Needing to Acquire a Physical Impairment/Disability: (Re)Thinking the Connections between Trans and Disability Studies through Transability

ALEXANDRE BARIL and translated from the French by CATRIONA LEBLANC

This article discusses the acquisition of a physical impairment/disability through voluntary body modification, or transability. From the perspectives of critical genealogy and feminist intersectional analysis, the article considers the ability and cis/trans* axes in order to question the boundaries between trans and transabled experience and examines two assumptions impeding the conceptualization of their placement on the same continuum: 1) trans studies assumes an able-bodied trans identity and able-bodied trans subject of analysis; and 2) disability studies assumes a cis* disabled identity. The perception of transsexuality and transability as mutually exclusive phenomena results from a nonintersectional analysis of transsexuality as an issue of sex/gender, but not of ability, and of transability as an issue of ability, but not of sex/gender. Difficulty recognizing continuities between these phenomena thus stems from an ableist interpretation of sex/gender and a cis(gender)normative* interpretation of ability. This article aims to: 1) enrich intersectional analysis in trans and disability studies and transability scholarship; 2) complicate disability studies, in which disabilities are often presumed to be "involuntary," and encourage the decentering of a cis* subject; 3) encourage trans studies to decenter an able-bodied subject; and 4) advocate for increased dialogue and the creation of alliances between trans and disability studies and movements.*

A Subject that Makes Headlines... But Rarely in Trans and Disability Studies

In January 2000, a scandal erupted in the Scottish press. Dr. Robert Smith allegedly performed two amputations on otherwise healthy patients (BBC 2000) who had requested the amputation of a leg in order to bring their bodies in line with their "core identity." According to Smith, these patients suffered from Body Integrity Identity Disorder (BIID) (Smith 2004; 2009). BIID, or transability, refers to an

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able-bodied person's need to modify his or her body to acquire a physical impairment (amputation, blindness, and so on). Although the incident made headlines throughout the United Kingdom, and literature on the subject, although marginal, is growing in medicine, psychiatry, ethics, and philosophy, few researchers or activists in transsexual/transgender (henceforth trans) or disability studies have shown an interest. When I discuss my research on transsexuality and transability, researchers in trans and disability studies react with surprise. After I describe the phenomenon, they report that it is the first time they've heard about it and, following their initial incredulity, demonstrate a variety of "visceral" reactions, including anger, disgust, and incomprehension, only to arrive, ultimately, at "why"?

This article proposes an exploration of transability in comparison to transsexuality. An intersectional analysis of the ability and cis*/trans*[1] axes within trans and disability studies calls into question the assumed boundaries between trans and transabled experiences. Without merging the two realities, I investigate two implicit assumptions in trans and disability studies impeding the conceptualization of continuities between them: 1) trans studies assumes an able-bodied trans identity; and 2) disability studies assumes a cis* disabled identity (that is, without "voluntary" transition[2]). I posit that the perception of transsexuality and transability as mutually exclusive phenomena results from a nonintersectional analysis of transsexuality limited to sex/gender and excluding ability and other elements of identity, and of transability limited to ability regardless of sex/gender identity, despite the interlocking nature of these elements. Difficulty recognizing continuities between these phenomena stems both from an ableist interpretation of sex/gender identity and a cis(gender)normative* interpretation of ability. Although I recognize the differences between transitions of sex and ability, critical genealogical (Foucault 1976; 2001) and intersectional (Crenshaw 1989) analyses of these categories reveal boundaries less clear than might be expected. The resulting heuristic value of this article is fourfold; it proposes to: 1) enrich intersectional analysis in trans and disability studies and transability scholarship; 2) complicate disability studies, in which disabilities are often presumed "involuntary," and encourage the decentering of a cis* subject; 3) encourage trans studies to decenter an able-bodied subject; and 4) advocate for increased dialogue and the creation of alliances between trans and disability studies and movements.

Transability: Definitions

"Transability" describes an able-bodied person's need to modify his or her body to acquire a physical impairment/disability.[3] In scientific studies and on websites dedicated to transabled issues (BIID info 2013; Transabled.org 2013), this need is limited to physical impairment: amputation, paralysis, blindness, incontinence, and so on. Researchers and transabled individuals have adopted various terms for transability. In the 1970s, John Money, Russell Jobaris, and Gregg Furth discussed "apotemnophilia" (Money, Jobaris, and Furth 1977); by 2000, Furth and Robert C. Smith preferred the term "Amputee Identity Disorder" (Furth and Smith 2002); and in 2005, Michael

