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A Social Model of Trans and Crip Theory

Narratives and Strategies in the Redefinition
of the Pathologized Trans Subject

SATURDAY 20TH OCTOBER 2012 saw the 6th annual "International Day of Action for Trans Depathologization" which is coordinated by the STP, International Campaign Stop Trans Pathologization. The goals of this international activist platform¹ include the removal of pathologizing trans diagnoses from international medical and psychiatric diagnostic manuals whilst simultaneously securing trans people's free access to hormonal treatments, surgery and other health care needs. This attempt to both depathologize trans and retain access to health care is the crux of a problem that trans activism and trans theory have struggled with from the start.² Within these bodies of work, the need to extricate the definition of trans from medical discourses has been well argued for. However, the concern for some theorists and activists has been that depathologization may also negatively impact access to medical services, and perhaps even the legal rights that have been secured through a "medical model" for understanding trans.³ This issue was thoroughly debated at the *Trans Rights as Human Rights – The Implications for Trans Health (Care)* conference in May 2012 in Linköping, Sweden. Academic theorists, activists and other delegates representing organisations from all over the world discussed different ways to approach the dilemma. As I was due to present a paper on this subject in one of the last sessions of

the conference, I found myself editing it each day following discussions and suggestions by fellow delegates, all forwarding different potential solutions. I also found myself having to take into account legal changes that were proposed that very weekend in Argentina. These proposals led to a change in Argentinian law that allows any person to legally change their gender without requiring any diagnosis by a medical professional. Furthermore, anyone over the age of 18 was guaranteed a right to access free trans hormonal or surgical options should they need it. This new legislation seemed to enact the very best practice that could have been wished for and perhaps would in fact neutralise this decades' long debate.

And yet problems remain, not least because the Argentinian model is far from being universally accepted and still applies only to a binary conception of gender transition. Furthermore, I have concerns about the way the debate itself is still being framed, as trans theorists and activists continue to fight for the opportunity to define outside of a medical model but still receive medical services, as well as crucial social and legal protection. I highlight a number of specific European and American examples of legal attempts to institutionalise the rights and health care for trans people in often hostile socio-political environments. Far from being a catalogue of all global contexts, I use these select examples to demonstrate how discourses of pathology have been inscribed and critiqued, and in particular how the debate has been framed in trans theory and activism. I conclude that a perspective of trans informed by a social model of disability may overcome the problems of this debate and offer a flexible approach to multiple and varied trans contexts and subjectivities.

The Origins of Pathologization

The medical model that currently functions as the basis for the medical diagnostic standards for transsexuals in almost every context that allows for it, broadly originates in the work of Harry Benjamin and his contemporaries in the United States in the 1950s and 1960s. Texts like Benjamin's *The Transsexual Phenomenon* (1966), despite their age, form the basis of a standard of medical care that in many regions remains mostly

unchanged in the early 21st century. It is beyond the scope of this article to account for the full history of the medicalisation of trans but there is a body of trans history that has emerged over the last two decades that covers this subject in great detail. Meyerowitz (2002) provides a very good example of this. Her history mirrors many trans theoretical historical accounts⁴ in that it broadly begins in the mid 20th century⁵ with the initial emergence of "transsexuality" as a concept in mainstream US and European media. These histories then track the establishment of institutionalised medical definitions in the following decades, and finally describe the emergence of contemporary trans theory and activism in the late 20th century.

I find that it is useful to approach this literature historiographically, locating the origins of the medical definition of trans very much in its historic/cultural context. Indeed, theorists such as Meyerowitz (2002) describe the origin of Benjamin's work in hostile theoretical, political and social mid-20th century environments, defined by the debate about transsexuality in the US mainstream media, and his attempt to validate his work in the academy. In 1952 Christine Jorgensen culturally became "the first transsexual in the world."⁶ Her emergence in news media led to mass in-depth reporting and analysis in both academic and popular press. This attention focused not only on Jorgensen herself and the medical treatment she had received, but also the practitioners who had provided it (Stryker 2008, 47). This led to the popularisation of the word "transsexual" itself (Meyerowitz 2002, 103). Harry Benjamin, both an advocate for, and a practitioner of, sex reassignment surgery (SRS) in the US also became (in)famous in popular culture and the academy (Califa 1997, 53).

Benjamin and his contemporaries had to justify their techniques and approaches in a uniquely difficult socio-political context. They had to provide a palatable, medically grounded theory that would be acceptable to a scornful public and a sceptical government. Furthermore, they had to defend their position within the academy against hostile critique from influential psychologists and psychoanalysts. These theorists and practitioners argued that transsexuality was a symptom of re-

pressed homosexuality, a fetishistic phantasy, or some other psychological problem, all of which should be treated through therapy (Bullough and Bullough 1993, 213–22). Thus Benjamin's definition and treatments of trans(sexuality) were formed, at least in part, by this socio-political circumstance. Benjamin is not painted as a malicious figure by theorists such as Califia (1997), Stryker (2000) and Meyerowitz (2002). They note that he regularly advocated for the rights of transsexual people and sought to provide medical standards and care where there simply were none before. And yet this cultural impact is still clear in Benjamin's definition of transsexuality as a disease whose "cause" is both complex and unknown and yet is only treatable by hormonal and surgical interventions (Benjamin 1966, 53–4).

