

EXPLORING ABLEISM AND CISNORMATIVITY IN THE CONCEPTUALIZATION OF IDENTITY AND SEXUALITY “DISORDERS”

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Abstract

This article explores different conceptualizations of, and debates about, Body Integrity Identity Disorder and Gender Identity Disorder to first examine how these “identity disorders” have been both linked to and distinguished from, the “sexual disorders” of apotemnophilia (the desire to amputate healthy limbs) and autogynephilia (the desire to perceive oneself as a woman). We argue that distinctions between identity disorders and sexual disorders or paraphilias reflect a troubling hierarchy in medical, social and political discourses between “legitimate” desires to transition or modify bodies (those based in identity claims) and “illegitimate” desires (those based in sexual desire or sexuality). This article secondly and more broadly explores how this hierarchy between “identity troubles” and paraphilias is rooted in a sex-negative, ableist, and cisnormative society, that makes it extremely difficult for activists, individuals, medical professionals, ethicists and anyone else, to conceptualize or understand the desires that some people express around transforming their bodies—whether the transformation relates to sex, gender or ability. We argue that instead of seeking to “explain” these desires in ways that further pathologize the people articulating them, we need to challenge the ableism and cisnormativity that *require* explanations for some bodies, subjectivities and desires while leaving dominant normative bodies and subjectivities intact. We thus end the article by exploring possibilities for forging connections between trans studies and critical disability studies that would open up options for listening and responding to the claims of transabled people.

Keywords: Trans and queer theories; disability studies; body modifications; sexual and identity disorders; pathologization, transability.

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Introduction

This article¹ examines recent work in trans and critical disability studies from a feminist and queer perspective to explore how debates about what sometimes gets called AID (Amputee Identity Disorder), or BIID (Body Integrity Identity Disorder), highlight the fraught relationship between pathologized identity disorders and sexual disorders or paraphilias. Both AID and BIID have been used to describe and diagnose non-disabled people (people who sometimes identify as transabled) who wish to become disabled through body modifications such as amputation or surgeries that would limit vision or hearing. In this paper, we examine debates in medical, scientific, social scientific and ethical fields about how to understand BIID. We argue that these debates reflect many of the same assumptions and discourses that characterize understandings of GID (Gender Identity Disorder), and that an implicit and explicit hierarchy gets established between the “legitimate” identity disorders of BIID and GID and the “illegitimate” paraphilias of apotemnophilia (the desire to amputate healthy limbs) and autogynephilia (the desire to perceive oneself as a woman). We maintain that in medical and social discourses around GID and BIID, surgery might be seen as justifiable in the context of an “identity disorder”, while people diagnosed with the paraphilias of autogynephilia or apotemnophilia are perceived as deviant or perverse and as not having a sufficient or justifiable motive for surgical or medical body modification.²

We argue that this hierarchy between “identity troubles” and paraphilias is rooted in a sex-negative³, ableist⁴, and cisnormative⁵ society, that makes it extremely difficult for activ-

1 The authors would like to thank the editors of this special issue and the two anonymous reviewers for their thoughtful and generous feedback.

2 Although we identify and examine a seeming hierarchy between “justifiable” desires based on identity and “illegitimate” or “unjustifiable” desires based on sexuality, it is very important to note that many people diagnosed with gender dysphoria still experience profound barriers to obtaining gender affirmation surgery, or good medical care at all. Please see Garner in this issue for a discussion of these barriers.

3 As Gayle Rubin (1984) argues, a sex-negative society, is characterized both by a fear of sex as dangerous or immoral and by the valorization or acceptance of only a narrow vision of sex and sexuality that involves, cisgender, heterosexual, monogamous, married, and reproductive sexual relations or practices. In sex-negative societies, sex between same-sex partners, public or group sex, sado/masochism and any other sexual practice that falls outside of the heteronorm is portrayed as deviant and threatening.

4 As scholars within the field of critical disability studies have argued (e.g. Wendell, 1996; Garland-Thomson, 2002; 2011; Lanoix, 2005; McRuer, 2006; Silvers, 2009; Davis, 2010; Hall, 2011), an ableist society is characterized by the cultural, social, political, legal and economic oppression of people with disabilities. Ableist societies are structured to privilege the normate body with cultural, political and social insulations and norms reflecting that body. People with disabilities face high levels of violence, marginalization, poverty and stigma, often perpetuated by medical institutions.

5 The term cisnormative is used here to refer to the assumption that it is more “natural” or “normal” to keep the body intact than to transition or transform your sex or gender. The term cisnormative

ists, individuals, medical professionals, ethicists and anyone else, to conceptualize or understand the desire that some people express around transforming their bodies—whether the transformation relates to sex, gender or ability. This difficulty is reflected in negative reactions—both societal and medical—to transgender, transsexual and transabled people. Negative reactions, we argue below, that are particularly strong if the desire for transformation is seen as a sexual desire instead of an “identity desire.” Just as many transgender and transsexual people are asked to *explain* and *justify* their desire to transition in ways that cisgender and cissexual people are never asked to justify their sex, gender or gender presentation, we see in the literature that people who identify as transabled must contend with cultures of compulsory able-bodiedness that assume a normate “able” body is always preferable and desirable. In both of these contexts, there are extremely high stakes attached to how trans*⁶ people are diagnosed, pathologized, sexualized and medicalized, since these diagnoses will often serve to either justify access to health care and other resources or serve to further marginalize individuals deemed perverse. In response to the social, political, medical and cultural context in which body modifications and transformations get regulated and evaluated, and in the spirit of feminist and queer theories that aim to destabilize dominant norms of sex, gender, sexuality and embodiment, this article has two objectives: first, to examine the ableist and cisnormative assumptions governing the debate, and secondly to explore options for discourses and practices that would respect the claims of trans* people.

We divide the article into four main sections. In the first, we briefly outline the history and development of the “new paraphilia” of apotemnophilia. We trace how desires for “disabling” body modifications were first conceptualized as sexual perversions or as para-

is inspired by the terms “cisgender” and “cissexual” which refer to persons who do not change sex and gender (non-transgender people and non-transsexual people). According to its Latin etymology and its initial use in pure science, the prefix “cis” means that an element remains intact and static, unlike the prefix “trans” which means a passage and a transition from one state to another. For an interesting history of the concept of “cis”, see Serrano (2007), Baril (2009b) and Enke (2012a). Cisnormativity, as defined by Bauer et al. (2009: 356), thus refers to the oppression experienced by transsexual and transgender people in a society that identifies and represents cissexual/cisgender people as dominant, normal and superior. Here we expand the term to include the oppression experienced by people who transform their bodies to achieve a disability or impairment.

6 In this article, we use the term “trans” to refer to transgender and transsexual people. We then use the term “trans*” to include other forms of transition such as the transitions pursued by people who identify as transabled. This second term therefore can refer to transabled, transgender and transsexual people.

7 We use quotation marks around the term “disabling” here to highlight our commitment to theorizations of the social model of disability. Critical disability studies scholarship in recent decades have analyzed two important models for understanding disability. The first, a medical model, is highly individualistic and characterizes disability as a problem that must either be accommodated or “cured”/rehabilitated (McRuer, 2006). The second social model of disability, makes important distinctions between debility or impairment, the disability *caused* by the impairment in the context that the person lives, and finally, the disability that lies at the intersection of disability and environment (architectural, material, social, cultural, political, etc.) of people living with disabilities (Wendell, 1989; Garland-Thomson, 2002; Lanoix, 2005; Meekosha, 2006; Tremain, 2008; Silvers 2009 Shakespeare, 2010). In the social model, it is the environment that creates disability by failing to provide the resources or modifications for the full recognition and integration of people with abilities that don’t fit dominant norms. By using quotes around the term disabling, we want to problematize the assumption that certain body modifications create disability instead of impairment.

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phobic disorders, and then later seen more commonly as linked to identity disorders (BIID). We then briefly introduce the comparisons between BIID/apotemnophilia and GID/autogynephilia that are made by both medical professionals and members of the transabled community. In the second section we examine the debates around causal explanations for the desire for sex or gender transitions—debates that have historically pitted a diagnosis of a paraphilia such as autogynephilia against a diagnosis of an identity disorder (GID). We explore the controversial work of researchers Ray Blanchard (1989; 1991; 1993; 2003; 2005) and Anne Lawrence (1998; 2003; 2004; 2006; 2007; 2009), along with a few others, who have advocated for explaining the desire to transition largely in terms of paraphilia. In this section we consider how these two different diagnoses might create a hierarchy between “true” and “false” trans people and thus look at the concrete effects of different diagnoses on trans people in terms of bodily autonomy, respect and access to treatment or resources. Importantly, we explore this debate not to evaluate or determine the “truth” or accuracy of any diagnosis, or of theories of autogynephilia or apotemnophilia. Instead, we seek to understand what debates about sexuality and identity disorders demonstrate about how cisnormativity shapes the broader society’s response to people who desire some form of transition.

The third section of the article moves from the discussion of GID/autogynephilia to a discussion of the controversies around similar debates in the diagnosis of BIID/apotemnophilia. We ask how sexuality (and the diagnosis of paraphilia) gets used to both pathologize and discredit complicated and diverse claims about bodily autonomy/integrity, desire, modification and identity. We explore why identity claims might be given more legitimacy and weight (if and when they are) than claims based in sexual desire, attraction or fantasy. There are many implications to the distinctions made between BIID and GID as identity disorders, and a diagnosis of a paraphilic sexual disorder such as autogynephilia or apotemnophilia. We argue again that these divisions can create a hierarchy between “real” and “false” desires for surgeries or body modification—the real desire constructed as coming from identity claims and the false desire coming from paraphilia (Sullivan, 2008a; 2009). We maintain that some contemporary research contributes to this distinction between real and false (even if researchers like Blanchard and Lawrence disavow this distinction), and also participates in the search for the “cause” of transsexuality and the desire for “disabling” body modification—a search that traps this research in a disease-oriented, individualistic model and one that leaves cis and normate bodies unexamined. Debates over discourses that both distinguish between real and false claims, and that present trans and transabled people as requiring “diagnosis” or “explanation” highlight the importance of challenging both cisnormative and ableist conceptions of normal bodies, sexualities and identities.