First adopted "Body Integrity Identity Disorder/BIID" (First 2005). This last, although not universal, quickly became the preferred term for researchers and the transabled community (Davis 2012).[4] Nonetheless, many authors still prefer "apotemnophilia," believing that the need to modify the body stems from sexual desire and paraphilia (Money and Simcoe 1986; Blanchard 2003; Elliott 2003; Lawrence 2003; Lawrence 2006; Braam et al. 2006; Blanchard 2008; Müller 2009). The paraphilia hypothesis has yet to be confirmed, and empirical research reveals that motives related to identity most frequently precede the need to transition (First 2005; Thiel et al. 2009; Blom, Hennekam, and Denys 2012; First and Fisher 2012),[5] and the identity disorder hypothesis is gaining consensus in the scientific community (Bridy 2004, 149; Richardson 2010, 201–03).

The use of the word "transability" in this article is guided by personal activism; the needs expressed by transabled individuals speak to me as a trans activist and transsexual man. In trans communities, the desire to develop terms allowing trans people to reclaim their experiences has long been expressed. "Transabled" was first coined by transabled activist Sean O'Connor at the beginning of this century (Marie 2007; O'Connor 2009, 89; Davis 2012). Word choice is significant; it reflects ideological perspectives guiding diagnosis and eventual "treatment" (Bridy 2004, 151; Mackenzie and Cox 2006, 369). In Foucauldian terms, the use of "transabled" may lead to the desubjugation of previously delegitimized transabled discourses and the justification of the claims of a community whose needs must be heard and respected rather than perceived as perverse or irrational.

Transability Today

Discussions about transability frequently turn to prevalence. Determining the number of transabled individuals is difficult for three reasons: 1) the recent emergence of relevant research; 2) the taboo, stigma, and marginalization that force many transabled people into silence;[6] and 3) the criminalization of the medical treatment of transability.[7] Prevalence is also difficult to establish due to the influence of the definition of transability used. Critical genealogical analysis increases understanding of the power/knowledge relations between transabled individuals and researchers and of how dominant interpretations of transability affect criteria for inclusion and exclusion. Three examples are given.

First, definitions vary with the motivation for transition. Researchers suggesting that transability is a paraphilia exclude individuals whose need to transition is not sexual. Conversely, including only individuals motivated by identity excludes those with other motivations (Blom, Hennekam, and Denys 2012). Second, defining transability exclusively in terms of amputation (First 2005) limits its prevalence by excluding individuals who wish to become paraplegic, blind, and so on. Third, including in the definition of transability the voluntary acquisition of diseases or viruses, such as HIV, must be considered. Given that a variety of diseases and chronic health conditions, such as HIV, are considered disabilities (Wendell 1996; 2001; Silvers 2009),

perhaps the voluntary acquisition of HIV (also called "bugchasing" [Tewksbury 2006]) could also be considered a form of transability. In this case, prevalence would increase. Although transability is rare, its rarity fluctuates according to who counts as "transabled."

Moreover, BIID is not an official disorder in the DSM-5, although it is mentioned in the text and appendices (APA 2013). Transability exists, but has no diagnosis, no legal status in most countries, and most researchers and medical professionals are unaware of it. Furthermore, due to an ableist vision of "normal" and "productive" bodies,[8] transabled people's requests are most often considered irrational and are denied. The consequences of this effacement[9] and the absence of legal and medical status are considerable. Despite significant psychological suffering (anxiety, obsessions, depression, suicide attempts), transabled individuals are isolated and left to fend for themselves (First 2005; Stirn, Thiel, and Oddo 2009; Blom, Hennekam, and Denys 2012); a significant number attempt the desired transformations on their own. First notes that 27% of his sample had successfully performed amputations and 54% were considering it (First and Fischer 2012, 5), and Rianne Blom, Raoul Hennekam, and Damiaan Denys report that 13% had performed amputations through a variety of strategies ranging from firearms to chainsaws (Blom, Hennekam, and Denys 2012; see also Smith 2004, 28; Bayne and Levy 2005, 79; Smith 2009, 43; Thiel et al. 2009, 60).

I propose that trans people's experiences and difficulties are similar to those of transabled people. Like transability, transsexuality was first appropriated by a psychiatric and medical establishment that marginalized trans knowledge and expertise. There has also been much debate on the role of identity and sexuality in transsexuality.[10] Also similar are the stigmatization, criminalization, and definitional issues that have limited the trans phenomenon's visibility and justified its marginalization under the pretext of particularist claims. Like transabled people, trans individuals suffer social, economic, medical, and other types of discrimination[11] and those without access to medical support often attempt to modify their bodies through illegal means (black-market hormones, silicone injections).

