative model, which I call the ‘composite model of disability’, to theorise societies’ ableist norms and structures along with the subjective/phenomenological experience of disability. This model maintains that ableist oppression is not the only source of suffering for disabled people: impairment can be as well. From a feminist, queer, trans activist, anti-ableist perspective and using an intersectional, autoethnographic methodology, I apply this composite model of disability to trans identities to consider the potentially ‘debilitating’ aspects of transness. I argue that transness, like disability, has too often been perceived from two perspectives, medical or social, without the benefit of a third option. From a medical perspective, transness is reduced to an individual pathology curable with hormonal/surgical treatments, a conceptualisation that erases structural oppression. From a social point of view, transness is conceptualised as a neutral condition and variation in sex/gender identity. In this model, structural oppression (transphobia/cisgenderism) is seen as the only cause of ‘trans suffering’. I argue that, just as the medical and social models of disability provide limited opportunities for reflection on the complex experience of disability, medical and social understandings of transness, respectively, are insufficient to describe the complexity of trans experience. I explore the possibilities presented by the application of a composite model of disability in trans studies. By both problematising cisgenderist oppression and acknowledging trans people’s subjective experiences of suffering through some of the debilitating aspects of transness, this composite model avoids the pitfalls of the medical and social models. The application of tools from disability studies to trans issues uncovers cisnormativity in disability movements and denounces ableism in trans movements. This will, I hope, solidify alliances between these communities and fields of study.

keywords
debility; transness; trans studies and movements; disability studies and movements; intersectionality; autoethnographic methodology
Rethinking Intersections between Trans and Disabled Identities

Naming one’s weaknesses and vulnerabilities requires courage. It has taken me this long to admit that I am psychologically frail, and have been since childhood. Although the obsessive–compulsive disorder, anxiety and depression (mental disabilities) I struggle with have interfered with many activities throughout my life, I resisted health professionals’ labels for many reasons. First, my resistance was informed by an internalised (mental) ableist perspective. ‘I am not mentally ill/disabled’, I told myself, not realising that my limited ontology of disability reserved this category for those with ‘visible’ and ‘physical’ disabilities. My interest in disability studies allowed me to deconstruct these assumptions and dismantle the ableist feeling of shame that led me to dissociate myself from other disabled people. Second, I feared the stigma that surrounds this identity: would employers hesitate to hire me, insurance companies refuse to insure me, and friends and colleagues treat me differently knowing that I suffer from mental disabilities? Last, my resistance was also based in part on my critical perspectives on medicine, psychiatry and psychology and the negative effects of the medicalisation of certain conditions. I believed that oppressive systems (sexism, heteronormativity, cisgenderism/cisnormativity) were the cause of my mental disabilities. Following the social model of disability, I perceived these disabilities as exclusively social/political. However, refusing the medical model of disability and adopting a social model focused on the structural aspects of ableist oppression left me, like many other disabled people, poorly equipped to reflect on suffering related to my disabilities.

Having rejected the medical model of disability, some authors in disability studies have also identified limits of the social model and sought either to refine it or develop an alternative capable of problematising the ableist oppression faced by disabled people and creating sites of reflection on the phenomenological experience of disability (Crow, 1996; Wendell, 1996, 2001; Nicki, 2001; Mallow, 2006; Shakespeare, 2010; Kafer, 2013). These alternative perspectives, which constitute a third model I have called the ‘composite model of disability’, recognise the difficulties experienced by disabled people who are unhealthy or suffer from chronic or mental illness, and argue that ableist oppression is not the only source of suffering for disabled people: physical or mental/psychological conditions can be as well. Although the dominance of the medical, then social, models of disability made it difficult for me to accept

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2 My use of the term ‘mental disabilities’, like Price (2011), refers to a variety of conditions, including cognitive deficits and mental/emotional health issues.

3 Mental ableism is sometimes called ‘sanism’ or ‘mentalism’ (Lewis, 2010 [1997]).

4 In trans studies, the prefix ‘cis’ is the antonym of ‘trans’. A cissexual and cisgender (cis) person is one who has not undergone a sex/gender transition (Serano, 2007). Some authors speak of transphobia (Shelley, 2008), some of cissexism (Serano, 2007), and still others use the terms ‘cismenstrualism’ and ‘cisnormativity’ (Bauer et al., 2009; Baril, 2013, pp. 396–397; Baril and Trevenen, 2014; Baril, 2015). While these terms are different (I leave their close analysis to others), they are variations on a theme designating the material, normative system of oppression that affects transgender/transsexual (trans) people, whom it considers inferior and less normal than cis people.

5 I refer here to both my mental and physical disabilities.

6 Kafer (2013, pp. 4–10) calls her alternative model a ‘political/relational model’ of disability.
my mental disabilities and their consequences, or to legitimately consider myself disabled based on my psychological state of being, it was even more difficult to conceive another of my ‘debilitating’ conditions as a legitimate disability: my transsexuality. ‘Debility’, according to Livingston (2005, p. 2), is ‘the impairment, lack or loss of certain bodily abilities’. I argue that, despite numerous ‘debilitating’ conditions associated with certain sex/gender transitions, transness is rarely seen as a legitimate disability. Inspired by critical reflections in disability studies, by using a composite model of disability I wish to propose an assemblage to theorise transness in a way that avoids the pitfalls of both the medical and social models.