The fourth and final section of the paper briefly examines the potential for building solidarities between different communities of people around a commitment to challenging the regulation, medicalization and stigmatization of non-normative bodies and sexualities. In this section, we build on work done by trans* and disability scholars to explore the similarities between how trans* people and disabled people are often both desexualized and hyper-sexualized and how both groups get rendered perverse, deviant or burdensome in our transphobic and ableist society. We pay particular attention to what queer disability scholar Robert McRuer (2006) calls the neoliberal imperative for bodies to be “flexible” and productive and the way this imperative shapes responses to desires or bodies that fall out-

side the ableist cis heteronorm (to stay in the “natural” given body). Arguing that ablesist and cishnormative systems of power are at the root of the requirement that trans* people justify their transitions in terms that are intelligible to medical, political and cultural norms but that might be problematic for trans* people themselves, we call for rethinking body modification and different forms of transition in a way that decenters the *necessity* for an explanation based on either pathologized sexuality or identity. We hope that this decentering of the cis, normate body will open up new ways of understanding and responding to the desire for body modification or transition.

I. “Strange” desires: When atypicality is pathologized

I.I. *The birth of a new paraphilia: Apotemnophilia*

Perhaps ironically, it is possible to say that the current list of paraphilias is as long as the histories of psychiatry and sexology from which they emerged. Throughout the 19th and 20th centuries, sexologists have counted, classified, analyzed and interpreted various sexual practices and preferences characterized as abnormal or strange. Among them have been homosexuality, transvestism, transsexualism and pedophilia, to name some of the most commonly known. While some of these practices have been increasingly normalized by social movements in the past few decades, (arguably homosexuality and transsexuality), others have continued to be criminalized and viewed as abnormal (pedophilia). Apotemnophilia (from the Greek: love of amputation) falls into a third category: a sexual desire or practice that has been largely unknown in the broader culture. Throughout the 19th and 20th centuries there was limited research into people who had sexual interest in people with disabilities. Researchers and doctors came to distinguish between abasiophilia (sexual attraction to people with mobility impairments) and acrotomophilia (attraction to people with amputations—a community now often called “Devotees” in certain sexual subcultures). Unlike both of these desires, apotemnophilia became distinguished by the sexual desire to *become* a person with a disability through amputation of a “healthy” limb, instead of an attraction *to* disabled people (Elliot, 2000; Smith, 2004; 2009).

Two things have led to increased scientific interest in the small but growing phenomenon of people “in good health” that want to transform their bodies into “disabled bodies.” The first, in 1977, was a case study published by John Money, a researcher known for his work on intersexuality and transsexuality. The study concerned two men who expressed the desire to amputate a limb (Money, Jobaris & Furth, 1977). Money and his colleagues believed that there was a strong sexual dimension to the desire for voluntary amputation, described this phenomenon as a paraphilia, and named it apotemnophilia. With few exceptions (Ryan, 2009; Swindell & St-Lawrence, 2009 for reviews; Bruno, 1997), the phenomenon remained in the shadows within the scientific community until the second event: in the late 1990s, Dr. Robert Smith performed voluntary amputation surgeries on two men with healthy limbs (Smith, 2004; 2009).

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These two events catalyzed growing interest from physicians, psychiatrists, psychologists, sexologists, ethicists and social scientists (*e.g.* Elliot, 2000; Furth & Smith, 2002; Dosanjh Kaur, 2004; First, 2004; 2005; Bayne & Levy, 2005; Sullivan, 2005; 2008a; 2008b; 2009; Tomasini, 2006; Brang, McGeoch & Vilayanur, 2008; Elliott, 2009; Patronne, 2009; Stirn, Thiel & Oddo, 2009; Stryker & Sullivan, 2009). Increased interest in people desiring this form of bodily modification has sparked debates among researchers, activists and community members, and has also led to an increased number of hypotheses about the cause of this “paraphilia” or “disorder.” The Internet has provided a further resource for individuals and groups of people who identify as transabled, or as having BIID, allowing them to share information and to increasingly start making their own arguments about their desire for body modification. Websites like BIID-Info.org, biid.org and transabled.org⁸ contain discussions and debates about the categorization of this desire as a paraphilia and raise questions about the process by which some desires and bodies get pathologized.

1.2. *Apotemnophilia: Between paraphilia and “identity” trouble*

The stakes of the debate about whether or not someone has a paraphilia or an identity disorder are high considering how people whose desires, practices, lives and experiences differ from the dominant norm are both pathologized and sexualized. Queer scholars have long pointed to the ways in which people outside of the heteronorm are represented as perverse, threatening and hypersexual, and queer scholar Jasbir Puar has recently traced how constructions of the Muslim “terrorist” depend on queering those terrorist subjectivities—often through processes that specifically queer racialized masculinity by portraying it as perverse, effeminate or excessive (Puar 2007). It is against the backdrop of the marginalization of people with non-normative sexual desires or preferences, then, that a small but growing transabled community, and individuals who desire “disabling” body modifications (who may or may not identify as transabled) began challenging the assumption that desire for these body modifications are primarily driven by sexual desires/paraphilia (Gheen, 2009). Some scholars support these questions; Furth & Smith (2002) put forward the hypothesis that the desire for a “debilitating” body modification might come from an identity disorder only slightly, or not at all, related to sexuality. This disorder was initially termed by Furth & Smith (2002) as Amputee Identity Disorder/AID but was reconceived by Michael First (2004; 2005; 2009) as Body Integrity Identity Disorder (BIID). First (2004) conducted the first quantitative study of 52 subjects who experienced what came to be described as BIID. Like Furth & Smith (2002), First (2004) argued that although there was sometimes a sexual component to the desire for amputation (it was the primary motivation for 15% of the research subjects), the majority of individuals in the study (73%) expressed their primary desire for amputation in terms of identity, “[...] to match their body to their identity [...]” (First, 2004, p. 8). First’s research supports discussions and comments about transabled identities found on blogs and websites devoted to BIID.

8 Some of these sites were no longer active as we were revising this article. We have retained the references, however, since they provided important data for our research at the time of writing and were influential in debates about BIID.

The most extensive website on the subject of BIID (BIID-Info.org), maintains that there is a clear distinction between apotemnophilia (the sexual desire to *become* a person with a disability) and BIID. In the “Frequently Asked Questions” section of the site, this response is posted to the question “Is BIID a sexual fetish?”⁹:

No, Body Integrity Identity Disorder is not a sexual fetish.

The majority of people who have BIID talk about a difference in body image, or self-perception, where sexuality does not come into play, or comes in minimally, as part of being a healthy, “normal” adult.

While some people have a primary sexual interest in acquiring an impairment, that is a different condition called Apotemnophilia, which John Money introduced as a paraphilia in the late 1970’s.

Above we see that the site references John Money and his research collaborators, and in other places further argues that in the 1970s, their research confused BIID and apotemnophilia. In response to the question “What is BIID?” the site offers the following response:

Body Integrity Identity Disorder, or BIID, is a condition characterised by an overwhelming need to align one’s physical body with one’s body image. This body image includes an impairment (some say disability), most often an amputation of one or more limbs, or paralysis, deafness, blindness, or other conditions. In other words, people suffering from BIID don’t feel complete unless they become amputees, paraplegic, deaf, blind or have other “disabling” conditions.

The term Body Integrity Identity Disorder was proposed by Dr. First in 2000, to replace *the inadequate apotemnophilia* [our emphasis]. Dr. First devised the term with a focus on people requiring amputations, but has stated that the definition should probably be expanded.

The term Amputee Identity Disorder, suggested by Furth and Smith was a precursor of the term Body Integrity Identity Disorder, although the later is more accurate and representative of the condition.

Most people who have BIID report memories related to the condition going back to early childhood, often before the age of 5¹⁰.

As Richardson (2010) notes, there was a significant paradigm shift in discourses surrounding transabled people at the turn of the millennium as discourses moved from a primary focus on sexuality to a focus on identity—and particularly to the idea of “identity

9 BIID-Info (2012). «Is BIID a sexual fetish?», Consulted February 16, Online : http://biid-info.org/Is_BIID_a_sexual_fetish%3F. The website BIID.org puts forward a similar answer.

10 BIID Info (2012). «What is BIID?», Consulted February 16, Online : http://biid-info.org/What_is_BIID%3F.

trouble” (p. 201-203). The shift has occurred not only within the transabled community and amongst people who identify as having BIID, but also within the medical and psychiatric community as the diagnosis of apotemnophilia has been both critiqued and now largely replaced by the diagnosis of BIID within scientific literature on the subject, even though BIID has not been formally included in the DSM-5 (First, 2004; 2009, p. 54)¹¹.

As a result of this shift, essentialist discourses putting forward biological or social/environmental arguments have arisen around BIID, insisting that each person has a fundamental identity that needs to correspond with their corporality¹². We see this kind of argument being made by Gregg, a transabled man quoted in a BBC report on BIID done in 2000. He explains that, “For me to have been born without my lower right leg would have been more the perfect theme of what I see my body as. It, it’s almost I could say almost a deformity. It’s, it’s a wrongness, *it’s not a part of who I am*” (our emphasis). A similar argument is made by Robert Vickers in a report by ABC Television (2009) who maintains that his leg is not his own. The title of the documentary, *Whole*, by Melody Gilbert (2003), also reflects the complex themes that characterize identity-based discourses: that transabled people must modify their bodies or bodily functions (limbs, hearing, sight, etc.) in order to feel at home and complete (“whole”) within themselves.