The Transsexuality-Transability Continuum: How Can Sex/Gender be Distinguished from Ability?

Although transsexuality and transability share certain similarities,[12] connecting and placing them on a continuum may not, at first, seem relevant. I reiterate that my goal is not to fuse these two phenomena. Unquestionably, the differences are many; consider the different identity categories to which transsexual and transabled people wish to belong or the various problems, discriminations, and violence they face.[13] One commonly raised difference is that transability results in disability whereas transsexuality does not. Adopting a genealogical approach and inspired by the works of C. Jacob Hale, Susan Wendell, Robert McRuer, and Susan Stryker, Paisley Currah, and Lisa Jean Moore, on the identity categories "trans person" and "disabled person"

(Wendell 1996; Hale 1998; McRuer 2006; and Stryker, Currah, and Moore 2008), I propose that these categories' boundaries are surprisingly malleable.[14] First, what are the criteria of inclusion and exclusion in each category? Second, through which power/knowledge relations have these categories historically been built? Who, as Wendell and Stryker and Stephen Whittle ask, has the power to define who belongs in these categories (Wendell 1996, 23–24; Stryker and Whittle 2006)? I argue that the relevant criteria of inclusion/exclusion have been defined by a cis*, able-bodied majority and that it is precisely these historically constituted constructions that have hindered the perception of the continuities between them. With the term "continuities," I propose not only that trans and transabled experiences present commonalities and exist on the same continuum, but also that they are interlocked and that these interconnections can be brought to light through intersectional analysis in trans and disability studies.

The claim that transsexual bodies remain "able-bodied" whereas transabled bodies become "disabled" obscures the fact that this distinction implicitly relies on dominant voices' limited definitions of what constitutes "trans" and "disabled" bodies. Many transsexual people who wish to modify their genitalia, or are forced to do so by the state in order to obtain civil status in their preferred gender, experience a loss of their "natural" ability to reproduce.[15] Surgery can also reduce function or sensation in erogenous zones or other parts of the body, cause incontinence from fistulas, or have other side effects. For these reasons, although transsexual people's primary motivation is not to modify their physical ability or functionality, it becomes difficult to distinguish so-called sex changes from ability transitions because many of the former imply minor or major transformations of the body's abilities, functions, and overall health. From this perspective, modifications to the trans body could belong to the realm of transability.

How is it decided which sex/gender markers must be modified for a transition to be considered a change of sex, rather than a change of ability? Inspired by Eli Clare, I propose that necessarily categorizing the modification of sex/gender markers as a sexual/gender transition is based on the implicit assumption of an able body. Clare argues that gender and ability are intimately intertwined (Clare 2009, 130–33); to be considered "real" men and women, certain linguistic and bodily codes (ways of moving, walking, standing) must be performed, but these performances are difficult, even impossible, for many disabled people. Men and women whose physical condition makes it impossible to "perform" the required codes are degendered and desexualized. Our conceptions of gender are founded on able bodies. Clare writes:

> disabled people find no trace of our sexualities in that world. We are genderless, asexual undesirables.... Think first about gender and how perceptions of gender are shaped. To be female and disabled is to be seen as not quite a woman; to be male and disabled, as not quite a man. The mannerisms that help define gender—the ways in which people walk, swing their hips, gesture with their hands, move their mouths and eyes as they talk, take up space with their bodies—are all

> based upon how nondisabled people move.... The construction of gender depends not only upon the male body and female body, but also upon the nondisabled body. (Clare 2009, 130)

This perspective allows an analysis of the ableist gendering and sexualization of specific parts of the body, and calls into question the definitions of transsexuality anchored in ableist views that preclude comparison to transability. Cross analysis of disabilities and sexualities (McRuer 2006; McRuer and Mollow 2012) reveals the ableism behind the dominant conceptions of sexuality focused on genitalia that marginalize disabled individuals for whom the genitals are one sexual referent among many. It therefore follows that gender, sex, and sexuality are signified not only by genitalia, secondary sexual characteristics, and traditional gender codes, but by the entire body/being. From an anti-ableist perspective, it is difficult to distinguish so-called sex changes and certain body modifications considered exclusively sex/gender-related from ability transitions because every part of the body can be marked as gendered/sexual. In this way, all body modifications, including transability, involve sex and gender. The difference lies in self-identification and individual subjectivity: one group desires to change sex/gender categories, the other to belong to the category of disabled people or to acquire a different form of corporeality in relation to function or capacity. Despite these significant differences, I maintain that the interpretation of transsexuality and transability as mutually exclusive phenomena is the result of a nonintersectional analysis in which transsexuality involves only sex/gender, regardless of ability, and transability is seen as affecting only ability, without considering sex/gender identity, despite the interconnection of these elements. That these continuities remain unrecognized reveals an ableist bias in trans studies and a cis(gender)normative* bias in disability studies. Beyond blurring boundaries and exploring similarities, comparing and establishing a continuum between these two phenomena also creates an opportunity to reexamine recurring feminist debates on autonomy and bodily freedom. This continuum invites broader investigation into the body's "normality" as assumed by dominant regimes and reveals the cis* (cis(dis)abled and cissexual) privileges on which negative reactions to these "extreme" modifications are founded.