Benjamin and his contemporaries produced a socially "palatable" conception of a trans(sexual) subject that could be offered somewhat legitimate medical "treatment" and ultimately perhaps even some social acceptance. This perspective *pathologizes* the "transsexual condition" and advocates a treatment that attempts to *normalise* the patient. The treatment is designed to produce women and men who look, act and think like acceptably "normal" *feminine* women and *masculine* men. These women and men are required to define themselves solely in terms of their newly assigned gender and to see their "transsexuality" as a temporary condition rather than a lasting subjectivity. The approach represents transsexuals as (normal) heterosexual feminine women and masculine men who seek to live out their lives in conventional ways free from the fear of arrest, exposure, social stigma, violence, or being "different" in any way.⁷ Since the time of Benjamin and his contemporaries, reams of research has been published from this perspective to prove this is the *universal* transsexual experience. Bullough and Bullough (1993) chart this body of medical research into trans subjectivity over the decades following Benjamin (citing amongst others key figures in the medicalisation of trans such as John Money, Robert Stoller and Richard Green). This research, they posit, is often conducted by medical practitioners on their own patients to prove that the transsexual is defined by universally persistent characteristics. Given that patients are defined by their doc-

tors who base their research on the characteristics of those same patients, this research is often considered self-fulfilling, and as such continues to function as social justification for normalcy and the maintenance of the status quo (Bullough and Bullough 1993, 268–74). In historiographic terms, the result is a medical definition that is based on conservative social definitions of gender from over half a century ago, and this model continues to be reproduced to this day.⁸

(Practical) Problems

This definition clearly presents a number of significant issues. Apart from the highly problematic gender discourses upon which it is based, it is a very narrow account of trans(sexual) subjectivity⁹ which excludes those who identify as trans in any way that is not traditionally binary.¹⁰ Not only can they not access hormonal or surgical treatments should they want or need them, they also cannot access the rights that are afforded to those who do meet these criteria. Legal statutes that recognise trans(sexual) people tend to be defined in terms of a medical diagnosis. Indeed, one of the most recent examples of this, the Irish Government's 2011 proposed legislation¹¹ that would legally recognise trans(sexual) people there for the first time, requires transsexuals be diagnosed with Gender Identity Disorder to be eligible. The proposed legislation is, at least in part, based upon laws found in other countries¹² as confirmed by Minister Joan Burton when speaking at the 4th Transgender Europe Council in Dublin, 7th September 2012 (Burton 2012). Furthermore, people would have to meet a number of other criteria to qualify, including not being married (forcing divorce for those who are), having lived in their gender for at least 2 years prior to application, and having undergone sex reassignment surgery. Some or all of these criteria might be impossible or undesirable for some and are heavily critiqued by activists. For example, the Irish lobby group Transgender Equality Network Ireland (TENI) has worked closely with Irish Senator Katherine Zappone, who has proposed a private member bill in July 2013 that directly challenges this proposed Government legislation in that it does not include such provisions for forced sterilisation or divorce.¹³

Another example of highly controversial medical criteria required for legal recognition can be found in Sweden. In 1972 Sweden became the first country in the world to legally allow trans(sexual) people to alter their identifying documents. However, one of the stipulations of this statute was that the persons seeking to alter their records must be sterilised. Reading this in context, sterilisation here has multiple cultural functions and implications. It allows for the retention of a culturally conservative conception of gender as it precludes the possibility of trans parents, who would challenge traditional definitions of mother- and fatherhood. Beyond this, trans(sexual) sterilisation in Sweden can further be read as a remnant of the Swedish eugenics programmes of the 1920s to 1970s,¹⁴ that sought to limit the reproductive capacities of those who were judged to be dangerous to or undesirable in society. However, Sweden is far from being the only country that requires sterilisation for trans(sexual) people, with countries like France, Italy, Greece and Denmark amongst those having similar legislation.¹⁵ Swedish law has recently been successfully challenged, but it underwent significant political and legal wrangling.¹⁶ An on-going class action lawsuit seeks damages for those who had to undergo sterilisation to achieve legal recognition.¹⁷

The removal of the sterilisation requirement has most certainly been welcomed in Sweden, however, there are no indications that any other aspect of the law will change. The basis of the law continues to be a pathological conception of the trans(sexual) "condition" and anyone who does not or cannot meet the other requirements of a medical diagnosis may not be able to access necessary medical or legal services. Even UK law, which allows trans people to alter their legal gender without any medical intervention, continues to cover only one definition of trans(sexual) subjectivity. In order to be eligible under the law one is still required to obtain a diagnosis from a medical professional. Furthermore, anyone who does not subsequently seek to obtain legal recognition under the Gender Recognition Act, is not covered by other statutory defences against discrimination.¹⁸

Currently it is only the 2012 law in Argentina that bypasses some of this. From previously not having any legal recognition of gender transi-

tion at all, Argentina with this brand new legislation now allows trans people to change their records and personal information without any need of medical intervention or diagnosis.¹⁹ Here, a person can change their official gender simply by applying at a civil registry office. This law also introduces a trans person's right to surgical and hormone based medical services should they wish. Hailed as a victory, this takes some of the legal definition of trans subjectivity out of the field of *stigmatising* medical discourse. This legislation, however, remains unique, and is not yet reproduced anywhere else in the world.