By adopting a feminist, queer, trans activist, anti-ableist perspective, applying an intersectional framework and employing an autoethnographic methodology based on my experiences as a transsexual, disabled man who suffers from invisible disabilities, I would like to reflect on the positive implications of and possibilities opened by the application, within trans studies, of a composite model of disability allowing for a conception of transness that includes its debilitating physiological, mental, emotional or social aspects. While still considering structural oppression, this composite model may also make it possible to reflect on transition-related subjective realities, affects and potential suffering for some trans people in terms of ‘debility’. This assemblage’s application of tools from disability studies to trans issues not only uncovers cisnormativity in disability studies and represents an opportunity to denounce ableism in trans studies and movements, but is also an invitation to conceptualise the intersections between trans and disability communities that too often remain unthought. This will, I hope, encourage solidarities between these movements and fields of study.

**the impossible debility of transness**

Use of the ‘disabled person’ category in disability studies is vast: disabled people may have physical, mental, psychological or emotional impairments or health conditions that may be stable or degenerative, visible or invisible, chronic or intermittent, mild or severe and so on. Disabled people may be amputees, paraplegic or blind or suffer from cognitive ailments, chronic pain (fibromyalgia, arthritis), depression or HIV, among other conditions. Impairments/disabilities interfere in one or more spheres of life, including economic, professional, citizenship, social, interpersonal, sexual and other activities. Despite the fact that some disabled people are trans and some trans people are disabled, intersections of these identities are rarely discussed. Furthermore, given this broad definition of disability, it is surprising that trans people are not generally considered or do not identify as disabled. I argue that trans people are excluded from the disabled category despite many reasons for their possible inclusion. I present four arguments to consider transness in terms of disability.

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1 Following Livingston (2005), Puar (2009) uses the concept of ‘debility’ in a broad view of disability.
2 Following Puar (2014, p. 78), who criticises the limitations of the few intersectional analyses of the realities of trans people who are disabled and of disabled people who are trans, and who calls for a rethinking of the boundaries between trans and disabled categories, I mobilise an intersectional framework that allows me to theorise the intersections of these categories through a critique of their frontiers.
3 My objective is not an analysis of the ‘disability’ category (see instead Wendell, 1996, pp. 11–33), but to demonstrate the variety of conditions it includes.
4 Levi and Klein (2006) examine various uses of the concept of disability in law. They assert that, like other disabilities, trans identity affects many aspects of a person’s life. They argue that resistance to using anti-discrimination laws designed for disabled people to defend trans people is based on the obscurity of these laws and trans people’s prejudicial attitudes towards this group (ableism).
First, the psychological/mental perspective. Since the 1980s, transsexuality has been considered a mental health disorder (previously ‘Gender Identity Disorder’, now ‘Gender Dysphoria’ in the DSM-V: APA, 2013). A number of trans activists, psychologists and physicians maintain that it is an identity disorder, and therefore a disability (Gorton, 2013).\(^\text{11}\) However, despite the existence of a mental health diagnosis, transsexuality is not considered a disability, as evidenced by many countries’ laws, such as the Americans with Disabilities Act (ADA) (Spade, 2003; Levi and Klein, 2006),\(^\text{12}\) private/public health insurance company regulations (Bauer et al., 2009) and collective agreements and sick leave policies that exclude it (Shelley, 2008). This is a double standard. Although transsexuality is categorised as a mental illness, trans people do not, generally speaking,\(^\text{13}\) have access to the same rights and protections as other disabled people.\(^\text{14}\) Regardless of the debates surrounding diagnosis, many trans people assert that the dissonance they feel between their body and gender identity creates varying degrees of emotional distress (Prosser, 1998; Rubin, 2003; Clare, 2013, p. 265). Along with the psychological concerns that come with it, this distress could be, but is rarely, qualified as debilitating or as a disability.

Second, the dysfunction or absence of organs, body parts or physical characteristics resulting from transitioning could be considered a disability, but is not. I offer three examples. (1) Hormone deficiencies in cisgender people are seen as a health condition/disability; the same is not true for trans people even though they must take hormones throughout their entire lives. (2) Cisgender men who have lost the use of their penis are considered disabled, while for trans men an absent penis is not recognised as a disability, but as ‘normal’ according to a cisnormative ontology that considers them ‘really’ female (Bettcher, 2014, pp. 392–393). Therefore, prosthetic penises are regarded as medical devices for cisgender men and sex toys for trans men. (3) Disabilities can emerge from transition-related treatments. Many trans people lose their so-called natural reproductive abilities after surgery, have little or no sensation in reconstructed organs and other operative sites, or lose mobility in their limbs from skin graft donor sites (Baril, 2013; Baril, 2015). Many share the complex negative and positive experiences of their surgical journey in forums and Internet groups (e.g., Yahoo groups such as The Deciding Line, FTM Metoidioplasty or Phalloplasty Info) or books (Cotton, 2012). Although the existence of these dysfunctions and deficiencies is not denied, they are generally excluded from the disability category through the lens of victim-blaming: trans people are denied support provided to disabled people because they are believed to have caused their disability.\(^\text{15}\) Difficulties considering some trans body issues in terms of debility have negative consequences for trans people on economic, professional, legal and social levels.