The Unthought Possibilities of Intersectional Analysis

> There are no parallels whatsoever between transsexuality and wanting to be handicapped, you sick person. Transsexual people identify with a healthy state, and any diminishment to their functions incurred by transition, such as infertility..., is unwanted, and only a product of the current state of medical technology.... The people on this site are unashamedly dishonest about transsexuality and its "parallels" because they see it as their hope for their pathological desires to be fulfilled by the medical establishment, which, however, will never happen.... Please, you sick people, leave us alone. It's not our fault

> you're deranged. (Sc, comment no. 85, January 15, 2009, in response to Marie 2007)

The violence of this post by Sc, a transsexual person, in response to a transabled and transsexual woman's comment comparing transability and transsexuality is striking but perhaps not surprising. Here, a nontransabled transsexual person insults transabled people and invalidates their reality in order to avoid any association between the two phenomena. For this person, the connections between transsexuality and transability are *unthought* and *unthinkable*. Although intersectional analysis may reveal these continuities, this approach is not without its limits.

On the Limits of Trans Studies

Recently, trans studies have taken an "intersectional turn," particularly in trans feminist works (Koyama 2006; Serano 2007) and trans analyses of sexualities (Vidal-Ortiz 2002; Valentine 2007). However, other dimensions of identity remain undertheorized, such as class (Feinberg 2006; Irving 2008) and race (Koyama 2006; Noble 2006). The same is true for ability. With rare exceptions (Clare 2009; Hall 2009; Clare 2013), the connections between sex/gender identity and ("(in)voluntary") disability remain *unthought* and *unthinkable*. Lack of theorization leaves them *unthought*, and negative reactions make them *unthinkable*. Two examples follow. First, the rare transactivists who discuss transability have not been sympathetic to establishing connections to transsexuality. On transability websites, many transsexual individuals post hateful comments and refuse all links between transsexuality and transability. One trans person writes:

> I guess I just don't/can't understand why you would want to mutilate a healthy body part. Why?... We don't merely have these body parts chopped off, and of course their alteration doesn't affect our ability to see, hear, or walk. In all honesty, I am not happy with the idea of you trying to draw comparisons between BIID and transsexualism. (Wolfgang E.B., comment no 36, May 29, 2008, in response to Marie 2007)

Lynn Conway, an American transactivist, agrees. Conway worries that bringing transsexuality and transability together might undermine the legitimacy of trans demands (Conway 2004). Second, although some transsexual people tend to distance themselves from transabled individuals, they may be more open to creating ties with people whose disabilities are "involuntary." Unfortunately, few such coalitions exist. Wendell's and Andrea Nicki's examinations of many disabled individuals' dissociation from people with mental illness could shed light on transactivists' efforts to "de-psychiatrize" transsexuality (Wendell 1996, 21–22; Nicki 2001; Wendell 2001). Although I am critical of the "gender dysphoria" diagnosis, I wonder about the unintended consequences of this position. "De-psychiatrization" slogans (for example,

"trans, not sick") may be harmful to people who are disabled, ill, or suffer from mental illness. If disease and mental health issues were less stigmatized, would trans people still seek this dissociation? Do transactivists (myself included) react with suspicion to medical diagnoses because of negative associations derived from ableist assumptions? Following Clare (2013) and others, I wonder if trans groups' fight against "psychiatrization" might increase divisions among marginalized groups. These analyses reveal that the trans movement may have stumbled into transnormativity: a white, able-bodied, middle/upper-class, transnormative subject is assumed, thereby marginalizing racialized, poor, or disabled trans people (Spade 2011).