The aphorism, “to be born/in the wrong body,” long explored by the transgender and transsexual movement,¹³ also reflects this conception of identity currently used in the transabled community (Sullivan, 2008b), and there are a growing number of comparisons being made between BIID and GID (Gender Identity Disorder) by transabled people on websites such transabled.org (Marie, 2007) and in the medical literature (Furth & Smith; 2002; Gheen, 2009; Stirn, Thiel & Oddo, 2009; BIID-Info, 2012¹⁴). Recently, queer and trans studies scholars have also drawn parallels between BIID and GID when comparing different types of bodily modification, such as “sex reassignment surgery”,¹⁵ amputations and cosmetic surgeries as part of a project of nuancing and challenging representations of BIID as “extreme” or “crazy” body modification (e.g. Stryker & Sullivan, 2009; Sullivan, 2004; 2005; 2008a; 2009). In fact, the majority of the literature considering BIID since 2000

11 In 2012 the APA website indicated that BIID was under review to be included in the DSM-5. The website said, “There are a number of conditions that are being recommended for addition to DSM-5 by outside sources, such as mental health advocacy groups, that are still under consideration by the work groups. The following conditions are considered “under review,” and work groups will make a recommendation about their inclusion after further assessing the evidence”. BIID is listed under “following conditions.” For details, see: <http://www.dsm5.org/proposedrevision/Pages/Conditions-Proposed-by-Outside-Sources.aspx>. However, BIID was not included as an official diagnosis in the DSM-5 (APA 2013). Instead it was included in an appendix referring to disorders that require further research before inclusion or exclusion in upcoming editions. BIID is mentioned twice, however, once in the relation to gender dysphoria and once under difficulties qualified as Body Dysmorphic Disorder (BDD).

12 Elliot (2000) and Clervoy (2009) address the construction of this discourse in the transabled community.

13 See especially: Halberstam (1998, p. 143-173), Rubin (2003, p. 149-156), Green (2006) and Sullivan (2008b).

14 See http://biid-info.org/Transabled_Vs_Transsexual.

15 There have been extensive critiques of the medical terms “sex reassignment surgery” and many people prefer the terms “gender affirmation surgery.” In this paper we use the terms sex reassignment surgery when we are referring to medical discourse as part of our critique of the pathologizing and reductionist impact of different medical terms or concepts.

makes more or less direct comparisons between these two phenomena (BIID and GID), and speculates on their differences and similarities (e.g. Blanchard, 2003; Elliot, 2000; Lawrence, 2003; 2006; 2009; First, 2004; 2005; 2009; Clervoy, 2009; Nieder & Richter-Appelt, 2009; Roth, 2009; Dua, 2010). Smith (2004), who distinguishes sharply between apotemnophilia and BIID, goes as far as speculating that BIID “appears to be very similar in development, progress and response to treatment as GID and could possibly be included in the same diagnostic category” (p. 29). First (2004) shares this perspective:

For the small group of study subjects for whom sexual arousal is the primary motivation (15%), the diagnosis of apotemnophilia is appropriate (DSM-IV-TR paraphilia not otherwise specified). However, for the majority (73 %) for whom the primary goal of amputation is to match their body to their identity, no DSM-IV-TR diagnosis even remotely fits. The diagnostic category that most resembles the phenomenology of this condition is Gender Identity Disorder (GID), with which it shares several key features. In both conditions, the individual reports feeling uncomfortable with an aspect of his or her anatomical identity (gender in GID, presence of all limbs in this condition) with an internal sense of the desired identity (to be the other sex in GID, to be an amputee in this condition) (p. 8).

First’s research highlights the fact that, for many reasons, the diagnosis of apotemnophilia does not accurately respond to the realities and discourses of transabled people or people who identify as having BIID. This nosological category (apotemnophilia) remains an entry in the DSM-IV-TR and now the recent DSM-5, while the category of BIID was not included (see footnote 11). Below, we argue that these debates are expanding conceptions of “trans” bodies and identities to include emerging conceptions of “transabled” people who are transitioning, or seeking to transition, between “able” and “disabled” bodies. Importantly, divergent theories of whether or not the desire for voluntary amputation belongs to a “paraphilia” or an “identity disorder” echo similar debates between researchers who view transsexuality as a phenomenon of identity, and researchers who argue that there is an aspect of paraphilia to many gender or sex transitions.

2. Debates surrounding transformations of sex and gender

2.1. *GID vs. autogynephilia: Competing histories, competing diagnoses*

Debates surrounding the diagnosis of GID are diverse and contested (Cohen-Kettenis & Gooren, 1999; Lev, 2005). Perspectives vary from conservative positions committed to preserving it as a nosological category (e.g. Mercader, 1994; Zucker & Bradley, 1995; Breton & Cordier, 1996; Chiland, 1997; Cordier, Chiland & Gallarda, 2001; Michel & Pédinelli, 2005), to reformist perspectives advocating a pragmatic balance between retaining the category to increase access to expensive treatment and lessening the stigma surrounding a diagnosis of GID (e.g. Winter, 2006; Coleman, 2009a; 2009b; Drescher, 2010; WPATH,

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2011), to abolitionists who advocate for eliminating gender transitions from psychiatric categories altogether (e.g. Burke, 1996; Isay, 1997; Wilchins, 2004; Hale, 2007). These debates highlight the many different reasons for retention, reform or eradication of the diagnosis—reasons such as access to healthcare and psychological services, the impact of a diagnosis on trans people’s lives, and the complex relationship between pathology and stigma. For the purposes of this article, however, we focus on the controversy surrounding the links made between trans subjectivities, and paraphilias or sexual “disorders.”

Controversies surrounding the connections between gender identity and sexual orientation/sexuality are not new. By the 1910s and 1920s, Hirshfeld (1910/1991) had already distinguished between homosexuality and transsexualism while Benjamin (1966) further distinguished between transvestism and transsexuality. This research laid the foundation for Freund who, in the 1980s, maintained that there were two different groups of transsexual women (male to female) based on their gender assigned at birth and sexual orientation: homosexual and heterosexual (Freund, Steiner & Chan, 1982). Ray Blanchard, mentored by Freund, continued this research into categorizing trans people and explained that he, “began [his] research by defining and labeling the same groups of male-to-female transsexuals identified by Hirschfeld: homosexual, heterosexual, bisexual, and asexual (i.e., transsexuals attracted to men, women, both, or neither, respectively)” (2005, p. 443). In 1989, Blanchard published research arguing that there were two types of transsexuals. Using this typology, he developed the concept of autogynephilia (someone who is sexually excited by the perception of themselves as a woman) to describe non-homosexual transsexual women (i.e. those who are not sexually attracted to men) (1989; 1991; 1993; 2005). According to Blanchard, many trans women belong to this group of autogynephiles and he therefore concluded that there was an aspect of paraphilia to many transitions. Blanchard also believed that many autogynephilic transsexuals refuse to recognize the sexual dimensions of their desire to transition, despite the fact that this condition characterizes the majority of sex changes from his point of view.

By the late 1990s, researcher Anne Lawrence—identifying herself as a transsexual autogynephile, revived work on Blanchard’s typologies in an attempt to further validate them (Lawrence, 1998; 2004; 2005; 2007; 2008; 2011). In spite of her methodological critique of Blanchard’s work, Lawrence supported his theory of autogynephilia. Bailey followed this work with his book, *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism*, in 2003 and ignited new controversy surrounding Lawrence and Blanchard’s work and around the diagnosis of autogynephilia (Bailey & Trica, 2007; Blanchard, 2008; Dreger, 2008; Serano, 2008; Zucker, 2008; Drescher, 2010). Discussion about changes to the newest edition of the DSM (DSM-5) revived old debates within the scientific community, as well as with (and within) communities affected by the nosographic categories established by this reference book.

The scientific community has critiqued the theorization and categorization of autogynephilia on both methodological and theoretical grounds (O’Keefe, 2007; Moser, 2009; 2010). Trans and broader LGBTQ communities have also criticized the theory for being transphobic, sexist, heteronormative and cisnormative (Allisson, 1998; James, 2004; Conway, 2006; 2008; Serano, 2007; 2008).

2.2. *The impact of controversies surrounding GID and autogynephilia*

Despite the critiques and controversies surrounding the notion of autogynephilia, however, Blanchard's influence can be seen throughout medical and psychiatric conceptualizations of trans identities and realities. In fact, although the reference to GID in the DSM-IV-TR doesn't mention autogynephilia, both autogynephilia and autoandrophilia (the sexual desire of a cissexual woman to perceive herself as a man) are categorized as paraphilias (APA, 2000). In addition, references to sexual orientation are present in the diagnosis of GID, echoing the distinctions historically established by Benjamin, Freund and Blanchard in their theory of autogynephilia.

Revisions made to the GID diagnosis proposed by the "Sexual and Gender Identity Disorders Work Group" for the DSM-5 are major and indicate a distancing from Blanchard's ideas. The revisions included changing the appellation GID (Gender Identity Disorder) to "Gender Dysphoria (in Adolescents or Adults)," and also abandoning any reference to sexual orientation¹⁶. Blanchard's presence in the "Sexual and Gender Identity Disorders Work Group" (Zucker, 2010), however, suggests that his theoretical framework regarding autogynephilia had influence on the DSM-5; this was particularly in relation to the category of "transvestic disorder" which had the additional specifiers of "with fetishism" and "with autogynephilia" (APA, 2013, p. 702). Importantly, the DSM-5 also includes attempts to depathologize conceptualizations of paraphilias by contextualizing them as disorders only if they cause distress or difficulties for the individual, or harm to others. In other words, there could be a more robust distinction made between a "healthy" nonnormative sexual attraction and an "unhealthy" sexual attraction (one that causes distress or harm). However, it's important to note, from a feminist and queer perspective, that sexualities labeled as paraphilic disorders are overwhelmingly those that don't conform to dominant sexual norms (Caplan, 1995; Wilkerson, 1998; Butler, 2004; Wilchins, 2004; Halperin, 2007). We argue that depathologizing a variety of sexual practices requires a less individualistic approach than that of individual diagnosis and also requires a structural analysis of the systems of oppression that *create* distress and difficulty for people with atypical sexualities or desires.

According to Blanchard, Bailey and Lawrence, the sexuality-based theory of autogynephilia strives to provide an alternative to discourses based on gender identity that prevail in both scientific and activist communities (Bailey & Triea, 2007, p. 531). All three authors are convinced that sexuality is central to many transitions but they also argue that a sexuality-based explanation of the desire to transition should not supplant an identity-based one but instead that the two explanations are possible. Despite this assertion and their insistence that one kind of claim shouldn't be seen as more legitimate than another, all three seem to fall into the very trap they denounce—at many points their research seems to

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16 See the APA's site concerning the revisions to the 5th edition of the DSM : <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=482>.