Third, with regard to the spheres of activity affected or limited by disability, transness interferes with every aspect of life (professional, financial, legal, social, interpersonal, sexual) (Levi and

\(^\text{11}\) For discussion of debates surrounding the abolition, reform or preservation of this diagnosis, see Spade (2003), Levi (2005), Serano (2007), Drescher (2010) and Gorton (2013).


\(^\text{13}\) Some people, and their lawyers, have made claims on this basis (Spade, 2003; Levi and Klein, 2006).

\(^\text{14}\) Disabled people face many obstacles and barriers to accessing resources. Depending on sex, class, race, level of education, national context, age and even the type of disability they experience (physical or mental, visible or invisible, etc.), disabled people have uneven access to recognition, support, resources and accommodation. As a result, some disabled people may find it more difficult than some trans people to obtain support and access to medical or state resources. I would like to thank one of the anonymous reviewers of this article for this suggestion.

\(^\text{15}\) This affects not only trans people. People whose disabilities are invisible or unmeasurable or who suffer from chronic pain or mental disabilities are also blamed for their conditions (Wendell, 1996; Nicki, 2001; Wendell, 2001; Mollow, 2006; Jung, 2011; McRuer and Mollow, 2012, pp. 9–12).
Klein, 2006, pp. 84–87). For example, unemployment and dismissal rates of trans people are very high (Levi and Klein, 2006; Shelley, 2008). Another example comes from the interpersonal and sexual sphere: if the lack of a hand or leg can have an impact on an individual’s personal and sexual life (and is considered a disability), then having sexual characteristics or genitals discordant with one’s sex/gender identity can have an enormous impact on trans people’s interpersonal relationships. Being trans therefore interferes with several spheres of activity before, during and after transition.

Fourth, trans people, like other disabled people, face multiple forms of violence and discrimination based on their identity and body/mind configuration. For example, they may have difficulty accessing certain spaces (such as women’s and homeless shelters) (Serano, 2007), facilities like washrooms (Mog and Swarr, 2008; Kafer, 2013), health care (Bauer et al., 2009) and civil identities (surgical sterilisation is required to obtain identification papers in most legal contexts) (Shelley, 2008; Baril, 2013).

I am not saying that trans and disabled realities are identical or interchangeable; despite significant similarities and intersections, trans and disabled people’s experiences are different. However, these arguments raise the possibility of conceptualising the potentially debilitating aspects of some trans people’s experience of transition. I am not suggesting that the presence of these four elements is necessary to qualify transness as a disability, nor am I suggesting that the presence of any particular element is necessary or sufficient to determine transness as a disability. For example, trans people who do not identify as having a mental disorder and reject diagnosis may nonetheless experience debilitating physical conditions as a consequence of their transition and thus be disabled by their transness. Personally, my previous lack of a male body and experience of transness have been sources of physical, psychological, interpersonal and structural suffering, even though transitioning was the best decision of my life. Yet, unlike my other disabilities, whose debilitating effects are partially or completely recognised and accommodated, my transsexuality is not considered a disability and its debilitating aspects in my daily life are not recognised. Why is the experience of transness excluded from the disability category? Why are the overlaps between trans and disabled experiences unthinkable?

I argue that there are three principal factors that have hindered the conceptualisation of transness as a debilitating condition: (1) a fragmented vision of the body and resulting disciplinary divisions; (2) cisnormativity in disability studies; and (3) ableism in trans studies. In order to explore the phenomenological experience of the debility of trans embodiments, I present and deconstruct these factors to complexify and problematise the boundaries between the ‘trans’ and ‘disabled’ categories.

First, an increasing number of analyses simultaneously consider (queer) sexuality and ability (e.g., Sherry, 2004; McRuer, 2006; Puar, 2009; McRuer and Mollow, 2012). However, as Mog and Swarr (2008) and Kafer (2013) indicate, comparable studies of trans and disability issues are far less common. The rare authors who propose such analyses (e.g., Clare, 2009[1999], 2013; Hall, 2009; Puar, 2009, 2014; Wilkerson, 2012; Baril, 2013, 2015) highlight the issues (e.g., self-definition, ‘passing’), forms of violence (e.g., pathologisation, stigmatisation) and challenges (e.g., access to washrooms: Mog and Swarr, 2008;...
Kafer, 2013, pp. 149–157) that affect trans and disabled people in similar ways. Although some have also begun to question the borders between these groups, the work of deconstructing them remains incomplete. The perceived mutual exclusivity of the categories ‘trans people’ and ‘disabled people’ has guided the construction of trans studies and disability studies as distinct disciplines. Foucauldian genealogy is useful to question the disciplinary divide and ‘territorial control’ (Foucault, 2001, p. 39, original translation) that remain between these fields despite their shared interest in body differences. Due to a fragmented view of the body, some of its parts are ascribed to disability studies and others to trans studies. As I have observed elsewhere,