On the Limits of Disability Studies

Although disability studies have diversified and many authors have proposed cross analyses of disability and gender (Wendell 1989; 1996; Garland-Thomson 2002; Silvers 2009; Hall 2011), race (Meekosha 2006; Bell 2010), class (McRuer 2006), and sexuality (Wilkerson 2002; McRuer and Mollow 2012), trans issues are all but absent. These connections remain unthought. Lennard J. Davis, well known in disability studies, illustrates the lack of problematization of cisgenderism (Davis 2010). In a personal text, Davis relates the difficulties he experienced when his trans child "came out" (Davis 2000). Despite his daughter asking him to use feminine or non-gendered pronouns, a majority of masculine pronouns appear in the text. Davis's anti-ableism did not prevent cisgenderist actions. This is but one example among many.

The connections between disability and trans* issues also remain *unthinkable*, particularly because disability studies often assume the "involuntary" nature of disability, thereby rendering transabled realities invisible. Indeed, disability studies have demonstrated little interest in the decision-making process involved in modifying the body's health and abilities to acquire a physical impairment. Theorizing the critical dimension of "involuntary"/"voluntary" (cis*/trans*) physical impairment/disability acquisition in disability studies offers a better understanding of the connections among disabled, transabled, and trans realities. Trans issues are generally left to the field of sexuality and gender without recognizing that many trans people consider the need to change sex a psychological condition requiring diagnosis and treatment (and therefore a form of mental disorder) and that changing sex also affects corporeality.

If research exploring the lived experiences of people lacking a particular ability or limb is worthwhile, how can the exclusion of individuals who lack specific genitalia be justified? If the implications for a person's sexuality of having only one leg are a suitable subject for disability studies, then I submit that the experiences of trans men without penises, among others, are as well. The critical point here is that disability studies are concerned with bodies that differ from ableist norms, but stop short at markers of sex/gender; a bodily difference involving the hand, back, and so on, is the domain of disability studies, but the moment genitalia are involved, these differences

become the concern of trans, gender, and sexuality studies. Seen through a genealogical analysis of the constitution of fields of knowledge, disciplinary "divisions" and the "organization of fields" (Foucault 2001, 39) according to specific parts of the body that associate gendered parts of the body to feminist, gender, trans, and queer studies while everything else falls under the purview of disability studies stems from historically normative conceptions of what constitutes a sexualized or nonsexualized body. From a holistic view of identity, this fragmentary conception of health, the body, and sex/gender seems unduly limited. The experience of disability varies in accordance with numerous aspects of identity, and adopting an intersectional analysis that includes the cis*/trans* dimension in disability studies is an opportunity to incorporate these differences.

Decentering the Able-Bodied Subject of Trans Studies

Why must intersectional analyses in trans studies take ability into account? One reason is that transitions differ depending on a person's physical, mental, and emotional abilities. Compared to an able-bodied person, the disabled trans person is disadvantaged in the "performance" of feminine or masculine codes communicated through gestures, stride, speech, and bearing. As a result, a "successful" transition is judged according to dominant ableist criteria, in addition to sexist and gender stereotypes. What role does the paternalism directed at disabled people (infantilization, discourse delegitimization) play in potential access to authorizations and health care for disabled trans people?[16] How do trans and disabled bodily experiences of "difference" differ from or resemble one another in terms of gendered/sexualized and nongendered/sexualized parts of the body? What are the similarities and/or differences between the experiences of missing a hand, arm, penis, or breasts? These questions remain unanswered; virtually no relevant research exists.

Engaging trans studies from an anti-ableist perspective also means examining how the trans community replays forms of exclusion that marginalize disabled individuals. Just as some trans people distance themselves from disabled and transabled people, these exclusions also exist on the level of language: the trans community has a "monopoly" over particular concepts and semantic fields. The prefixes and adjectives "trans" and cis" are an excellent example.[17] Although linguistically applicable to a variety of people and realities (transracial, that is, requiring "ethnic cosmetic surgeries" [Zane 2003], or transabled [Heyes 2006]), their usage has thus far been restricted to trans (gender/sexual) realities. "Trans studies," "trans movement," "cis person," "transactivism," "cis identities," and so on all implicitly refer to transgender/transsexual and cisgender/cissexual realities. In order to decenter trans movements and theories from the sex/gender axis, one must imagine how theorizing transabled realities could have positive implications for redefining trans studies' vocabulary (as in the present use of "trans*" and "cis*" to refer to transgender/transsexual and transabled or cisgender/cissexual and cis(dis)abled individuals) by broadening both linguistic and identity categories and separating them from an exclusively able-bodied subject.

These theoretical and linguistic exchanges represent an opportunity to build solidarity and political alliances between these oppressed groups.