(Health) Care Concerns

Access to health care has been a key concern when challenging the continued medical definition of trans. But is this concern now quelled by legislation like that found in Argentina? It might be, though time will tell if this legislation can continue to live up to such promises, and, indeed, if it will be adopted by other countries and broadened. Also, this legislation still sets up trans as a binary state, with an ability to change from one gender to the other being the only right afforded here. It raises the question of how this will influence access to medical services for other trans people, and if it will eventually be possible for those who identify as trans in other ways to access those services. And will they eventually be given the right to define their gender in non-binary ways and be similarly covered under civil law?

As I highlighted above, the Argentinian model is currently something of an anomaly. The question for many remains: Could depathologization affect access to health care and rights? It is not inconceivable that this might be the case. Indeed, trans health care is vulnerable even without further depathologization. In the current UK economic crisis, some of the first funding cuts to public services were applied to health care for trans people.²⁰

The US model is perhaps another such potential example. Despite in many ways being the birthplace of the medical definition (as I describe above), until recently almost no medical insurance companies would cover trans medical services. In 2008, the American Medical Associa-

tion (AMA) passed a resolution insisting that private and public insurance policies cover treatments for Gender Identity Disorder (GID) as prescribed by a physician. GLAD (Gay & Lesbian Advocates & Defenders) note that such a mandate was required to force medical insurance companies to pay for such treatments (GLAD 2008) and this was confirmed by an Associated Press report by Lisa Leff (2011). Since then there has been significant development in medical definitions, for example, in the recently published *Diagnostic and Statistical Manual of Mental Disorders V* (DSM). In this new edition, the American Psychiatric Association (APA) approved revisions that see GID replaced with the term "Gender Dysphoria."²¹ Hailed by some as a success, this change is described as a move away from seeing trans(sexuality) as a disorder and a shift in focus to the discomfort an individual experiences from an incongruence between their gender identity and their socially assigned gender. This is an interesting and subtle change that I will return to below.

However, there are still some who are concerned. For example, Shannon Minter, legal director of the National Center for Lesbian Rights speaking to the *Advocate* magazine in July 2012 notes that:

Having a diagnosis is extremely useful in legal advocacy [...] We rely on it even in employment discrimination cases to explain to courts that a person is not just making some superficial choice [...] that this is a very deep-seated condition recognized by the medical community. (Minter in Beredjick 2012)

Here the practical concern of losing the discursive weight of a diagnosis is very clearly expressed. However, there are other concerns found elsewhere in the new DSM-V. Theorists and activists like Kelly Winters (2010) and Julia Serano (2009; 2012) are highly critical of a different change in another section of the DSM-V. The controversial diagnostic category of "Transvestic Fetishism" has been replaced with the term "Transvestic Disorder" in the section on Paraphilic Disorders. This definition is based in part on Ray Blanchard's (1989) view that

any trans(sexual) woman who is not attracted exclusively to men, has transitioned instead because of a sexual fetish.²² In this new extended definition of "Transvestic Disorder," this concept is also be applied to non-heterosexual trans(sexual) men as well.²³ This diagnostic category for Serano (2009; 2012) solidifies the notion that there is a singular viable trans(sexual) subjectivity and that those who fall outside of it are considered disordered and pathologized even further.

Clearly practical and theoretical concerns remain, and the debate is still very much located within the medical discourse. Solutions were postulated throughout the *Trans Rights as Human Rights* conference that sought to alleviate the tension between the need to access health care and the depathologization of trans. For example, Susan Stryker suggested that abortion could be a potentially useful discursive model. In the case of abortion, a person is not considered ill but is still afforded medical services, a fact that provides a potential for validated claims to medical services without a pathological diagnosis. However, my concern here is that abortion, like trans(sexual) medical services, is often moralised. One merely has to look to the recent 2012 US Presidential campaign,²⁴ to see the constant attack that abortion rights has experienced in just one country where abortion is (currently) still legal. Does this mean that it is an invalid model? I think not. These are practical concerns that can be debated; however there is a discursive correlation that can be made and the point could, and in my opinion should, be so argued. However, what is illustrated by this example is the notion of relative and contextual moral "stigma", and how this can function in a *practical* approach to a given socio-political debate. I will return to this below as a critical issue to trans depathologization, but for now I turn to another suggestion that seeks to sidestep this problem of "stigma."

Another delegate contended that perhaps pregnancy itself could function as a useful rhetorical and legal model. Once again, the individual here is not considered ill, but very much retains the right to medical health care services. However, convincing wider social, political and medical communities to adopt such an approach might also prove difficult. Political activist strategy would have to reflect that culturally the

two are not considered in the same way, precisely because one is regularly stigmatised and the other is not. Again, this is not a reason to disregard such an approach. However, it is important to incorporate such an understanding into theory and activism. Furthermore, it once again highlights the notion of "stigma." I turn to the attempts to avoid such stigma now, as a key concern of this debate.