Second, I would add that disability studies are interested in conditions affecting sexed/gendered parts of the body (e.g., infertility, breast/penile cancer), but only when they do not result from sex/gender transitions. This double standard reveals the presence of cisnormativity in disability studies (Baril, 2013, 2015; Kafer, 2013, pp. 153–157). Indeed, medical problems and treatments involving sexed/gendered parts of a trans person’s body are not perceived as belonging to disability studies, but to trans, gender or queer studies. Third, trans studies and movements are often ableist. For example, poster slogans supporting the depsychiatrisation of trans identities (that I myself carried and now dispute), such as ‘Trans, not disabled’ and ‘Trans, not ill’, distance trans people from disabled people and relegate them to the status of ‘Others’. Not only is the question of disability forgotten, but the quest to depathologise trans identities also often uses disabled people for its own purposes (Baril, 2013; Clare, 2013; Kafer, 2013, pp. 156–157; Puar, 2014). I argue that these three factors have prevented the conceptualisation of transness together with disability in its potentially debilitating experience.

an alternative to the medical and social models of disability

Historically, medicine has understood disabilities as pathologies that affect individuals and for which cures must be found. The medical model of disability seeks to ‘fix’ people and their presumed defective conditions rather than examine the social, economic and architectural structures that disable them (McRuer, 2006, pp. 8–11; Kafer, 2013). Focused on prevention, treatment, rehabilitation and the assimilation of disabled people into able-bodied communities, the medical model is considered reductionist and ableist by many activists (Lewis, 2010[1997]; Shakespeare, 2010, p. 268). The disability movement has sought to free disabled people from medicine’s pathologising gaze through a social model of disability that distinguishes between impairment, that is, a physical/mental condition, and disability, seen as situated at the junction of impairment and the environment (Crow, 1996; Wendell, 1996; Baril (2013, 2015), Puar (2014) and Kafer (2013, p. 151) have begun to question these groups and categories.

19Baril (2013, 2015) and Puar (2014) establish connections between these fields by linking transsexuality and transability (Baril, 2015).

20Baril (2013, 2015) and Puar (2014) have begun to question these groups and categories. Establishing connections between these fields by linking transsexuality and transability (Baril, 2015).

21The social interpretation of transness and its critique of the medical model have numerous advantages, including recognising the structural oppression that affects trans people, empowering trans communities and so on. An anti-pathology trans perspective has value and merits extensively discussed in trans studies. Space limitations prevent me from discussing these advantages here. For the advantages of this interpretation, see Meyorewitz (2002) and Spade (2003).
Shakespeare, 2010). In this model, disability is the result of an environment that does not offer disabled people the tools required for their participation. Clare writes:

The disability rights movement, like other social change movements, names systems of oppression as the problem, not individual bodies. In short it is ableism that needs the cure, not our bodies. Rather than a medical cure, we want civil rights, equal access, gainful employment, the opportunity to live independently, good and respectful health care, desegregated education. (Clare, 2009[1999], pp. 122–123)

There are numerous advantages to the social model of disability: empowering disabled people; collectivising their struggle; rendering visible the obstacles and systemic oppression they face; and identifying possible solutions to eliminate these problems (Crow, 1996, pp. 55–56; Wendell, 1996, pp. 35–56; Shakespeare, 2010, pp. 268–269; Kafer, 2013).

Nonetheless, the social model of disability has limits. Specifically, it relies on a binary division between the physical and the social not found in reality. Physical elements are influenced by social realities and social realities are composed of physical materialities; in short, they interact (Wendell, 1996, p. 35; Shakespeare, 2010, p. 270; Kafer, 2013, p. 7). Mollow (2006, pp. 68, 77–78) notes that this opposition leads to the ‘depoliticisation of impairments’ by relegating them to a biological domain into which the social supposedly does not penetrate. This model also tends to neglect disabled people’s subjective experiences. This neglect is facilitated by the utopian belief that an accessible society adapted to all levels of ability would eliminate disability (Shakespeare, 2010, pp. 269–271). In other words, the disappearance of ableist oppression would suffice to liberate all disabled people, but a more complex approach reveals this as reductive. The social model of disability is also criticised for thinking in terms of typical disabilities that are physical, visible, measurable and unrelated to illness and suffering. Wendell (2001, p. 21) writes: ‘The paradigmatic person with a disability is healthy disabled and permanently and predictably impaired. Both attitudes towards people with disabilities and programs designed to remove obstacles to their full participation are based on that paradigm’. Nevertheless, for people whose disabilities are mental, invisible, unmeasurable or chronic, or who are unhealthy, the social model’s solutions can only partially resolve their problems (Crow, 1996; Wendell, 1996; Nicki, 2001; Mollow, 2006; Jung, 2011; McRuer and Mollow, 2012, pp. 9–12). Some people who suffer from their disabilities fight for structural change while also seeking individual treatments. Indeed, although the social model has many collective, social and political advantages, it contributes little to the theorisation of more difficult experiences of disability and has led to the condemnation of some disabled people’s desire for a cure (Kafer, 2013, p. 7).