Decentering the Cis* Subject of Disability Studies

Intersectional analyses must also take into account the cis*/trans* dimension in disability studies. The experience of disability varies according to whether a person is cis*, that is, cisgender/cissexual or cisdisabled ("involuntary" disability), or trans*, that is, transgender/transsexual or transabled. How is the reception (and hierarchization) of requests for medical care based on gender identity different from that of requests based on physical ability? In the case of disabled transsexual individuals, would the medical establishment respond more favorably to requests to "cure" their physical condition than to change their sex? Is the (ableist) perception of disability more or less pronounced when a person does, or does not, conform to cisgenderist norms? The potential list of unanswered questions is very nearly endless, given the dearth of relevant analyses.

Taking the cis*/trans* "intersectional turn" in disability studies also means remaining vigilant to the more subtle forms of exclusion potentially being reproduced within the discipline, whether through perspectives adopted or terminology chosen. Although some authors insist on the importance of reserving judgment against people who opt for medical solutions to their disability or illness (Garland-Thomson 2002; Clare 2009; 2013), critiques of the medical curative model remain significant. The unfortunate result is the delegitimization of the need to transform the body to meet able-bodied norms (Wendell 1996; 2001). I posit that such discourses may also have negative implications for many trans* people (transabled and transsexual) for whom an unaltered (cis*) body is not an option. I contend that the belief that keeping one's "original" body (able or disabled) is preferable to changing it is founded on a cisnormative* assumption both common and rarely subject to critical analysis in disability studies.

Wendell provides an illustration of cisnormativity* (Wendell 1989). Despite theorizing the importance of various facets of identity to the experience of disability, the cis*/trans* dimension is absent. Given the text's publication date, this absence could be attributed to a lack of relevant contemporary theorization. However, her insistence on the "real body" seems not only to ignore the cis*/trans* dimension, but also reinforces the idea that "real" bodies exist in contrast to "false" ones. Wendell writes: "We are perpetually bombarded with images of these ideals, demands of them, and offers of consumer products and services to help us to achieve them. Idealizing the body prevents everyone, able-bodied and disabled, from identifying with and loving her/his real body" (Wendell 1989, 112). The phrase "real body" is not incidental; it is used repeatedly (116; 119). Although I agree that pressure to change the body according to aesthetic, racial, gender, and able-bodied norms exists and has a negative impact on many, it is overly

simplistic to reduce a person's need for body modification of whatever type to social and consumer pressures and problematic to conceive these transformations as a failure to "identif[y] with... her/his real body." Transsexuality and transability provide informative examples; individuals sometimes risk their lives to achieve their desired "ideal body." Have they failed to love and identify with their "real bodies"? What does Wendell mean by "real body"? Are surgically modified bodies "false bodies"? Wendell seems to equate the "real body" with the cis* (dis)abled body, an assumption that hinders the creation of alliances with trans* communities whose bodies are surgically transformed.

Rosemarie Garland-Thomson makes similar observations. Through a critique of plastic/aesthetic surgeries, she denounces the normative ideology that informs body modification. According to her,

> Cosmetic surgery, driven by gender ideology and market demand, now enforces feminine body ideals and standardizes female bodies toward what I have called the "normate"—the corporeal incarnation of culture's collective, unmarked, normative characteristics.... Cosmetic surgery's twin, reconstructive surgery, eliminates disability and enforces the ideals of what might be thought of as the normalcy system. Both cosmetic and reconstructive procedures commodify the body and parade mutilations as enhancements that correct flaws to improve the psychological well-being of the patient. (Garland-Thomson 2002, 10–11)

Although I agree with Garland-Thomson's critique of the pressure to present a "normalized" body, particularly for women and disabled people, one must remember, as do many feminist authors who study the autonomy and agency of women who chose aesthetic surgeries (Pitts-Taylor 2003; Davis 2009), that interpreting these surgeries as alienation due to dominant norms is reductive. Does Garland-Thomson's critique of surgery and derogatory vocabulary ("mutilations") lapse into an indictment of individuals who chose surgery, presenting them as being fooled into following norms to be deconstructed rather than literally embodied? Where does this critique leave trans people for whom corresponding to aesthetic norms is desired both as an end in itself and to be correctly gendered and thereby avoid a myriad of discriminations and violence? A trans woman may modify her body and facial hair to correspond to aesthetic norms of femininity, but also because facial hair is read, in a cisgenderist society, as a sign of nonfemininity, a preexisting masculinity potentially judged more "real" (Serano 2007). An intersectional analysis that includes gender identity offers a more complete perspective on the choice of aesthetic surgery. I also disagree with Garland-Thomson's claim that "our unmodified bodies are presented as unnatural and abnormal while the surgically altered bodies are portrayed as normal and natural" (Garland-Thomson 2002, 12). Although I appreciate her observations on the stigmatization of (ab)normal bodies, maintaining that surgically altered bodies are considered "natural" and "normal" sidesteps an analysis of cisnormativity* as well as the structural barriers, discrimination, and stigma experienced by trans* people whose

bodies are seen as false, fake, and unnatural. In a field of study whose central interest is the body, overlooking the cis*/trans* dimension and eschewing critiques of cis* identities excludes not only trans people, but transabled people as well. In fact, in a cisnormative* society, both able and disabled cis* bodies confer certain privileges.