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support replacing one monolithic discourse (identity) with another (pathological sexuality).

The stakes of these arguments, and their implications for trans people seeking medical treatment or intervention, are fraught. Blanchard, Bailey and Lawrence are all accused of implicitly reintroducing a form of the historical distinction between primary and secondary transsexuality, a distinction used by the medical profession to either legitimize or deny sex reassignment surgery.¹⁷ In response, Lawrence (1998) argued that this typology of trans identities was not intended to create a distinction between “true” and “false” transsexuals:

It would be a mistake to conclude that if autogynephilic transsexuality [MTF attracted to women] is in large part about sexual desire, then it is somehow suspect, or is less legitimate than homosexual transsexuality [MTF attracted to men]. Although the focus of this essay is not on homosexual transsexuality per se, I do want to say enough about it to dispel any mistaken notions that homosexual transsexuals are the “real” transsexuals, or that their motivations are exclusively non-sexual. Neither is true. By definition, transsexuals are those who undergo sex reassignment as a treatment for gender dysphoria. The gender dysphoria of autogynephilic transsexuals is every bit as real as that of their homosexual counterparts. And it matters not a whit if that dysphoria stems in whole or in part from an inability to achieve sexual satisfaction in one’s existing body or role. Autogynephilic transsexuals have just as much claim to being “real” transsexuals as their homosexual sisters.

Here Lawrence highlights the argument that gender dysphoria can stem from multiple causes and later she again insists that her theory of autogynephilic transsexuality is simply an alternative explanation of the desire to transition and should never be used to deny surgery or other treatment (Lawrence, 2004).

Despite the attempts of these authors, and specifically Blanchard and Lawrence, to dispel any notion of a hierarchy of legitimacy, it is important to consider both the historical context for this hierarchy, and the social, political and medical cultures that govern our understanding of sexuality and identity claims. In particular, we need to ask what kind of possibilities or foreclosures this theory creates for trans people, and how it contributes to or diminishes the regulation, pathologization and stigmatization of trans people. As Lawrence herself acknowledges, (1998, 2004, 2006) distinctions between “true” and “false” transsexuals still persist in medical and popular discourses, and these perceptions have concrete effects on the types of services and support trans people have access to. If, as Serano argues (2007, p. 131-132), theories of autogynephilia extend the differentiation between primary and secondary transsexuality, this theory can have hugely negative impacts on health care access for some trans people¹⁸. Serano similarly highlights the power/knowledge dynamics behind competing “explanatory” theories and argues that although a majority of transsex-

17 This problematic distinction refers to the view that primary transsexuals (often seen as “true” transsexuals) are those who desire sex reassignment early in childhood and that secondary transsexuals (often represented as “false”) are those individuals who transition later in life.

18 Sullivan (2008a) highlights similar issues of concern around medicalized hierarchies established in the categorization of transabled people.

uals do not identify with the autogynephilic theories put forward by Blanchard, Lawrence and Bailey, these “expert researchers” continue to be given more credibility in the public eye than trans individuals, activists or communities (Serano, 2008, p. 493-494). Serano highlights these issues in her critique of Bailey’s work (Serano, 2008, p. 492):

Those of us who reject causal theories of autogynephilia typically do so, not because we believe that we are “women trapped in men’s bodies,” or that sexuality plays no role in our explorations of gender, but because such theories naively conflate sexual orientation with gender expression, gender identity, and sex embodiment in a way that contradicts our personal life experiences and that is inconsistent with the vast diversity of trans women that exist. In fact, most trans critiques of autogynephilia center on the fact that this scientifically unsubstantiated theory forces all trans women into one of two rigid categories, nonconsensually defines us in ways that contradict our own personal sense of selves, mistakes correlation for causation, handwaves away nonpathological alternative models that better explain the data, unnecessarily sexualizes and delegitimizes our identities, and has the potential to jeopardize our access to sex reassignment and our social and legal status as women (e.g., Barnes, 2001; Johnson, 2001; Roughgarden, 2004; Serano, 2007; Wyndzen, 2004).

Serano’s argument highlights the dangers of any monolithic theory, as well as the complex ways in which medical or expert narratives often reduce complex experiences, subjectivities, identities and diversities into rigid diagnoses or categories. Although we think that it is important to explore and discuss theories like the ones Blanchard develops, we agree with Serano’s analysis and critique. We would also challenge “expert” language that implies that trans people don’t understand, or lie about the “real” reasons for their transitions. Bailey & Triea (2007) write for example, “We believe, however, that in this domain, as in others, people’s own narratives do not always correspond to the true reasons for their choices and behaviors” (p.527). This formulation not only discredits the voices and experiences of trans people, it also fails to fully account for the many transphobic and cisnormative social, political, cultural financial and medical discourses that trans people must negotiate in describing and advocating for their own realities. Blanchard, Lawrence and Bailey all argue that autogynephilic transsexuals might misrepresent the reasons for their transitions because they are afraid of their claims being rejected, or because they’ve been taught to think that sexuality-based reasons for transition are perverse or less legitimate. But they do not then take this insight further to acknowledge the possibility that sex-negative, transphobic and cisnormative societies don’t simply constrain possible explanations in one direction (i.e. in suppressing sexuality claims and focusing on narrowly defined, identity-based ones) but in many different directions. As Serano argues above, even if we are to consider both identity and sexuality based explanations for transitions, that still can’t account for the complexities of diverse trans sexualities, identities, subjectivities, desires, experiences, and forms of gender expression and nonconformity. Although Blanchard and Lawrence’s theories of autogynephilia could be seen as potentially legitimizing non-identity based explanations for transitions, we believe that they are still rooted in pathological conceptions of sexuality and that they simplify the complexities that Serrano points to. Blanchard and Lawrence’s perspective, as we discuss more below, also doesn’t challenge the cisnormative

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imperative to *explain* the desire to transition or to identity as trans*—an explanation that is never required of cis people.

The literature evaluating and contesting theories of autogynephilia is extensive and well-established, and this article clearly does not seek to evaluate the legitimacy or truth of these theories. We are interested instead in examining what the parameters of the debates surrounding different “explanations” for transitions reveal about hierarchies between sexuality and identity claims, and about how (in the case of “disabling” body modifications and transabled identities) feminist, queer and trans studies might engage with critical disability studies to understand how cisnormative and ableist assumptions interlock to govern these claims. To further this exploration, we now turn to a discussion of the paraphilias associated with transabled people and BIID, where some of the principle protagonists in the debates are once again Blanchard and Lawrence.

3. Debating “disabling” bodily transformations

3.1. *BIID vs. apotemnophilia: Controversies and comparisons*

As we argued above, debates about apotemnophilia/BIID echo those relating to autogynephilia/GID. In both cases, a small number of researchers link the desire to transition to theories of paraphilia, a medical and sexological term referring to “abnormal” “unusual” or “atypical” sexual desires. A larger number see identity disorders or “identity trouble” as the cause. Here again, Blanchard and Lawrence have argued that a large number of people requesting “disabling” body modifications do so due to a paraphilia. In response to people who identify as having BIID or as being transabled, both Blanchard (2003; 2008) and Lawrence (2003; 2006, p. 272; 2009) have maintained that many apotemnophilic people lie (unconsciously or consciously) about the sexual dimension of their desire to modify their bodies in an attempt to get access to surgery, acceptance or medical treatment. Blanchard (2008, p. 437) explains that,

I made this point in a lecture on the parallels between gender identity disorder (GID) and body integrity identity disorder (BIID), a condition characterized by the feeling that one’s proper phenotype is that of an amputee, together with the desire for surgery to achieve this. Most, but not all, persons with BIID report some history of erotic arousal in association with thoughts of being an amputee (apotemnophilia). In discussing the taxonomic problems common to the study of GID and BIID, I noted the following: There are some nonhomosexual male-to-female transsexuals [attracted to women or autogynephilic in that typology] who state that they were never erotically aroused by cross-dressing or cross-gender fantasy. Similarly, there are some persons with BIID who claim that they were never erotically aroused by the idea of being amputees. I’ve published two studies that suggest at least some transsexuals who deny autogynephilic arousal are consciously or unconsciously distorting their histories.

Blanchard and Lawrence aren't the only researchers who adhere to theories of apotemnophilia—some of the articles in Stirn, Thiel & Oddo (2009), Bruno (1997) Braam, Visser & Cath (2006) and formerly Money, Jobaris & Furth (1977), Money & Simcoe (1986) and Money (1991), all support the idea that the desire for a “disabling” body modification is linked to a paraphilia. Explanations for the origin of the paraphilia vary, however. While Money *et al.*, Lawrence and Blanchard all focus on the sexual component of apotemnophilia; Bruno (1997) argues that acrotomophilic (attraction to people with amputations) and apotemnophilic individuals express emotional or psychological distress *through* sexuality or sexual desire. Bruno maintains that these individuals have often experienced emotional deprivation or trauma in childhood that has led them to believe that the only way to get love and attention is through the acquisition of a disability. For Bruno, then, treatment should be focused on resolving these psychological disorders. In contrast, Lawrence and Blanchard stress the possibility of an “erotic target location error.” Lawrence explains this distinction (Lawrence, 2006: 269):

When a person's preferred erotic target is amputees, uncomplicated attraction to that erotic target is called acrotomophilia. Some acrotomophilic men who experience erotic target location errors for their preferred erotic target might be sexually aroused by temporarily presenting themselves as amputees; this would manifest as pretending. Other acrotomophilic men who experience erotic target locations errors for their preferred erotic target might be sexually aroused by the idea of changing their bodies to become amputees themselves; this would manifest as apotemnophilia.

The connections between the desire for “disabling” body modifications and sexual paraphilias have not been confirmed, and debates within scientific and nonscientific communities are still fairly new. As we discussed at the beginning of the paper, First's preliminary research on BIID contradicts research that identifies apotemnophilia as a primary cause of the desire for body modification in these cases. As with our discussion of autogynephilia/GID, the social, political and cultural context for people advocating for body modification or treatment is also directly impacted by preconceptions of who might be “true” or “false” in their account of their desire for transition. In addition to again considering how sexuality and identity claims are evaluated in the case of apotemnophilia/BIID, we simultaneously must pay attention to how ableist and sex-negative assumptions about the undesirability of “disabled” bodies—both sexually and otherwise—shape responses to this issue.