To overcome these limits, some authors in disability studies have proposed alternative approaches to escape the quandary of explanations and solutions anchored either entirely in individual pathologies or entirely in social structures. Wendell (2001, p. 18) observes that some disabled people ‘[…] experience physical or psychological burdens that no amount of social justice can eliminate. Therefore, some very much want to have their bodies cured, not as a substitute for curing ableism, but in addition to it’. In other words, for some disabled people, suffering is not merely a consequence of ableism and would not disappear in an ideal society. This ‘phenomenology of impairment’ (Wendell, 2001, p. 23;
Mollow, 2006, p. 68) does not imply adopting an individualist, medical approach; nor does it exclude critical social analysis of ableism. Crow (1996, p. 56) remarks that ‘[t]his debate has no need to denigrate the social model: at a fundamental level it already works; now is our chance to make it work better’. This alternative model, which I call ‘the composite model of disability’, is therefore a tool to critically examine specific assumptions in disability studies, including ‘its reluctance to understand disability in terms of sickness or suffering, its tendency to define disability in visual terms, and its resistance to stories of overcoming’ (Mollow, 2006, p. 71). I would now like to consider the heuristic value of this composite model for understanding the complex experience of transness.

the possible debility of transness

trans identities through the lens of the medical and social models of disability

I argue that transness has too often been perceived through the lens of two paradigms, medical or social, without the benefit of a third option capable of theorising both cisgenderism and the subjective experience of trans people’s suffering. Although the medical model of disability has not been directly applied to trans identities, it would seem that transsexuality has historically been viewed through a similar model (Meyerowitz, 2002). From a medical perspective, transsexuality has been reduced to an individual pathology curable with hormonal and surgical treatments, a conceptualisation that erases structural oppression. Transness, like disability, is considered a personal tragedy, something negative to be eliminated through normalisation. Since the 1960s, a variation of the medical model, the ‘trapped in the wrong body’ discourse, has emerged within trans communities (Prosser, 1998; Rubin, 2003). While this discourse is still being used, it is increasingly criticised within trans studies and movements. The medical model and ‘wrong body’ discourse sometimes directly refer to disability. Be it physicians or psychiatrists discussing transsexuality as an anomaly, error or gender disorder, or trans people describing their situation as a defect or error of nature, the idea of transsexuality as disability is often present. Clare (2013, p. 262) writes, ‘I often hear trans people […] name their transness a disability, a birth defect. They say, “[…] I simply need a cure”’. I have also heard this in trans support groups. The problem resides, I believe, not in the concept of transness as disability, but in such individualist, ableist, pathologising views of disabilities. From a social point of view, trans identities are understood not as an individual disorder, but as varieties of sex/gender identity stigmatised by cisgenderist norms and structures. Although recourse to medical treatment is not condemned, social solutions are prioritised. I maintain that the social model of transness, like the social model of disability, has certain limits rarely discussed in trans studies. I argue that, like anti–ableist activists who distinguish between a neutral impairment on which oppression is built (i.e., disability) (Crow, 1996), trans activists who try to counterbalance the medical model—in which transness is the source of the problem—set transness aside and cast it as a neutral element to which stereotypes, prejudice and discriminatory attitudes are attached. In this view, the problem is not

23 Rubin (1999) and Bettcher (2014) have developed an alternative to the medical and social approaches, but have not applied the alternative model of disability to trans issues or conceptualised transness as disability.
24 For criticism of this discourse, see Sullivan (2008) and Bettcher (2014).
25 Limited space prevents me from doing justice to the complexities of the medical conception of trans identities. For example, from a medical perspective that takes oppressive structural elements into account, Gorton (2013) suggests keeping the diagnostic category to increase disadvantaged trans people’s access to health care.
transness, but what society does with it. This model assumes that the eradication of cisgenderism would be sufficient to eliminate all ‘trans suffering’.

However, the social model of transness also has limits. For example, according to Spade (2003), Levi and Klein (2006) and Baril (2013, 2015), the social interpretation of trans identities endorsed by most trans activists and authors in trans studies is marked by ableism. In order to reject the stigma attached to mental illness, most activists who seek to reform or abolish the gender dysphoria diagnosis based on the argument that transness is not a mental illness are demonstrating mental ableism (Wilkerson, 2012, pp. 184–185; Gorton, 2013, pp. 646–647). These arguments repathologise disabled people and distance the two communities. Among authors who establish connections between trans and disabled communities, like Mog and Swarr (2008), Wilkerson (2012) and Clare (2013), to date, none has applied a composite model of disability to trans identities: they favour the social model. But the social model of disability offers a disembodied view of transness that neglects to address the debilitating aspects of transness in some trans people’s experience. For example, Wilkerson (2012) considers neither disability nor transness capable of causing suffering beyond that created by oppressive structures. She writes:

Writing about intersex and transgender sexuality through a disability lens may nonetheless seem a perverse and wayward impulse. Neither transgender, transsexualism, nor intersexuality can be readily assimilated into conventional notions of disability; they are not motor, sensory, psychiatric, or cognitive impairments; nor are they chronic illnesses. Moreover, given cultural perceptions of disability as lack, loss, or pathology, many intersex and transgender activists vehemently refuse any association with it. (Wilkerson, 2012, pp. 184–185)

While I applaud Wilkerson’s efforts to denounce the limits imposed on disabled, trans and intersex people, especially regarding sexuality, and her desire to build bridges between these groups, her view leaves little room for trans people who perceive their transsexuality as a physical impairment, mental illness or emotional disorder (dysphoria).