To Avoid Stigma

Clearly the issue of trans pathologization and its medical definition is fraught and despite the potential pragmatic advantages of medical definition, it continues to present a limiting and excluding definition of trans(sexual) subjectivity. The potential solutions offered during the conference suggested ways to redefine the conceptualisation of trans subjectivity *within* a medical model. However, there is one aspect of the debate that remains extremely problematic, but that might also present a potentially useful perspective.

One consistent criticism levelled at the (pathologized) medical definitions of trans subjectivity is that it is *stigmatising*. Labelling trans subjectivity as pathological carries with it the cultural stigma of "disease." Activists and theorists note that one of the main motives to remove homosexuality from the DSM in 1973 was to remove the social stigma this caused (Silverstein 2009). In the same way, it has been argued, defining trans as a mental health issue stigmatises trans people. However, this argument is circular. Whilst the medical model is challenged for its attempt to "normalise" the trans subject, it is postulated that the trans subject would never be accepted as "normal" because of this very definition. This is reproduced time and again in political activism that seeks to remove trans subjectivity from the medical domain. For example, a resolution adopted in the European Parliament in September 2011 calls for the World Health Organization (WHO) to stop considering trans people mentally ill, by redefining trans in the WHO's *International Classification of Diseases* (ICD).²⁵ Emine Bozkurt (MEP) (2011) specifically notes this is because of the negative stigma this produces. And recently there has been some indication that – similarly to the changes

to the DSM – the WHO is indeed considering altering its definitions too, so that trans(sexuality) might fall outside the categories of “mental disorders,” citing the problems of stigma as a critical reason for change (Drescher, Cohen-Kettenis and Winter 2012).²⁶ The discursive axioms here are that mental health issues are, and remain, a social stigma and, as such, trans should be removed from a stigmatised medical discourse. What concerns me is that this perspective often slips into problematic reproductions of wider stigmatised “mental health discourses” which are critiqued by crip theory and disability activism. However, as I outline this problem below, I find that crip theory may also offer a solution.

The Social Model Solution

Robert McRuer (2006) locates the crip²⁷ theoretical and activist tradition very much in the same field as queer theory and activism. He draws a parallel between a cultural compulsory able-bodiedness with what queer theorists have described as a compulsory heterosexuality (2006, 2). Both disability and queer identities challenge the norm, they both deviate from hegemonic concepts that are as such difficult to define (namely heterosexuality and ability), and they both contend that cultural hegemonies are broadly invisible to scrutiny while their “opposites” are considered deviant. As queer theory scrutinises the heterosexual matrix, crip theory seeks to make the problematic hegemonies of ability visible. A crucial crip theoretical and disability activist position of the past decades is that it is necessary to remove stigma from mental health issues and physical/sensory disabilities.²⁸ The goal is to reconceptualise a notion of disability in terms of a “social model” as opposed to a medical model. In crip theory and activism, the medical model of disability is conceptualised as one that locates the disability or pathology in the individual.²⁹ It is characterised by statements such as “that person cannot walk upstairs” or “that person cannot see.” Pathology in this perspective resides in the individual and as such is conceptualised as their individual deficiency. The upshot of this is that disabled people are discursively positioned as “the problem”, perhaps, at best, to be solved by (altruistic) interventions by society.

In contrast, a social model approach inverts this. Here, an individual is not regarded as disabled by conditions they may have, but rather by a world that does not account for their needs. This perspective is characterised by statements like "that person cannot enter that house because the architect, working on a presumption of a certain type of body, put those stairs in the way." This represents a subtle shift in perspective with a significant impact. Essentially, the person is not disabled, but rather it is the world that is *disabling*. The person is not pathological; it is the culture that has a pathological perspective. The next logical step is a destigmatisation of the disabled individual and a campaign to depathologize culture. This lies at the heart of the social model of disability.³⁰ An individual has different experiences and needs, the discursive shift is that culture and society, discursively, practically, legally and socially is asked to acknowledge and provide for this. This includes all disabilities, mental, physical, sensory, and so forth. In terms of law, for example, the UK provides anti-discriminatory legislation based on this model, named the Disability Discrimination Act (2004). It should be noted however, that many institutions and corporations often do not follow this statute, and even the government and social service providers do not really seem to acknowledge it (Gooding 2000). However, the point remains that in this case, despite retaining a sense of disabled or crip subjectivities, stigma is not removed by simple disassociation. Rather, it is achieved through a redefinition of the debate.

In the debate on trans depathologization this leads to a significant tension. While the negative stigma of mental health issues is cited as a concern in the depathologization of trans, there is no discursive engagement with the causes of those stigmas. In crip theoretical terms, there is instead a reproduction of a medical model understanding and reinscription of a notion that mental health issues are pathological. And as I have noted above, disassociation does not simply remove stigma. Rather this is a counterproductive theoretical and activist standpoint that simply recreates the pathological discourses that this perspective seeks to critique.