Decentering the Transabled Subject's Normativity

If intersectional analysis is rare in trans and disability studies, it is all but nonexistent in transability research. Most of the relevant studies do not adopt anti-oppression perspectives and focus exclusively on transability, to the exclusion of race, gender, and other intersectional axes. Ableism, cisnormativity*, heterosexism, as well as neoliberalism and its productive norms, are rarely questioned. Nonetheless, it is important to critically examine ideas and discourses surrounding transability. What impact do discourses seeking to distance transability from mental illness have on people suffering from mental health issues? How might many transabled people's rejection of sexuality and "sexual perversion" and their insistence on leading normal (heterosexual) family lives negatively affect sexually marginalized groups? Emergent transability literature is largely characterized by the normalization of race, class, sex/gender, age, and so on; the assumed transabled subject is white, Western, male, of a certain class, well-employed, of average age, and so on. Three examples follow.

First, women are under-represented in the few existing transability studies. According to some quantitative studies (Roth 2009, 145), men more easily "qualify" for potential surgeries than women do, indicative of a sexist bias common in medical research. Second, although issues of race are absent from existing discussions of transability, one might ask how racial prejudice could influence how transabled people are judged. A number of authors who oppose transability argue that transabled individuals seek to live on society's dime and collect unearned benefits (Müller 2009; Patronne 2009). From this perspective, racialized individuals who reveal their transabled desires may be at greater risk of being accused of "freeloading" than are their white counterparts. Third is the question of socioeconomic class. The aforementioned Dr. Smith insists on post-operative transabled people's employability; they must remain "active" and "productive" in order to participate in economic life. Many transabled individuals also emphasize "productivity," asserting that they will be more productive and less costly to society (in terms of mental health care) after their transformation. It may be that "productivity above all" is a harmful message for both disabled and able-bodied people who, for whatever reason, do not or only occasionally participate in the labor market. Current studies on transability and the transabled movement are silent on matters of sex/gender, race, and socioeconomic class, and the integration of intersectional analyses presents an opportunity for the transabled community to develop alliances with other social movements.

This analysis attempts to shed light on ableism and cisnormativity* in our societies and social movements. Until now, disability studies have shown little interest in

trans* issues or "voluntary" disabilities. Similarly, trans analyses have limited the study of body modification to the sex/gender axes, leaving aside questions of ability and transabled transitions. This examination of the weaknesses of intersectional analysis revealed through the transsexuality-transability continuum is an invitation to develop analyses open and generous enough to respond with respect to emerging and as yet unthought claims for justice.

Notes

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1. Here, "trans*" refers to transsexual, transgender, and transabled individuals. The neologisms "cissexual," "cisgender," and their derivatives refer to nontranssexual people (Serano 2007, 33, 364). Anne Enke defines "cisgender" as "the condition of staying with birth-assigned sex, or congruence between birth-assigned sex and gender identity. . . . [C]isgender implies staying within certain gender parameters (however they may be defined) rather than crossing (or trans-ing) those parameters" (Enke 2012, 61). "Cis" refers to cissexual and cisgender realities. Here, "cis*" refers to cisgender, cissexual, and cis(dis)abled individuals. Please note that the neologism "cis(dis)abled" suggested here includes both disabled and able-bodied individuals who are not transabled, that is, who did not voluntarily modify their ability.

2. I am aware that the involuntary/voluntary distinction presents pitfalls. As mentioned by one reviewer, many people with "involuntary" disabilities do not consider their reality/corporality a disability to be cured and refuse treatment for a variety of reasons, and this refusal itself blurs the involuntary/voluntary distinction. The rights claims of the Deaf community (Lane 2010; Kafer 2011) are an illustrative example. In this article, the concept of cis(dis)abled people problematizes the involuntary/voluntary distinction by including people with "involuntary" physical impairments who "voluntarily" choose not to cure/change their bodies, thus remaining in a cis* disabled body. Furthermore, "voluntary transition" here refers to measures undertaken to modify one's body, whether to lose or gain abilities, physical functions, and so on. By asserting that disability studies remain centered on a cis* subject and under-theorize "voluntary transitions," I argue that: 1) the question of trans* identities is marginalized; 2) the disabilities studied are assumed "involuntary"; and 3) when "involuntary" disabilities become "voluntary" through the rejection of treatment, cis* identities remain dominant because of the value placed on cis* disabled identities refusing to submit to the medical imperative to cure.