Clare (2013) adopts a similar approach. In suggesting the establishment of alliances among disabled and trans communities, he reveals how the latter could benefit from the lessons of disability studies. However, his insistence on the social model could lead to the omission of the perspectives of disabled and/or trans people who suffer from their condition. In reference to people who view their transness as a disability, he states:

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 activists who frame disability as an issue of social justice, not of medical condition: disability lodged not in paralysis, but rather in stairs without an accompanying ramp; not in depression or anxiety but rather in a whole host of stereotypes [...]. It ignores the reality that many of us aren’t looking for cures, but for civil rights. I’ve been asked more than once whether I’d take the hypothetical cure pill, always asked in ways that make it clear there’s only one real answer: ‘Why, of course, in a heartbeat’. But that’s not my answer. For me, having cerebral palsy is like having blue eyes and red hair. (Clare, 2013, pp. 262)

Once again, space limitations prevent me from doing justice to the complexity, debates and nuances of this model. Bettcher (2014, pp. 384–385) places the ‘wrong body’ model in opposition to the ‘beyond the binary’ model. The latter creates a hierarchy between trans people with discordant sexes/genders and those who modify their bodies to match their identities (transsexuals) (Rubin, 1998, pp. 272–276; Baril, 2013, pp. 121–135). The ‘beyond the binary’ model differs from the social model discussed here, which is broader and theorises transness as a socially oppressed, neutral element. The social model can include the ‘beyond the binary’ model or not.
Although Clare (2009[1999], p. 123; 2013, p. 263) does not criticise trans people who wish to modify their bodies and even stresses the limits of an exclusively social analysis of gender dysphoria by recognising ‘body dissonance as a real, sometimes overwhelming, force’, his focus on ableist and cisgenderist structures makes it challenging to theorise disability or transness as difficult in and of itself (and not as neutral). I support Clare’s invitation to extract disability or transness from a medical model in order to ‘frame bodily difference as neither good nor bad, but as profoundly familiar’ (Clare, 2013, p. 265), but am even more moved by Crow’s proposition:

We need a new approach which acknowledges that people apply their own meanings to their own experiences of impairment. This self-interpretation adds a whole new layer of personal, subjective interpretations to the objective concept of impairment. The personal interpretation incorporates any meaning that impairment holds for an individual (i.e. any effects it has on their activities), the feelings it produces (e.g. pain) and any concerns the individual might have (e.g. how their impairment might progress). Individuals might regard their impairment as positive, neutral or negative, and this might differ according to time and changing circumstances. (Crow, 1996, p. 60)

Just as medical and social models of disability are inadequate to name the subjective experience of my disabilities, medical and social understandings of trans identities/embodiments insufficiently describe the complexity of the experience and suffering related to my transness. This suffering remains despite the surgeries I have undergone (the medical model’s solution) and would persist in a world without transphobia/cisnormativity (the social model’s solution). I propose that Clare’s analyses could be improved by applying a composite model of disability. Clare (2013, p. 263) affirms ‘that medical technology alone will never be the whole answer for any of us’, and I would add that the social model’s solutions alone are also insufficient to account for all trans and disabled people’s complex experiences. Because our realities are multiple, contradictory, complex and sometimes elusive, our theoretical models and solutions must be as well. Clare (2013, p. 265) concludes his text with a discussion of the importance of a ‘disability politics of transness’, an idea full of potential but left undeveloped. I will now take up this concept and examine it through the lens of a composite model of disability.

transness as debility: an alternative to the medical and social models

The experience of suffering linked to some of the debilitating aspects of transness should not be overlooked. It is central to the lives of many trans people, including myself, who accept the risk of compromising their social status, job security, financial investments, family ties, friendships, romantic relationships and particularly their health to undergo treatments and surgeries that sometimes extend over many years in order to alleviate the feeling of dysphoria. I am not arguing that our subjective experiences can be detached from the social; separating them from the context within which a person is constructed and reflects is all but impossible. It is clear that internalised cisnormativity can have negative consequences on the phenomenological experience of transness. When I discovered that I am trans, I thought, ‘no … anything but THAT’. I did not want to be ‘that’, a socially abject identity and body. Tools from trans studies helped me deconstruct my internalised cisnormativity but, as mentioned above, trans suffering cannot be reduced to internalised cisgenderist oppression.
As Crow (1996, p. 58) remarks, although the anti-ableist movement resembles other social movements, there is a critical difference: the potential of a number of conditions to cause mental and physical suffering. I argue that trans people occupy a position similar to disabled people in that transness has the potential to cause suffering. With regard to the lesbian, gay, bisexual and queer groups with which they are often associated, trans people’s medical/bodily realities are different from those of other sexual minorities. In addition to facing oppression from without, many trans people suffer from within and require medical support to live in their identity. To be a woman, black or gay does not necessarily cause suffering; rather, these experiences are rendered difficult by our sexist, racist and heteronormative societies. The lives of some disabled and/or trans people, however, are complicated by physical/mental suffering. Even if ableism and cisgenderism were eradicated, these people would still be affected by their conditions. For these reasons, impairment and transness are not always neutral conditions onto which social oppressions are layered; they can also be sources of hardship. Crow (1996, p. 57) writes: ‘Instead of tackling the contradictions and complexities of our experiences head on, we have chosen in our campaigns to present impairment as irrelevant, neutral and, sometimes, positive, but never, ever as the quandary it really is’. I contend that this same logic is at work within trans movements. Transness has been neglected in favour of the fight against cisgenderism, but this fight is insufficient for a portion of trans people who would nonetheless continue to suffer and feel dysphoric. For some, transness is a neutral, even positive, aspect of their lives. For some, it is difficult. For others, it is both. But transness, like impairment, cannot be brushed aside.