Whilst this is potentially a circular problem, it could however also

provide a unique opportunity. In her exploration of the intersections between trans and crip theory, Ute Kalender (2010) examines both theoretical perspectives with regards to new reproductive technologies and asks us simply to consider how each perspective could inform the other. In this case, the social model of disability offers a challenge to the understanding of pathology and as such also has implications for trans activism, theory and the conception of the medical model of trans. By redefining and depathologizing "mental health," the medical model of trans is also redefined. This opens up the possibility for new strategies to approach inequalities in trans health services, as well as the possibility for wider social conceptions of (multiple) trans subjectivities. In this conception, different trans subjectivities, like disabilities, are not pathological but simply present different access needs that are currently not met. The Argentinian model seems to be based in part on this principle, despite this legislation still being premised upon a binary gender model. Following the social model perspective used in crip theory, if trans subjectivities are understood as multiple and varied, it can similarly be argued that there is a need to create access for these people too. They can be understood as having differing access needs, rather than simply being discredited as not meeting the criteria of a diagnosis for which it is singularly legislated.

This potentially side-steps the two-horned problem of depathologization and continued access to health care, just as the social model of disability can for disabled people and the Argentinian legislation does for trans(sexual) people there. This model offers a way to challenge medical pathologization of trans subjectivities without reinscribing the problematic "stigmatising" mental health discourse, and also maintains medical services for those who need them. Furthermore, it allows for a secondary conceptualisation of mental health issues that trans people may experience, which arise from an inability to access society in the ways that they should.³¹ The prevalence of "other" mental health issues in the trans community (and indeed LGBTQ communities) has been used by those opposed to LGBTQ equalities to argue that this is evidence that trans is a mental deficiency in itself.³² Instead the social model shows that

these problems most likely are the result of an inaccessible environment and not intrinsic to trans subjectivities. Returning to the example of the DSM-V, I propose a further change to the definition of "Gender Dysphoria." The initial change is ostensibly a move away from pathologizing the transsexual subject to emphasising the dysphoria associated with incongruence between gender expression and gender assignment. I suggest that instead of locating dysphoria in the individual, it is located in society. And it is society that needs to be addressed.

In short, the social model of disability, and also trans, offers a flexible model that can account for multiple and varied access needs, and provides a perspective to conceptualise stigmatising and pathologizing environments which are also varied and complex. It offers a strategy to navigate what may seem like contradictory needs, as the model can be flexible to both the individual and the differing contexts. Practical approaches can be formulated on that basis, taking into account the particulars of a socio-political context, but always with the common understanding that it is society that is being asked to change, not the individual. Problems with the social model may however be practical. As I have noted, the concern that trans medical services can be limited is real, and in terms of political activism, such discourse would always have to be approached cautiously, lest a redefinition of the trans "condition" be twisted into a justification to withdraw, rather than improve, access to rights and services. This is of course the practical activist concern of the social model, that it may be ineffectual, ignored, or worse, used against trans people. Despite this concern, rhetorically, at least, the social model allows us to track the impact of such possibilities, and may yet offer further solutions.

Conclusion

Far from offering a simple "silver bullet" to the debate on trans pathologization and access to medical services, I instead present a different way to look at the debate itself. Despite the practical concerns connected to a social model approach, rhetorically it offers a shift in focus to the *disabling* world that needs to be addressed. A trans subject

is not a pathological subject, but rather it is the impairing world that is pathological. In such a perspective, whether trans is considered a mental health issue or not is relatively moot to this underlying point as stigma is avoided by redefining the debate itself. Medical services can be considered a necessary and integral part of some, but not all, trans peoples' needs. Furthermore, this model could be the basis to advocate for other trans subjectivities, specifically those that do not easily fit into current medical model. Taking on board the potential overlaps with crip and disability theory allows a more nuanced perspective on the debate and also provides for potentially fruitful partnerships with disability theorists/activists (amongst others) as similar discursive positions are argued for.

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REFERENCES

- American Psychiatric Association. 2013a. "Gender Dysphoria". <http://www.dsm5.org/Documents/Gender%20Dysphoria%20Fact%20Sheet.pdf> (accessed 2013-07-13).
- . 2013b. "Paraphilic Disorders". <http://www.dsm5.org/Documents/Paraphilic%20Disorders%20Fact%20Sheet.pdf> (accessed 2013-07-13).
- Barnes, Colin, and Geof Mercer. 2004. *Implementing the Social Model of Disability: Theory and Research*. Leeds: Disability Press.
- Benjamin, Harry. 1966. *The Transsexual Phenomenon*. New York: Julian Press.
- Beredjick, Camille. 2012. "DSM-V To Rename Gender Identity Disorder 'Gender Dysphoria'". *Advocate*, July 23. <http://www.advocate.com/politics/transgender/2012/07/23/dsm-replaces-gender-identity-disorder-gender-dysphoria> (accessed 2014-02-03).
- Blanchard, Ray. 1989. "The Concept of Autogynephilia and the Typology of Male Gender Dysphoria". *Journal of Nervous and Mental Disease* 177.10:616–23.
- Bloom, Amy. 2003. *Normal: Transsexual CEOs, Crossdressing Cops, and Hermaphrodites*