3. Transabled people need to modify their body in ways that produce physical impairments leading to disabilities within dominant societal structures. As observed by one reviewer, there is a difference between transabled people who seek forms of corporeality deemed disabled from an ableist perspective, but who do not identify as disabled, and those who want to modify their bodies because they self-identify as disabled. Having a

physical impairment does not necessarily mean having a disability or being disabled. As observed by Harlan Lane and Alison Kafer in discussions about Deaf communities, certain individuals identify as disabled whereas others do not. The same is true for transabled people (Lane 2010; Kafer 2011).

4. Others, such as McGeoch et al. 2011, employ the term "xenomelia."

5. For feminist and queer analyses of the debate between identity and sexual "disorders," see Sullivan 2005; 2008a; Stryker and Sullivan 2009; Baril 2013; and Baril and Trevenen 2014a.

6. For transabled people's narratives, see Furth and Smith 2002; Stirn, Thiel, and Oddo 2009; and the documentaries BBC 2000 and Gilbert 2003.

7. For more information on criminalization and legal context, see Johnston and Elliott 2002, 432–33; Mackenzie 2008; Elliott 2009; Ryan 2009, 31; and Bennett 2011.

8. For discussions of normality and productivity and the links among the ableist, heterosexist, and capitalist systems behind discourses on transability, see Baril 2013 and Baril and Trevenen 2014a; 2014b. See Sullivan 2005; 2008b and Stryker and Sullivan 2009 on productivity and the neoliberal subject.

9. The notion of effacement, as developed by Namaste 2000, is borrowed from the field of trans studies.

10. I refer here to Ray Blanchard's and Anne Lawrence's controversial work on autogynephilia (Lawrence 2004; Blanchard 2008).

11. As mentioned by one reviewer, the attitude of some cis* feminists toward trans women illustrates one type of discrimination. These feminists see trans women as dominant group members and are suspicious of their abandonment of male privilege. They consider them threats and oppose their inclusion in women-only spaces. Similarly, transabled people are often suspected of passing from a privileged majority to a less-privileged minority. In both cases, analysis of negative discourses around these types of body modifications reveals tensions between discourses based on pity (trans* people as victims) and betrayal (trans* people as traitors). For an analysis of double discourses based on cisnormativity*, see Baril 2013, 188–92. The analogy between suspicions aimed at trans and transabled people may be politically useful, particularly to target analogous oppressive processes that affect them.

12. Several authors offer pathological comparisons of these phenomena (Blanchard 2003; Elliott 2003; Lawrence 2006; Blanchard 2008; Nieder and Richter-Appelt 2009). Others offer more positive comparisons (Sullivan 2005; 2008a; 2008b; Stryker and Sullivan 2009; Baril 2013; and Baril and Trevenen 2014a; 2014b).

13. Space limitations prevent further discussion of the differences between these phenomena. For more information, see Stirn, Thiel, and Oddo 2009. This article focuses on the heuristic potential of theorizing the similarities between these phenomena as a contribution to intersectional analyses in the fields of trans and disability studies.

14. The concept of "trans" has been critiqued as insufficiently fluid, and certain members of the trans community (genderqueer and transgender individuals) who do not identify with binary sex/gender categories have attempted to render the term more inclusive by adding a hyphen or asterisk. Stryker, Currah, and Moore, for example, have extended the meaning of trans- or trans* (trans-national, trans-racial, trans-species, and so on) beyond the dimension of sex/gender (Stryker, Currah, and Moore 2008). These were

particular interests of the TransSomatechnics Conference (Vancouver 2008). I would like to thank the anonymous reviewers for their contributions on this point.

15. Disabled individuals have been and are still subjected to forced sterilization (Wendell 1996; Meekosha 2006; Silvers 2009); this is also true of trans people. Transabled people who transition are likely to encounter similar problems.

16. Although the intersection of the cis*/trans* and ability dimensions is at the heart of this article dedicated to the epistemological and theoretical dimensions of intersectionality in trans and disability studies, space does not allow a detailed discussion of the many forms of discrimination suffered by disabled trans people. I thank an anonymous reviewer for raising this point and refer readers to Clare 2009; 2013.

17. Stryker, Currah, and Moore 2008 explore broadening the use of "trans," but do not mention the wider definition of "cis" proposed here.

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