Transforming perspectives on impairment and recognising the diversity of experiences leads to reconceptualising the notion of pride for certain disabled people. While it is possible to be proud of being a woman, gay, black or in a wheelchair when limited mobility is not associated with chronic pain or other health issues, pride does not operate in the same way for people who are ill, depressed or have chronic pain (Crow, 1996; Wendell, 1996, 2001, pp. 30–31; Mallow, 2006). These people can be proud of fighting ableism, overcoming obstacles with courage and learning from their experience, but can they be happy and proud that they suffer from depression or chronic pain? I am proud of what I have become, of the courage it took to be the man I am today, of facing the contempt of numerous people and institutions with dignity, and of fighting to change cisgenderist laws, prejudice and stigmatisation, but, as with my depression or anxiety, the fact of my transness is not itself the source of satisfaction and pride. On the contrary, it has always been and continues to be a daily source of suffering. Even if trans people had access to trans-friendly washrooms, how many trans men would nonetheless mourn the ability they will never have to urinate standing up, have natural erections and ejaculate? How many trans women, even if cisgenderism were extinguished, would still mourn the natural lubrication they will never have despite a vaginoplasty and the pain of daily dilations required after surgery? How many trans people are so haunted by their previous body image that, ten years after transitioning, they still have nightmares of being back in their old body? How many trans people, despite all the treatments, surgeries and structural changes that may eventually eradicate cisgenderism, feel a sense of profound dysphoria that forever lingers in their minds? I experience transness in much the same way I experience depression or anxiety; although I know that these states are influenced by structural factors (oppressive systems), the suffering is nonetheless real. Trans suffering can neither be separated from social oppression nor be reduced to it.

In addition to silencing dissenting voices in trans communities, the social model’s vision of trans identities as neutral elements has also suppressed the paradoxes and complexity of our experience.
For example, many trans people, including myself, feel that asserting that we would rather not have been trans will be seen as illegitimate, and fear being accused that this desire is the work of internalised cisgenderism. We feel guilty at the thought that, given the choice, we would prefer our children to be cis. Our hope for a miraculous ‘cure’ for dysphoria feels illegitimate (Crow, 1996, pp. 58, 65). As I write about this complicated reality, I fear the repercussions I may face in the trans communities with which I am involved. Will they perceive an offence, a hostile position for which I should be condemned? Will I be considered a traitor? Or will my words resonate with them? Because many trans people have confided in me over the years, I know that there are others who feel as I do. But how many, and where? We are scattered and isolated from one another by taboos that prevent us from talking about a complex experience in which the social meaning of trans identities prevails over phenomenological concerns. It is in this interstice that a number of trans people’s voices are erased. In her critique of the social model of disability, Crow asks:

Do we believe that admitting there could be a difficult side to impairment will undermine the strong, positive (SuperCrip?) images of our campaigns? Or that showing every single problem cannot be solved by social change will inhibit or excuse non-disabled people from tackling anything at all? […] Or even that admitting it can sometimes be awful to have impairments may fuel the belief that our lives are not worth living? (Crow, 1996, p. 57)

I find these questions inspiring. What are we afraid of when we refuse to listen to the distress and suffering of some trans people? Do we fear that legitimising these voices may encourage our cisgenderist societies to revive discourses denying trans people rights, access to health care and respect? Do we think it necessary to toe the party line, speak a common message, and present society, the media and our politicians with a positive collective image free of dissident voices? Following Crow (1996, pp. 58–59), who argues that the taboos surrounding impairment prevent a more complex theorisation and politicisation of anti-ableist struggles, I also believe that silence is harmful to trans communities and our ability to problematise the diversity of our experiences. I am convinced that achieving greater social justice for all trans people means placing diversity of experience at the heart of our reflections and collective action. It is true that the discourse of suffering can be used in ableist and cisgenderist ways to further oppress disabled and trans people. However, representations of our identities, discourses, and theoretical and epistemological (e.g., essentialist, constructivist) frameworks are but the tools we use to defend a political agenda linked to particular values of equality, and they can always be repurposed by other groups to increase oppression. The history of social movements and counter-movements reveals many contradictory uses of the same discourses and theoretical frameworks by oppressed groups fighting for their rights and by those who oppress them (Halley, 1994; Rubin, 2003; Lane, 2009; Salamon, 2010, p. 80; Baril, 2013, pp. 364–390). The concept of transness as debility possesses this same conceptual and political polysemy. Although these tools can be appropriated, we must recognise the importance of minoritised groups’ ability to use them to speak, name their experiences and influence the course of their lives.