- with Attitude*. London: Bloomsbury.
- Bozkurt, Emine. 2011. Cited in "European Parliament: World Health Organization Must Stop Treating Transgender People As Mentally Ill". *European Parliament's Intergroup on LGBT Rights*, September 29. <http://www.lgbt-ep.eu/press-releases/who-must-stop-treating-transgender-people-as-mentally-ill/> (accessed 2014-02-03).
- Bullough, Vern L, and Bonnie Bullough. 1993. *Cross Dressing, Sex, and Gender*. Philadelphia: University of Pennsylvania Press.
- Burton, Joan. 2012. Keynote speech delivered at the 4th Fourth Transgender Europe Council, Dublin, September 7. <http://www.youtube.com/watch?v=NKsLknSoxac&feature=plcp> (accessed 2013-06-19).
- Cabral, Mauro. 2012. Keynote speech delivered at the 4th Transgender Europe Council, Dublin, September 9. <http://www.youtube.com/watch?v=ELK4HjNw2Do&feature=plcp> (accessed 2013-06-19).
- Califa, Pat(rick). 1997. *Sex Changes: The Politics of Transgenderism*. San Francisco: Cleis Press.
- Channel 4. 2010. "How Will NHS Cuts Affect my Area?". News, December 15. <http://www.channel4.com/news/how-will-nhs-cuts-affect-my-area> (accessed 2013-06-19).
- Christian Institute. 2003. "Transsexualism: Mind Over Matter". <http://www.christian.org.uk/pdfpublications/transsexualism.pdf> (accessed 2013-06-19).
- Drescher, Jack, Peggy Cohen-Kettenis, and Sam Winter. 2012. "Minding the Body: Situating Gender Identity Diagnoses in the ICD-11". *International Review of Psychiatry* 24.6:568-77.
- Drouard, Alain. 1999. "Concerning Eugenics in Scandinavia: An Evaluation of Recent Research and Publications". *Population: An English Selection* 11:261-70.
- Ekins, Richard, and Dave King. 2006. *The Transgender Phenomenon*. London, Thousand Oaks and New Delhi: Sage Publications.
- Ellis, Havelock. 1943. *Studies in the Psychology of Sex* [1905]. New York: Random House.
- Gartland, Fiona. 2013. "Senator Zappone Publishes Gender Recognition Bill". *Irish Times*, July 2. <http://www.irishtimes.com/news/social-affairs/senator-zappone-publishes-gender-recognition-bill-1.1450385> (accessed 2014-02-03).
- GLAD. 2008. "Removing Barriers to Care for Transgender Patients". <http://www.glad.org/uploads/docs/publications/ama-resolution-fact-sheet.pdf> (accessed 2013-06-19).
- Gooding, Caroline. 2000. "Disability Discrimination Act: From Statute to Practice". *Critical Social Policy* 20.4:533-49.
- Hirschfeld, Magnus. 1991. *Transvestites: The Erotic Drive to Cross-Dress* [1910]. Translated by Michael A. Lombardi-Nash. Buffalo: Prometheus Books.
- Kalender, Ute. 2010. "Subtle Pressures, Coercive Sterilizations and Denials of Access: A Trans-Crip Approach to Reproductive Subjectivation". *Graduate Journal of Social Science* 7.2:76-94.
- Krafft-Ebing, Richard von. 1999. *Psychopathia Sexualis* [1886]. Berkeley, Calif.: Bloat Books.

- Leff, Lisa. 2011. "More Companies Covering Transgender Surgery". MSNBC, February 21. http://www.msnbc.msn.com/id/41705893/ns/business-personal_finance/t/more-companies-covering-transgender-surgery/ (accessed 2013-01-03).
- Liberty. 2010. "Your Rights: Transgender Discrimination". Last modified August 5. <http://www.yourrights.org.uk/yourrights/right-to-receive-equal-treatment/transgender-discrimination/> (accessed 2013-01-03).
- Mackenzie, Gordene Olga. 1994. *Transgender Nation*. Bowling Green, Ohio: Bowling Green State University Popular Press.
- McRuer, Robert. 2006. *Crip Theory: Cultural Signs of Queerness and Disability*. New York: New York University Press.
- Meyerowitz, Joanne. 2002. *How Sex Changed: A History of Transsexuality in the United States*. Cambridge, Mass.: Harvard University Press.
- Oliver, Michael, and Bob Sapey. 2006. *Social Work with Disabled People*. 3rd ed. Basingstoke: Palgrave Macmillan.
- Rudacille, Deborah. 2006. *The Riddle of Gender: Science, Activism and Transgender Rights*. New York: Anchor Books.
- Sandahl, Carrie. 2003. "Queering the Crip, or Crippling the Queer?: Intersections of Queer and Crip Identities in Solo Autobiographical Performance". *GLQ: A Journal of Lesbian and Gay Studies* 9.1-2:25-56.
- Serano, Julia. 2009. "Psychology, Sexualization and Trans-Invalidations". Keynote speech delivered at the 8th Annual Philadelphia Trans-Health Conference, Philadelphia, Pennsylvania, June 11-13. <http://www.juliaserano.com/av/Serano-TransInvalidations.pdf> (accessed 2014-02-03).
- . 2012. "Trans People Still 'Disordered' According to Latest DSM". Whipping Girl (blog), December 3. <http://juliaserano.blogspot.se/2012/12/trans-people-still-disordered-according.html> (accessed 2013-01-03).
- Silverstein, Charles. 2009. "The Implications of Removing Homosexuality from the DSM as a Mental Disorder". *Archives of Sexual Behaviour* 38.2:161-3.
- Society for Disability Studies. 2010. "Guidelines for Disability Studies". <http://disstudies.org/guidelines-for-disability-studies-programs/> (accessed 2013-02-27).
- Spade, Dean. 2006. "Mutilating Gender". In *The Transgender Studies Reader*, edited by Susan Stryker and Stephen Whittle, 315-33. New York: Routledge.
- Spektorowski, Alberto, and Elisabet Mizrachi. 2004. "Eugenics and the Welfare State in Sweden: The Politics of Social Margins and the Idea of a Productive Society". *Journal of Contemporary History* 39.3:333-52.
- Stone, Sandy. 1998. "The Empire Strikes Back: A Posttranssexual Manifesto". In *The Visible Woman: Imaging Technologies, Gender and Science*, edited by Paula A. Treichler, Lisa Cartwright, and Constance Penley, 285-309. New York and London: New York University Press.
- STP. 2013. "About Us". <http://www.stp2012.info/old/en/about-us> (accessed 2013-06-19).