In sex-negative, ableist societies, the relationship between people with disabilities and sexuality are conceptualized and regulated in contradictory ways—at times people with disabilities are represented as asexual, (or are coerced into asexuality by institutions that restrict their sexual freedoms and practices) at other times they are subject to surveillance or representation as erotic/exotic “freaks.” Eli Clare (2009) demonstrates how our very conceptions of sexual and gendered identities are based on compulsory able-bodiedness. Clare argues that codes of masculinity and femininity require the implementation of certain body movements, postures, and forms of expression that are sometimes difficult to negotiate for people with some impairments. In these cases, people who fail to embody the ableist norms of gender or sex are degendered and desexualized by the dominant culture. Clare explains that (2009: 130),

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[...] disabled people find no trace of our sexualities in that world. We are genderless, asexual undesirables. This is not an exaggeration. 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. A woman who walks with crutches does not walk like a “woman”; a man who uses a wheelchair and a ventilator does not move like a “man.” The construction of gender depends not only upon the male body and female body, but also upon the nondisabled body.

This is also the case for transsexual and transgender people, who are often seen as sexual aberrations, monstrosities, asexual, or as exotic and hypersexual (Serano, 2007). And if ableism interlocks with dominant gender norms to degender and desexualize people with disabilities in some ways, (Wendell, 1989: 113; Garland-Thomson, 2002; Meekosha, 2006: 169-170), it also *reinforces* dominant cisgender and sexuality stereotypes on the bodies of people with disabilities in other ways. Clare (2009: 121), for example, examines the frequent and spurious associations made between disability and passivity and Meekosha (2006: 169-170) and Garland-Thomson (2002: 17), explore how passivity is frequently read onto women with disabilities in particular. As many scholars in the field of critical disability studies have argued, people with disabilities, and those who find disabled people desirable, are subject to intense (and often pathologizing) scrutiny and surveillance (Wilkerson, 2002; Solvang, 2007, Ilse, 2009; Harmon, 2012; Kafer, 2012; McRuer and Mollow, 2012). This scrutiny largely flows from the ableist assumption that only able bodies are desirable and that people who are attracted to disabled people might be perverse or deviant themselves. It is in this context of both ableism and transphobia that people who desire to transform or modify their bodies must somehow justify or explain this desire.

3.2. *The impact of the controversies surrounding BIID and apotemnophilia*

Historically, connections between sexuality and transsexuality (particularly in discussions about paraphilias) were used to justify refusing medical treatment for trans people (Stone, 1991; Cromwell, 1999; Meyerowitz, 2002; Reucher, 2005; Sullivan, 2008b; Macé, 2010). According to trans activists, bloggers, authors, and trans individuals, this dynamic is still present in contemporary gender identity disorder clinics where people are refused medical treatment or put through a slower process of evaluation if they report a sexual dimension to their desire to transition. Although there are many fewer examples of transabled people reporting this treatment by medical professionals (since there are currently fewer people approaching medical professionals for “disabling” body modifications), there is evidence that similar problems are arising and will continue to confront transabled people. Smith (2004, 2009), the only doctor known to date to have performed amputations for transabled patients, rejects the idea of providing surgeries for apotemnophilic patients (who are seen as requesting surgery for reasons related to sexual desire/paraphilia) and only supports surgeries for patients with BIID (who are seen as making the request based on an account of their identity). Similarly, the two psychiatrists who conducted assessments of patients for

a BBC report maintained that sexuality should not be the motivation for a transition and indicated that it would eliminate the small chance that someone would be considered for voluntary amputation. Dr. Reid explains that, “When I met Gregg [the transabled patient] it was very clear that he was very sane and *there was absolutely no question that he was thought disordered in any way or mentally ill or sexually bizarre*” (BBC, 2000, p. 3-4, our emphasis). The other psychiatrist, Dr. Richard Fox, seems to share a similar perspective as he asks Corinne (another candidate for surgery) intrusive questions about her sexual life and fantasies to ensure that sexual desire is not a factor in her request (BBC, 2000, p. 7).

Despite the dangers for trans* people, Lawrence and Blanchard persist in forwarding theories of autogynephilia and apotemnophilia and argue that it is important to highlight the ways in which both trans* communities and the broader society seem to accept the argument that transitions are more palatable if they are justified through identity-based arguments. We end our discussion of Blanchard and Lawrence by stressing two key arguments. First, we maintain that Blanchard and Lawrence have added an important dimension to understanding the connections between sexuality and the desire for some forms of transition. Lawrence especially emphasizes the many factors that might lead trans* people to downplay or remain silent about sexual motivations for transition. She also insists, against doctors who are suspicious of sexual motives, that paraphilias are no less legitimate a motivation for transition than identity disorders. Secondly, however, we argue that while Blanchard and Lawrence’s research could contribute to productive discussions about why sexuality claims are seen as illegitimate and “false” in comparison to identity claims, their insistence on pathologizing sexual desires as paraphilias is deeply problematic. Their research not only further stigmatizes an already marginalized group, but it also persists in creating disease-based and individualistic explanations for transitions that shut down, rather than encourage, nuanced discussions of the complex interactions between sexuality, identity, embodiment and subjectivity.

4. Potential solidarities?

Work in the field of disability studies encourages and supports nuanced discussions of processes of medicalization, pathologization and stigma. In this final section of the paper, we call for rethinking body modification and different forms of transition in a way that decenters the *necessity* for an explanation based on either pathologized sexuality or identity. We argue here that ableist and cisnormative systems of discourse and power are at the origin of the need to justify sex or ability transitions to medical/psychiatric institutions and to provide simplistic reasons and explanations on the basis of either sexuality or identity. We hope that highlighting how ableism and cisnormativity shape our conceptions of both sexuality and identity opens ways to imagine the possibility of body modifications pursued for diverse and *overlapping* “legitimate” reasons—some of them possibility rooted in individuals’ understanding of their identity and/or sexuality. By challenging the necessity for a medicalized “explanation” we could challenge both the characterization of some sexual desires or orientations as “perverse” and examine the ways that psychiatric discourses often marginalize certain experiences by sexualizing them.

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Gender and Sexuality

Here, the possibilities and challenges of forging solidarities between queer, disabled and transabled activists and communities are raised. On the one hand, LGBTQ communities and disabled communities have fought long battles to make their sexualities and sexual lives visible and possible. People with disabilities and queer and trans* people share experiences of having their bodies and desires represented as freakish, perverse, undesirable, disruptive, threatening or “un(re)productive.” (McRuer & Mollow, 2012; Serano, 2007). These shared experiences make connections and solidarities seem possible and nourishing for both scholars and activists. On the other hand, people with disabilities might be understandably wary of allying themselves with communities of people who could be perceived to be objectifying, fetishizing, or exploiting people with disabilities. As Alison Kafer (2012, p. 335) writes in her nuanced consideration of devoteeism, “the rhetoric of devoteeism relies as heavily on *disgust* for disabled bodies as it does *desire*. Devotees typically define themselves not simply as people sexually attracted to amputees but as the *only* people sexually attracted to amputees.” Kafer is concerned about the ways in which devoteeism reinforces ableist representations of disability as inherently unsexy (except to an exceptional few devotees), but she also challenges the “eww” response that conversations about devoteeism inspire—arguing that this response assumes that anyone attracted to amputees must be perverted or “crazy.” Finally, Kafer’s work reminds us that any discussion of sexuality and desire for “disabling” body modifications or people with disabilities must not disregard the material impact of ableism on the lives of people with disabilities.

People from both transgender/transsexual and transabled communities might also raise concerns about the effects of conflating or superficially comparing the experiences of very diverse individuals and groups of people. There has been a long tradition of struggle within the trans movement to affirm the specific realities of transsexual and transgender people and not conflate them with LGBTQ people (Califia, 1997; Cromwell, 1999; Valentine, 2007; Stryker, 2008; Baril, 2009b). Many transsexual people have ardently defended the distinction between gender identity and sexual orientation, and have sometimes sought to disassociate themselves from both the LGBTQ movement, and other forms of trans identity, such as cross-dressing and transgender (Namaste, 2000; 2005; Meyerowitz, 2002; Baril, 2009a). As Meyerowitz (2002), explains, many of the schisms between marginalized groups have been driven by the pathologizing practices of the medical community. She writes (2002, p. 176-177):

While the doctors wrestled with definitions and diagnoses, self-identified homosexuals, transvestites, and transsexuals engaged in a parallel practice in which they tried to distinguish themselves from one another. They hoped to make themselves intelligible to others and also to convince doctors, courts, and the public to accord them dignity, rights, and respect. Some chose to align themselves with other sexual and gender variants or wondered out loud which of the existing categories best embraced their sense of themselves. But mostly, it seems, they hoped to explain their differences. In a sense, they constructed and affirmed their own identities by telling themselves and others how they differed. For some, the social practice of taxonomy involved a “politics of respectability.” Those who identified as homosexual, transvestite, or transsexual sometimes attempted to lift their own group’s social standing by foisting the stigma of transgression onto others.

People who identify as having BIID have similarly sought to distinguish their identity from different pathologized sexualities associated with body modification (BBC, 2000; First, 2004; 2009; Stirn, Thiel & Oddo, 2009). There are certainly disagreements within transabled communities about the legitimacy of sexuality and identity claims (Sullivan, 2008a), and these disagreements might come from histories of being pathologized by medical communities and also just from the fact that diverse groups of people have competing experiences, understandings and analysis. These struggles reveal the high stakes of building solidarity and highlight the ongoing need for both caution and humility as we forward a vision of what some of the grounds for solidarity between groups might look like.