Following the example of some anti-ableist activists, I ask how we can develop a composite model within trans communities that is capable both of denouncing cisgenderism and its systemic barriers, and of considering the expression of subjective experience linked to transness, the way it affects multiple spheres of activity in our lives, and the sensations, affects and emotions that transness implies. In short, can we adopt a complex ‘disability politics of transness’? Without making transness shameful, are we able to make room for trans people who, like me, consider their transness neither neutral nor positive? If we want
to represent all trans people, recognise their experiences and needs, and fight for their rights and access to the care and services they require in ways that are grounded in reality rather than in generalist theoretical models, we must listen to them. The proposed composite model does this by complementing the social model and contributing to its structural analyses. Approaching transness as debility instead of locating the source of trans people’s problems solely within transness or within society’s cisgenderist structures could, inspired by Garland-Thomson’s concept of ‘misfitting’, apprehend transness as a ‘misfitting’ experience rather than one of the ‘wrong body’:

Fitting and misfitting denote an encounter in which two things come together in either harmony or disjunction. When the shape and substance of these two things correspond in their union, they fit. A misfit, conversely, describes an incongruent relationship between two things: a square peg in a round hole. […] Misfit emphasizes context over essence, relation over isolation, mediation over origination. Misfits are inherently unstable rather than fixed, yet they are very real because they are material rather than linguistic constructions. (Garland-Thomson, 2011, pp. 592–593)

The aim of conceptualising transness as misfitting and debility is not to describe every trans person’s reality. My goal is to make sense of my reality and that of other trans people in my life. My claim is not that the composite model is superior to others, but that a phenomenological point of view offers an alternative for reflecting on the complicated experience of transness.

towards a ‘disability politics of transness’

I believe it is important to adopt Clare’s (2013, p. 265) ‘disability politics of transness’ through a composite model of transness capable of creating a space receptive to the voices of trans people, currently silenced by the social model, whose transness is debilitating or experienced as a disability. We must embrace the expression of trans people’s sometimes contradictory, complex and dissident views as they challenge the broad homogenising discourses of our communities. The application of tools from disability studies to trans issues in the proposed assemblage not only uncovers cisnormativity in disability movements, but also denounces ableism in trans movements. This will, I hope, solidify alliances between these communities and fields of study. These all too often unthinkable connections are fundamental for people, like me, who experience transness as a disability, and who are at the crossroads of multiple identities (e.g., disabled, trans).

My transness has been and continues to be a debilitating and disabling component of my life. My dysphoria, although much less intense than before my transition, is a constant presence that manifests itself through a variety of concerns that, taken separately, might seem insignificant but that, taken together, reveal a persistent discomfort about my body. This dysphoria is as psychologically disabling as my other mental disabilities. Furthermore, the interactions between gender identity and ability may be rarely discussed, but they are very real and need to be better understood. To take just one example, my transition has an impact on my mental health (e.g., transition creates anxiety about health; cisgenderist violence provokes anger or pain) and my mental health influences my experience of transness. The calmer, happier and less obsessive I feel, the more positive I am about my gender identity and body

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27Bettcher (2014, p. 384), for her part, was seeking something other than the ‘wrong body’ and ‘beyond the binary’ discourses to help her understand her own experience as a trans woman. Her text inspired me.
image, and vice versa. My transition included treatments and surgeries that have resulted in physical problems and chronic pain. Such treatments and surgeries also consume time, energy and money. I am not the only person to experience their embodied-medical trans journey as debilitating; many other trans people, even when satisfied with the results, have testified to the difficulties encountered and consequences of surgical transformations in their lives (Cotton, 2012). In sum, like other disabled people who experience forms of ‘crip time’ (Kafer, 2013, pp. 25–46), that is, the ‘extra’ time often needed to perform certain tasks and the energy, emotional strain and temporal burden experienced in ableist societies, trans people experience ‘trans-crip time’ (e.g., time required to find information on surgical procedures, educate doctors and society, heal) and a financial burden that affects the whole of their lives, activities and opportunities. In addition to being sufficient to qualify my transness as a disability, these combined factors (to name only these) are also a source of suffering. Layered over this pain is the suffering caused by the lack of recognition or refusal of this debilitating reality by social movements. For all of these reasons, a ‘disability politics of transness’ is needed.

It is not my intent to imply that transness is an exclusively negative aspect of my life. On the contrary, my transition is the best thing I have ever done. It was a turning point, a first step I had to take towards my hopes and needs instead of listening to my fears. Had I not done it, I would quite literally not be here. In the complex interstice of transness as a source of suffering and great satisfaction, of dysphoria and euphoria, it is worth mentioning that transition, like disability, changes your relationship not only to your identity and your embodiment, but also to others. It is on this note that I would like to conclude. The richest and most potent aspect of my transition has been its power to transform relationships; many were changed, deepened or made more intimate. Livingston (2005, p. 3) asserts that debility ‘troubles, mobilises, and intensifies social relations’. She is not alone in observing the paradoxical effects, sometimes negative, sometimes positive, of debility. Crow (1996) and Wendell (1996) have both demonstrated how disabilities transform interpersonal networks and individual relationships. Although my transition is the source of ruptured relationships with certain family and friends, it has also been an occasion for significant reconciliation with others. My transition has also frequently been an opportunity (during medical and surgical procedures, trans rights activities, public affirmation) to deepen and solidify relationships with my chosen family: my friends and life partners. Just as other disabled people are at the heart of social networks in which self-care and care for others are key, I have been and am still, as a trans person, at the centre of a similar network of care. At various times and in different ways, my friends and life partners have supported and respected my decisions; encouraged me to assert my identity; reminded others to use masculine pronouns; listened when I was down; supported my political battles; accompanied me to the hospital; injected me with hormones; and washed, fed and cared for me. All this has made my transition both possible and bearable. By ‘intensifying’ these relationships, my transition has allowed me to establish and/or solidify interpersonal connections that go beyond my transness, connections that create and recreate us, enrich our lives, and make collective action possible.

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