- Stryker, Susan. 2000. "Introduction". In *Christine Jorgensen: A Personal Autobiography*, Christine Jorgensen, v–xiii. San Francisco: Cleis Press.
- . 2008. *Transgender History*. Berkeley, Calif.: Seal Press.
- Stryker, Susan, and Stephen Whittle. 2006. *The Transgender Studies Reader*. New York: Routledge.
- TENI. 2013. "Press Release: Senator Zappone Sets High Bar with Legal Recognition of Gender Bill 2013". July 2. http://www.teni.ie/press_release_senator_zappone_sets_high_bar_with_legal_recognition_of_gender_bill_2013 (accessed 2013-01-03).
- Weindling, Paul. 1999. "International Eugenics: Swedish Sterilization in Context". *Scandinavian Journal of History* 24.2:179–97.
- Whittle, Stephen. 1999. "Introduction 2". In *Reclaiming Genders: Transsexual Grammars at the Fin de Siècle*, edited by Kate More and Stephen Whittle, 6–15. London: Cassell.
- Wilchins, Riki. 2004. *Queer Theory, Gender Theory: An Instant Primer*. Los Angeles: Alyson Books.
- Winters, Kelley. 2010. "Comments on the Proposed Revision to 302.3 Transvestic Fetishism". April 20. <http://www.gidreform.org/201004APATFkwB.pdf> (accessed 2014-02-03).

NOTES

1. The platform is made up of a diverse set of international organisations from Europe, North and South American countries, African countries, and India amongst others (STP 2013).
2. Pat(rick) Califia (1997), and Stephen Whittle (1999), amongst others convincingly locate the origin of contemporary trans theory to the early 1990s. The "origins" of contemporary trans activism is harder to locate, given the large number of activist, support and lobby groups and individuals that operate globally. Suffice to say, the last two decades has similarly seen a wealth of trans activism, criticising of the ways in which trans communities are represented and discriminated against by governments, policy makers, institutions and corporations.
3. I will further outline what I mean by a medical model of trans below, but in summary, this is the perspective that broadly understands trans as a "condition", experienced by an individual that can be resolved through medical intervention such as hormonal and surgical treatments.
4. Similar histories can be found in Mackenzie (1994), Califia (1997), Bloom (2003), Wilchins (2004), Ekins and King (2006), Rudacille (2006), Stryker and Whittle (2006), and Stryker (2008), amongst others.
5. Though earlier work by sexologists on "trans" by the likes of Krafft-Ebing (1999) in 1886, Ellis (1943) in 1905, and Hirschfeld (1991) in 1910, are also often referenced in these histories, they are generally considered to be influential forerunners of