In all cases, we believe that challenging ableist, neo-liberal, heteronormative and cisnormative conceptions of “productive” and non-productive bodies will open up space for this experimental thinking and activism. In *Crip Theory*, Robert McRuer (2006) helps us to imagine the complex ties between queer, trans and disabled subjectivities through his analysis of compulsory able-bodiedness and compulsory heterosexuality in neoliberal societies. McRuer explains that neoliberalism requires and produces bodies and subjects that can respond with *flexibility* to moments of crisis. In economic terms, this response to crisis might involve working longer hours for less pay, complying with downsizing regimes and ideology, retraining and “rehabilitating” bodies or skills to respond to corporate or state needs, or crossing a national border to fill temporary “superexploitative” jobs (McRuer, 2006). The ideal flexible subject is cis, male, able-bodied, white and heterosexual; however, minoritized populations are constantly encouraged to aspire to inclusion by conforming as closely as possible to the norm. Flexible subjects are not simply able-bodied and heterosexual, they are also *tolerant*: “Neoliberalism and the condition of postmodernity, in fact, increasingly needs able-bodied, heterosexual subjects who are visible and spectacularly tolerant of queer/disabled existences” (McRuer 2006, p. 2). Limited tolerance/‘valorization’ of some queer/crip subjects masks the ongoing and multiple ways that other populations are marginalized, while also reinforcing the dominant norm—in this case—cis and able-bodied sexualities. McRuer looks at how some crip subjects are cast out as “benefit scrounging scum” while others are pitied and valorized as disability “poster” boys/girls (McRuer, 2012). Similar neoliberal imperatives form the backdrop for claims about body modifications related to sex and ability and the paraphilia (autogynophilia and apotemnophilia) associated with them. By *queering* the “perverse” sexualities of trans* and disabled people, and *cripping* their bodies and identities as unproductive or burdensome for partners, families, health systems, societies, and economies (Roth, 2009: 142-143), the dominant neoliberal society marks trans* and disabled people as always threatening and excessive. Underlying many of the debates are the neoliberal imperatives that, modified or not, bodies and subjects be flexible and productive—and that their claims to bodily autonomy not violate powerful neoliberal commitments to privatization and personal responsibility (Irving, 2008; Stryker & Sullivan, 2009; Duggan, 2003). We see the neoliberal imperative most powerfully in discussions of BIID when doctors or commenters express concern about the impact of a modification like amputation on a person’s ability to care for themselves, remain in a particular kind of work, or support themselves financially. McRuer’s analysis of narratives of “benefit scrounging scum” (2012) points to the assumption that disabled bodies are always less productive and more burdensome than able bodies. This assumption means that all people who want to modify their bodies in “disabling” ways must take *individual responsibility* for the “burden” that they might become. In these narratives it seems

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inconceivable that people with disabilities could contribute to and enrich a neoliberal society—they are always simply either a pitiable burden or (in the case of someone with BIID) perhaps a suspiciously “lazy” or deviant subject seeking to “take advantage” of able-bodied society.

Challenging cisnormativity and neo-liberal compulsory able-bodiedness might create new spaces for reflection about the complex claims made by people who desire body transformations or modifications. Moving away from an explanatory or diagnostic model that requires a pathologized sexuality or a rigidly defined identity disorder, we could look at the complex assemblages of experience, sexuality, embodiment, subjectivity, identity and desire that might motivate people to make modifications to their bodies. In fact, people describe varied motivations for body modifications: aesthetic, artistic, as processes of healing, political, sexual, economic, for reasons of tradition or spirituality, etc. Without an initial challenge to cisnormative and ableist assumptions, we will always be operating from a social, cultural and political context that assumes someone would “have to be crazy” to change sex/genders or become “disabled”, or more broadly to transform their bodies from “how nature made them.” Instead of *requiring* that trans* people articulate their desires for transformation on these terms, we hope that both the medical community and the broader society can cultivate humility and respect in how they listen to claims made by trans* people, and learn from their experiences and desires.

Conclusion

With the release of the new edition of the DSM-5 and amidst the numerous debates and discussions over additions, modifications and diagnostic categories, it is crucial to continue to reflect on the implications that these diagnoses and categorizations have for many marginalized and stigmatized people. This article intervenes in these debates to consider how paraphilias and identity disorders get constructed to reinforce hierarchies between “legitimate” and “illegitimate” reasons for desiring body modification or transition. We argue that both identity and sexuality discourses must be understood in the context of an analysis that accounts for the impact of an ableist, sex-negative and cisnormative society. Indeed, while identity-based conceptions of transition have led to very limited social, political and medical acceptance for some trans* people who are diagnosed with GID or BIID, desires for transition rooted in sexual desire are still treated overwhelmingly with pathologizing fear, dismissal or even scorn. As we have explored above, while it is useful to examine work like Blanchard and Lawrence’s to continually expand our understanding of what grounds a desire for sex/gender or ability/impairment transitions, this work still operates within a frame of pathological sexuality and a medical model of disability. Instead of adopting a pathological or “single explanation” orientation to the question of body modification or transition, we examine Blanchard and Lawrence’s work critically to both challenge hegemonic identity discourses within medical and other communities, and to imagine an approach to body modification that is open to the possibility of more nuanced and complex understandings of embodiment, respect, desire and identity.

References

- ABC Television (dir.) (2009). *Body Identity*, Prod.: J. Newby, U.S.A., Online with transcript: <http://www.abc.net.au/catalyst/stories/2576978.htm>, 12 minutes.
- Allisson, B. (1998). Janice Raymond and Autogynephilia. 8 pages. Retrieved from <http://www.drbecky.com/raymond.html>
- American Psychiatric Association (APA) (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text-Revision (DSM-IV-TR)*. Washington: American Psychiatric Association.
- BBC (dir.) (2000). Complete Obsession. London, Online with transcript: http://www.bbc.co.uk/science/horizon/1999/obsession_script.shtml, 50 minutes.
- Bailey, M. J. (2003). *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism*. Washington: Joseph Henry Press.
- Bailey, M., & Tricia, K. (2007). What Many Transgender Activists Don't Want You To Know and Why You Should Know it Anyway. *Perspectives in Biology and Medicine*, 50(4), 521-534.
- Baril, A. (2009a). Trente ans d'activisme et de théories: examen rétrospectif des études trans et de leur apport critique aux champs du savoir. Paper presented in a colloquium: Identités trans: enjeux intimes, sociaux, médicaux et scientifiques, 77th Acfas Congress, Ottawa.
- Baril, A. (2009b). Transsexualité et privilèges masculins. Fiction ou réalité? In L. Chamberland *et al.* (Eds.), *Diversité sexuelle et constructions de genre* (pages, pp. 263-295). Québec: Presses de l'Université du Québec.
- Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I Don't Think This Is Theoretical; This Is Our Lives": How Erasure Impacts Health Care for Transgender People *The Journal of the Association of Nurses in AIDS Care*, 20(5), 348-361.
- Bayne, T., & Levy, N. (2005). Amputees By Choice: Body Integrity Identity Disorder and the Ethics of Amputation. *Journal of Applied Philosophy*, 22(1), 75-86.
- Benjamin, H. (1966). *The Transsexual Phenomenon*. New York: Julian Press.
- Blanchard, R. (1989). The Concept of Autogynephilia and the Typology of Male Gender Dysphoria. *Journal of Nervous and Mental Disease*, 177(10), 616-623.
- Blanchard, R. (1991). Clinical Observation and Systematic Studies of Autogynephilia. *Journal of Sex and Marital Therapy*, 17(4), 235-251.
- Blanchard, R. (1993). Varieties of Autogynephilia and their Relationship to Gender Dysphoria. *Archives of Sexual Behavior*, 22(3), 241-251.
- Blanchard, R. (2003). Theoretical and Clinical Parallels between Body Integrity Identity Disorder and Gender Identity Disorder. Paper presented at the Third Annual International BIID Meeting, Columbia University, New York.
- Blanchard, R. (2005). Early History of the Concept of Autogynephilia. *Archives of Sexual Behavior*, 34(4), 439-446.
- Blanchard, R. (2008). Deconstructing the Feminine Essence Narrative. *Archives of Sexual Behavior*, 37, 434-438.
- Blanchard, R. (2010). The DSM Diagnostic Criteria for Transvestic Fetishism. *Archives of Sexual Behavior*, 39(2), 363-372.
- Braam A., Visser S., & Cath D., *et al.*, (2006). Investigation of the syndrome of apotem-

Exploring
ableism
and
cisnorma-
tivity

A. Baril and
K. Trevenen

- nophilia and course of a cognitive-behavioural therapy. *Psychopathology*, 39, 32-37.
- Brang, D., McGeoch, P. D., & Ramachandran, V. S. (2008). Apotemnophilia: A Neurological Disorder. *NeuroReport*, 19(13), 1305-1306.
- Breton, J., & Cordier, B. (Eds.). (1996). *Aspects psychiatriques du transsexualisme: étude nosographique et médico-légale*. Paris: Masson.
- Bruno, R. L. (1997). Devotees, Pretenders and Wannabes: Two Cases of Factitious Disability Disorder. *Sexuality and Disability*, 15(4), 243-260.
- Burke, P. (1996). *Gender Shock: Exploding the Myths of Male and Female*. New York: Doubleday.
- Butler, J. (2004). *Undoing Gender*. New York/Londres: Routledge.
- Califia, P. (1997). *Sex Changes: The Politics of Transgenderism*. Berkeley: Cleis Press.
- Caplan, P. J. (1995). *They Say You're Crazy. How the World's Most Powerful Psychiatrists Decide Who's Normal*. New York: Addison-Wesley Publishing Company.
- Chiland, C. (1997). *Changer de sexe*. Paris: Odile Jacob.
- Church, Jennifer (1997). «Ownership and the Body», dans Diana Meyers Tietjens (dir.), *Feminists Rethink the Self*, Coll. «Feminist Theory and Politics», Boulder/Colorado, Westview Press, p. 85-103.
- Clare, E. (2009). *Exile & Pride: Disability, Queerness and Liberation*. Cambridge: South End Press.
- Clervoy, P. (2009). «Mon corps n'est pas le bon». Discours sur le corps, amplifications médiatiques et compromissions médicales. *Champ Psychosomatique*, 1(53), 47-56.
- Cohen-Kettenis, P. T., & Gooren, L. J. G. (1999). Transsexualism: A Review of Etiology, Diagnosis and Treatment. *Journal of Psychosomatic Research*, 46(4), 315-333.
- Coleman, E. J. (2009a). Special Issue: Toward Version 7 of the World Professional Association for Transgender Health's Standards of Care. *International Journal of Transgenderism*, 11(1).
- Coleman, E. J. (2009b). Special Issue: Toward Version 7 of the World Professional Association for Transgender Health's Standards of Care: Psychological Assessment and Approaches to Treatment. *International Journal of Transgenderism*, 11(2).
- Conway, L. (2006). An investigation into the publication of J. Michael Bailey's book on transsexualism by the National Academies. 11 pages. Retrieved from <http://ai.eecs.umich.edu/people/conway/T5/LynnsReviewOfBaileysBook.html>
- Conway, L. (2008). Categorically Wrong? A Bailey-Blanchard-Lawrence Clearinghouse. 4 pages. Retrieved from www.tsroadmap.com/info/bailey-blanchard-lawrence.html
- Cordier, B., Chiland, C., & Gallarda, T. (2001). Le transsexualisme, proposition d'un protocole malgré quelques divergences. *Annales médico-psychologiques*, 159(3), 190-195.
- Cromwell, J. (1999). *Transmen and FTMs: Identities, Bodies, Genders, and Sexualities*. Urbana/Chicago: University of Illinois Press.
- Davis, L. J. (Ed.) (2010). *The Disability Studies Reader* (Third ed.). New York/Londres: Routledge.
- Dosanjh Kaur, D. H. (2004). Producing Identity: Elective Amputation and Disability. *Scan: Journal of Media Arts Culture*, 3(1). Retrieved from http://scan.net.au/scan/journal/display.php?journal_id=38
- Dreger, A. D. (2008). The Controversy Surrounding the Man Who Would Be Queen: A Case History of the Politics of Science, Identity, and Sex in the Internet Age. *Archives of Sexual Behavior*, 37, 366-421.
- Drescher, J. (2010). Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the *Diagnostic and Statistical Manual*. *Archives of Sexual*

- Behavior*, 39, 427-460.
- Dua, A. (2010). Apotemnophilia: Ethical Considerations of Amputating a Healthy Limb. *Journal of Medical Ethics*, 36(2), 75-78.
- Duggan, L. (2003). *The Twilight of Equality? Neoliberalism, Cultural Politics, and the Attack on Democracy*. Boston: Beacon Press.
- Elliot, C. (2000). A New Way to Be Mad. *The Atlantic Monthly*, 286, 72-84.
- Elliott, T. (2009). Body Dismorphic Disorder, Radical Surgery and the Limits of Consent. *Medical Law Review*, 17, 149-182.
- Enke, A. F. (2012a). The Education of Little Cis. Cisgender and the Discipline of Opposing Bodies. In A. Enke (Ed.), *Transfeminist Perspectives In and Beyond Transgender and Gender Studies* (pp. 60-77). Philadelphia: Temple University Press.
- Enke, A. F. (2012b). *Transfeminist Perspectives In and Beyond Transgender and Gender Studies*. Philadelphia: Temple University Press.
- First, M. B. (2004). Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder. *Psychological Medicine*, 34, 1-10.
- First, M. B. (2005). Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder. *Psychological Medicine*, 35(6), 919-928.
- First, M. B. (2009). Origin and Evolution of the Concept of Body Integrity Identity Disorder. In A. Stirn, A. Thiel & S. Oddo (Eds.), *Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical and Legal Aspects* (pp. 49-57). Lengerich/Allemagne: PABST Science Publishers.
- Freund, K., Steiner, B. W., & Chan, S. (1982). Two types of cross-gender identity. *Archives of Sexual Behavior*, 11, 49-63.
- Furth, G., & Smith, R. (2002). *Amputee Identity Disorder: Information, Questions, Answers, and Recommendations About Self-Demand Amputation*. London: 1st Books.
- Garland-Thomson, R. (2002). Integrating Disability, Transforming Feminist Theory. *NWSA Journal*, 14(3), 1-32.
- Gheen, M. (2009). Clear Definitions and Scientific Understanding: Thoughts of an Academic Physician with BIID. In A. Stirn, A. Thiel & S. Oddo (Eds.), *Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical and Legal Aspects* (pp. 94-102). Lengerich/Allemagne: PABST Science Publishers.
- Gilbert, M. (dir). (2003). Whole: A Documentary. Prod.: M. Gilbert, U.S.A., DVD, 56 minutes.
- Green, J. (2006). Look! No, Don't! The Visibility Dilemma for Transsexual Men. In S. Stryker & S. Whittle (Eds.), *The Transgender Studies Reader* (pp. 499-508). New York/Londres: Routledge.
- Halberstam, J. (1998). *Female Masculinity*. Durham/Londres: Duke University Press.
- Hale, C. J. (2007). Ethical Problems with the Mental Health Evaluation Standards of Care for Adult Gender Variant Prospective Patients. *Perspectives in Biology and Medicine*, 50(4), 491-505.
- Hall, K. Q. (2011). *Feminist Disability Studies*. Bloomington/Indianapolis: Indiana University Press.
- Halperin, D. (1995). *Saint Foucault*. New York: Oxford University Press.
- Harmon, K. (2012). Hearing Aid Lovers, Pretenders, and Deaf Wannabes. The Fetishizing of Hearing. In R. McRuer & A. Mollow (Eds.), *Sex and Disability* (pp. 355-372). Durham/London: Duke University Press.

Exploring
ableism
and
cisnorma-
tivity

A. Baril and
K. Trevenen

- Hirschfeld, M. (1991). *Transvestites* (M. A. Lombardi-Nash, Trans.). Buffalo, NY: Prometheus Books. (Original work published 1910)
- Irving, D. (2008). Normalized Transgressions: Legitimizing the Transsexual Body as Productive. *Radical History Review*, 100, 38-59.
- Isay, R. A. (1997). Remove Gender Identity Disorder in DSM. *Psychiatric News*, 32, 9.
- James, A. (2004). A Defining Moment in Our History: Examining Disease Models of Gender Identity. 11 pages. Retrieved from <http://www.tsroadmap.com/info/gender-identity.pdf>
- Kafer, A. (2012). Deisre and Disgust: My Ambivalent Adventures in Devoteeism. In R. McRuer & A Mollow (Eds.), *Sex and Disability* (pp. 331-354). Durham/London: Duke University Press.
- Koyama, E. (2001). *Transfeminism: A Collection*. Portland: The Feminist Conspiracy Press.
- Lanoix, M. (2005). Autonomie et inclusion. In M. N. Mensah (Ed.), *Dialogues sur la troisième vague féministe* (pp. 135-143). Montréal: Les éditions du remue-ménage.
- Lawrence, A. A. (1998). «Men Trapped in Men's Bodies:» An Introduction to the Concept of Autogynephilia. 9 pages. Retrieved from home.swipnet.se/~w-13968/autogynephilia.html
- Lawrence, A. A. (2003). BIID and GID: Paraphilia, Identity, and Access to Care. Paper presented at the Third Annual International BIID Meeting, Columbia University, New York.
- Lawrence, A. A. (2004). Autogynephilia: A Paraphilic Model of Gender Identity Disorder. *Journal of Gay and Lesbian Psychotherapy*, 8(1/2), 69-87.
- Lawrence, A. A. (2005). Sexuality Before and After Male-to-Female Sex Reassignment Surgery. *Archives of Sexual Behavior*, 34(2), 147-166.
- Lawrence, A. A. (2006). Clinical and Theoretical Parallels Between Desire for Limb Amputation and Gender Identity Disorder. *Archives of Sexual Behavior*, 35(3), 263-278.
- Lawrence, A. A. (2007). Becoming What We Love: Autogynephilic Transsexualism Conceptualized as an Expression of Romantic Love. *Perspectives in Biology and Medicine*, 50(4), 506-520.
- Lawrence, A. A. (2008). Male-to-Female Transsexual Subtypes: Sexual Arousal with Cross-dressing and Physical Measurements. *Psychiatry Research*, 157(1/3), 319-320.
- Lawrence, A. A. (2009). Parallels between Gender Identity Disorder and Body Integrity Disorder: A Review and Update. In A. Stirn, A. Thiel & S. Oddo (Eds.), *Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical and Legal Aspects* (pp. 154-173). Lengerich/Allemagne: PABST Science Publishers.
- Lawrence, A. A. (2011). Do Some Men Who Desire Sex Reassignment Have A Mental Disorder? Comment on Meyer-Bahlburg (2010). *Archives of Sexual Behavior*, 40, 651-654.
- Lev, A. I. (2005). Disordering Gender Identity: Gender Identity in the DSM-IV-TR. *Journal of Psychology and Human Sexuality*, 17(3/4), 35-69.
- Macé, É. (2010). Ce que les normes de genre font aux corps / Ce que les corps trans font aux normes de genre. *Sociologie*, 4(1), 497-516.
- Marie. (2007). A Comparison Between Transsexuality and Transableism. Retrieved from <http://transabled.org/thoughts/a-comparison-between-transsexuality-and-transableism.htm>
- Martin, I. (2009). Facination Handicap — A Desire for Differentness. In A. Stirn, A. Thiel & S. Oddo (Eds.), *Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical*