- contemporary medical theory established in the 1960s.
6. She was certainly not the first "actual" transsexual, however one defines the term. Jorgensen was instead the first transsexual to receive prolific attention by the mass media, and in that sense she is the "first" transsexual that modern popular culture became aware of (Stryker 2000).
 7. "Benjamin's description of an ideal adjustment is that of a young woman who, after surgery, married a slightly older man who knows only that Joanna as a child had to undergo an operation which prevented her from ever menstruating or having children. They have had a distinctly happy marriage now for seven years. Joanna no longer works but keeps house and they lead the lives of normal, middle-class people." (Califa, 1997, 59)
 8. See for example the recently proposed legislation in Ireland that I detail below.
 9. Theorists such as Spade (2006) note that some changes in the criteria used by Gender Identity Clinics have slowly begun to occur, so that for example, the insistence on heterosexual orientation may no longer be a factor in some clinics in the US and other countries. However, he notes that social conservatism continues to be the norm in most places in assessing trans(sexual) people.
 10. For example, any person who identifies outside of the male/female binary such as a person who might identify as genderqueer or androgynous, and as such does not transition simply from, or to, "male" or "female".
 11. Though this legislation still has no timetable for release (TENI 2013).
 12. This further demonstrates how medical narratives and discourse on trans (even wholesale legislative practices) can spread across socio-political contexts and national borders.
 13. See TENI (2013) and Gartland (2013) for more details on this private member's bill.
 14. The history of Swedish eugenics programmes, which included the systematic sterilisation of disabled people, sexual, racial and class minorities amongst others to preserve a "pure" and desirable Swedish population, is documented by Drouard (1999), Weindling (1999) and Spektorowski and Mizrachi (2004), amongst others.
 15. Though this policy is in review in several of these countries.
 16. Following an activist campaign in 2012, the current Swedish government committed to remove forced sterilisation in the summer of 2013. The delay was criticised by Swedish activists including the RFSL (the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights), and despite a further challenge to the law being upheld by the European Court in December 2012 (which effectively deemed the sterilisation of trans people illegal in Sweden), the current government only voted to formally change the law in May 2013.
 17. RFSL is currently spearheading a class action lawsuit representing 135 trans individuals seeking reparations from the state for having undergone forced sterilisation.
 18. Liberty, the human rights organisation of England and Wales, provides on its

"Your Rights" website an extensive description of trans people's rights, including under the Sex Discrimination Act, 1975 and Gender Recognition Act (GRA), 2004 (Liberty 2010). There are significant rights that are not afforded to those who cannot or choose not to be defined by the GRA. This covers all aspects of society, from provision of goods and services to employment and more. Clearly, "[i]f no gender recognition certificate has been obtained the legal position of pre-operative transsexuals is weaker than post-operative transsexuals." And the case for trans people who do not define as transsexual is weaker still.

19. Cabral (2012) gives a description of how this law came about, and its scope and functions.
20. For example, in 2010 Gender Reassignment Surgery was cut for a full financial year in some National Health Service Districts in UK, as reported by Channel 4 (2010).
21. See APA (2013a) notes on the changes to "Gender Dysphoria" in DSM-V.
22. The term he employs for this is "autogynephilia," Blanchard (1989).
23. See APA (2013b) notes on the changes to definitions within Paraphilic Disorders.
24. For example in the run up to the last presidential election, the 2012 Republican National Convention voted for a platform banning abortions with no exceptions.
25. It is beyond the scope of this article to explore the similarities and differences between the DSM and ICD, however they serve similar functions in different regions. The DSM holds great significance to the US context, whilst the ICD has greater impact in European and other non-US territories. Activists seek to remove pathologizing definitions from both (for example by International Campaign Stop Trans Pathologization).
26. The recently published DSM-V also lists the avoidance of stigma by the removal of trans from the category of "mental illness" as a critical reason for their change in terminology and definition, APA (2013a)
27. Forwarded by authors like Carrie Sandahl (2003) and Robert McRuer (2006), crip theory examines disability from a perspectives inspired by queer theory, feminism and intersectionality.
28. This is one of the working guidelines of the Society of Disability Studies (2010), in its attempt to define the field of Disability Studies in the Academy.
29. This perspective that people are disabled by their culture, rather than by their "condition" originates in 1970s activism and is reproduced by disability theorists from the 1980s onwards (Oliver and Sapey 2006).
30. A comprehensive outline of the history of the social model of disability and its application in varying contexts is provided by theorists like Barnes and Mercer (2004)
31. These being mental health issues *caused* by a disabling world, rather than intrinsic to *being* a trans person.
32. See for example the Christian Institute's (a conservative Christian lobby group in the UK) reference to greater levels of suicides and depression in trans people (2003).

SAMMANFATTNING

Definitionen av trans som medicinsk patologi fungerar både som ett diskursivt och bokstavligt förnekande av existerande transsubjekt och som en politisk strategi för att få tillgång till såväl vissa sociala och lagstadgade rättigheter, som (medicinska) samhällstjänster. Utifrån olika exempel på samtida internationell transaktivism och förändringar i rättsliga definitioner, belyser jag hur försöken att avpatologisera trans (av politiska, pragmatiska, hälsovårdsrelaterade, etiska och anti-diskrimineringsbaserade skäl) ofta medför ett problematiskt återskapande av stigmatiserande diskurser runt mental hälsa. Jag presenterar ett alternativt debattperspektiv som bygger på *crip theory* och funktionshinderforskning och -aktivism, samt den s.k. sociala modellen för funktionshinder. Denna ansats utmanar föreställningar om att det patologiska finns hos den enskilda individen, och betonar istället att det är en funktionshinderande värld eller kultur som är patologisk. Genom att tillämpa denna tolkning på transaktivism och -teori kan vi omdefiniera debatten om avpatologiserandet av trans, och därigenom möjliggöra nya strategier för att åtgärda såväl ojämlikheter i transhälsovården, som större, problematiska sociala föreställningar om transsubjekt.

Keywords: trans, disabilities, crip theory, social model, depathologization