- and *Legal Aspects* (pp. 175-180). Lengerich/Allemagne: PABST Science Publishers.
- McRuer, R. (2012). The Crip's Speech in an Age of Austerity: Composing Disability Transnationally, 4th Annual Sexuality Speaker's Series, Carleton University, Ottawa, Ontario, February 16th 2012.
- McRuer, R. (2010). Disability Nationalism in Crip Times. *Journal of Literary & Cultural Disability Studies*, 4(2), 163-178.
- McRuer, R. (2006). *Crip Theory: Cultural Signs of Queerness and Disability*. New York/London: New York University Press.
- McRuer, R., & Mollow (dir.), A. (2012). *Sex and Disability*. Durham/London: Duke University Press.
- Meekosha, H. (2006). What the Hell are You? An Intercategorical Analysis of Race, Ethnicity, Gender and Disability in the Australian Body Politic. *Scandinavian Journal of Disability Research*, 8(2/3), 161-176.
- Meyerowitz, J. (2002). *How Sex Changed: A History of Transsexuality in the United States*. Cambridge/London: Harvard University Press.
- Michel, A., & Pédinielli, J.-L. (2005). Vers une conceptualisation du transsexualisme. *Annales Médico-Psychologiques*, 163, 379-386.
- Money, J. (1991). Paraphilia in Females. *Journal of Psychology and Human Sexuality*, 3(2), 165-172.
- Money, J., Jobaris, R., & Furth, G. (1977). Apotemnophilia: Two Cases of Self-Demand Amputation as a Paraphilia. *The Journal of Sex Research*, 13(2), 115-125.
- Money, J., & Simcoe, K. W. (1986). Acrotomophilia, Sex, and Disability: New Concepts and Case Report. *Sexuality and Disability* (7), 43-50.
- Moser, C. (2009). Autogynephilia in Women. *Journal of Homosexuality*, 56(5), 539-547.
- Moser, C. (2010). Blanchard's Autogynephilia Theory: A Critique. *Journal of Homosexuality*, 57(6), 790-809.
- Namaste, V. K. (2000). *Invisible Lives: The Erasure of Transsexual and Transgendered People*. Chicago/Londres: The University of Chicago Press.
- Namaste, V. K. (2005). *Sex Change, Social Change: Reflections on Identity, Institutions, and Imperialism*. Toronto: Women's Press.
- Nieder, T. O., & Richter-Appelt, H. (2009). Parallels and Differences between Gender Identity Disorders (GID) and Body Integrity Identity Disorder (BIID) and Implications for Research and Treatment of BIID. In A. Stirn, A. Thiel & S. Oddo (Eds.), *Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical and Legal Aspects* (pp. 133-138). Lengerich/Allemagne: PABST Science Publishers.
- Observatoire des transidentités (2012). *Dépsychiatriser : journée d'études*, Paris, Observatoire des transidentités. En ligne. <[http://natamauve.free.fr/download/Dossier-CIM\(g%E9n%E9ral\).pdf](http://natamauve.free.fr/download/Dossier-CIM(g%E9n%E9ral).pdf)>. Consulté le 14 avril 2012.
- O'Keefe, T. (2007). *Autogynephilia and Autoandrophilia in Non-Sex and Gender Dysphoric Persons*. Paper presented at the Paper presented at the World Association for Sexual Health conference, Sydney, 15-21 April, 2007. Retrieved from www.tracieokeefe.com/Autogynephilia.htm
- Patronne, D. (2009). Disfigured Anatomies and Imperfect Analogies: Body Integrity Identity Disorder and the Supposed Right to Self-Demanded Amputation of Healthy Body Parts. *Journal of Medical Ethics*, 35(9), 541-545.
- Prosser, J. (1998). *Second Skins: The Body Narratives of Transsexuality*. New York: Columbia

Exploring
ableism
and
cisnorma-
tivity

A. Baril and
K. Trevenen

- University Press.
- Reucher, T. (2005). Quand les trans deviennent experts. Le devenir trans de l'expertise. *Multitude* (20), 159-164.
- Richardson, N. (2010). *Transgressive Bodies: Representations in Film and Popular Culture*. Farnham/England: Ashgate.
- Roth, R. (2009). Consent to an Elective Amputation: Response of Students and Experts. In A. Stirn, A. Thiel & S. Oddo (Eds.), *Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical and Legal Aspects* (pp. 139-153). Lengerich/Allemagne: PABST Science Publishers.
- Rubin, G. S. (1984). Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality. In C. S. Vance (Eds.), *Pleasure and Danger: Exploring Female Sexuality* (pp. 267-319). Boston: Routledge and Keagan Paul.
- Rubin, H. S. (1999). Trans Studies: Between a Metaphysics of Presence and Absence. In K. More & S. Whittle (Eds.), *Reclaiming Genders: Transsexual Grammars at the Fin de Siècle* (pp. 173-192). London/New York: Cassell.
- Rubin, H. S. (2003). *Self-Made Men: Identity and Embodiement among Transsexual Men*. Nashville: Vanderbilt University Press.
- Ryan, C. J. (2009). Out on a Limb: The Ethical Management of Body Integrity Identity Disorder. *Neuroethics* (2), 21-33.
- Serano, J. (2007). *Whipping Girl. A Transsexual Woman on Sexism and the Scapegoating of Femininity*. Berkeley: Seal Press.
- Serano, J. (2008). A Matter of Perspective: A Transsexual Woman-Centric Critique of Dreger's "Scholarly History" of the Bailey Controversy. *Archives of Sexual Behavior*, 37, 491-494.
- Shakespeare, T. (2010). The Social Model of Disability. In L. J. Davis (Ed.), *The Disability Studies Reader* (Third Edition ed., pp. 266-273). New York/Londres: Routledge.
- Sherry, M. (2004). Overlaps and Contradictions Between Queer Theory and Disability Studies. *Disability & Society*, 19(7), 769-783.
- Silvers, A. (2009). Feminist Perspectives on Disability. In E. N. Zalta (Eds.), *Stanford Encyclopedia of Philosophy*, Standford, The Metaphysics Research Lab/Center for the Study of Language and Information/Stanford UniversityStanford University. Retrieved from <<http://plato.stanford.edu/entries/feminism-disability/>>.
- Smith, R. C. (2004). Amputee Identity Disorder and Related Paraphilias. *Psychiatry*, 3(8), 27-30.
- Smith, R. C. (2009). Body Integrity Identity Disorder: The Surgeon's Perspective. In A. Stirn, A. Thiel & S. Oddo (Eds.), *Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical and Legal Aspects* (pp. 41-48). Lengerich/Allemagne: PABST Science Publishers.
- Solvang, P. (2007). The Amputee Body Desired: Beauty Destabilized? Disability Re-valued? *Sexuality and Disability*, 25(2), 51-64.
- Spade, D. (2003). Resisting Medicine, Re/modeling Gender. *Berkeley Women's Law Journal* (18), 16-26.
- Spade, D. (2006). Mutilating Gender. In S. Stryker & S. Whittle (Eds.), *The Transgender Studies Reader* (pp. 315-332). New York: Routledge.
- Stirn, A., Thiel, A., & Oddo, S. (Eds.) (2009). *Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical and Legal Aspects*. Lengerich/Allemagne: PABST Science Publishers.

- Stone, S. (1991). The Empire Strikes Back: A Posttranssexual Manifesto. In J. Epstein & K. Straub (Eds.), *Body Guards: The Cultural Politics of Gender Ambiguity* (pp. 280-304). New York/Londres: Routledge.
- Stryker, S. (2008). *Transgender History*. Berkeley: Seal Press.
- Stryker, S., & Sullivan, N. (2009). King's Member, Queen's Body: Transsexual Surgery, Self-Demand Amputation and the Somatechnics of Sovereign Power. In N. Sullivan & S. Murray (Eds.), *Somatechnics: Queering the Technologisation of Bodies* (pp. 49-63). Farnham/England: Ashgate.
- Sullivan, N. (2004). "It's as Plain as the Nose on His Face": Michael Jackson, Modificatory Practices, and the Question of Ethics. *Scan: Journal of Media Arts Culture*, 3(1). Retrieved from http://scan.net.au/scan/journal/display.php?journal_id=44
- Sullivan, N. (2005). Integrity, Mayhem, and the Question of Self-demand Amputation. *Continuum: Journal of Media & Culture Studies*, 19(3), 325-333.
- Sullivan, N. (2008a). Dis-orienting Paraphilias? Disability, Desire, and the Question of (Bio)Ethics. *Journal of Bioethical Inquiry*, 5(2/3), 183-192.
- Sullivan, Nikki (2008b). «The Role of Medicine in the (Trans)Formation of 'Wrong' Bodies», *Body & Society*, vol. 14, no. 1, p. 105-116.
- Sullivan, N. (2009). Queering the Somatechnics of BIID. In A. Stirn, A. Thiel & S. Oddo (Eds.), *Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical and Legal Aspects* (pp. 187-198). Lengerich/Allemagne: PABST Science Publishers.
- Swindell, M., & St-Lawrence, J. (2009). Body Integrity Identity Disorder: An Overview. In A. Stirn, A. Thiel & S. Oddo (Eds.), *Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical and Legal Aspects* (pp. 11-19). Lengerich/Allemagne: PABST Science Publishers.
- Taylor, E. (2010). Cisgender Privilege: On the Privileges of Performing Normative Gender. In K. Bornstein & S. B. Bergman (Eds.), *Gender Outlaws: Next Generation* (pp. 268-272). Berkeley: Seal Press.
- Tomasini, F. (2006). Exploring Ethical Justification for Self-Demand Amputation. *Ethics & Medicine*, 22(2), 99-115.
- Tremain, S. (2008). The Biopolitics of Bioethics and Disability. *Journal of Bioethical Inquiry*, 5(2/3), 101-106.
- Valentine, D. (2007). *Imagining Transgender. An Ethnography of a Category*. Durham, NC: Duke University Press.
- Wendell, S. (1996). *The Rejected Body: Feminist Philosophical Reflections on Disability*. New York/Londres: Routledge.
- Wilchins, R. (2004). *Queer Theory, Gender Theory. An Instant Primer*. Los Angeles: Alyson Books.
- Wilkerson, A. (2002). Disability, Sex Radicalism, and Political Agency. *NWSA Journal*, 14(3), 33-57.
- Wilkerson, A. L. (1998). *Diagnosis: Difference. The Moral Authority of Medicine*. Ithaca/Londres: Cornell University Press.
- Winters, K. (2006). Gender Dissonance: Diagnostic Reform of Gender Identity Disorder for Adults. *Journal of Psychology and Human Sexuality*, 17(3/4), 71-89.
- World Professional Association for Transgender Health (WPATH). (2011). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version*: World Professional Association for Transgender Health.

Exploring
ableism
and
cisnorma-
tivity

A. Baril and
K. Trevenen

Zucker, K. J. (2008). Special Issue: The Controversy Surrounding the Man Who Would Be Queen. *Archives of Sexual Behavior*, 37(3).

Zucker, K. J. (2010). Reports from the DSM-V Work Group on Sexual and Gender Identity Disorders. *Archives of Sexual Behavior*, 39, 217-220.

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