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Trans Health Is Queer (and Queer Health Isn't Normal)

I AM VERY honored to be here at the *Trans Rights as Human Rights* conference at Linköping University.¹ Thank you to the organizers for extending the invitation, especially Ulrica Engdahl, who I met last year when I was doing some workshops and lectures in Copenhagen. I am really inspired by the critical mass of work on transgender issues going on in Scandinavia, particularly here at Linköping. I know there was another conference here in 2009, on expanding the field of transgender studies in a Nordic context, which although very small, turns out to have been very influential.² I regretted at the time that I could not attend because I was in Sydney, coincidentally with Ulrika Dahl from Stockholm, at another conference. I want to pause for a moment, before properly launching into my talk, to highlight the two things that I, as a person from the United States, find so exciting about the way that transgender issues are being approached here.

The first is the level of engagement with government that is both possible and necessary – like many in the room today I have been following as best I can from afar and across the language barrier the recent controversy surrounding the sterilization, divorce, and age requirements in the Swedish law on gender recognition. I am inspired by the progress here, to end compulsory sterilization as the price of gender recognition. However far trans people still have to travel in Sweden to gain full equality

under law, and however much struggle remains, the conversation on these issues is in a more productive, engaged, and effective place than it is in the US, and in many other parts of the world. In general, I think, this is because the health care system and the apparatuses of state have a very different relationship with each other in Europe than they do in the US, which is a mixed blessing.

The second thing that excites me about the current attention to trans politics and social policy in the "Nordic Context", as the 2009 conference framed it, is the opportunity to bring pragmatic, policy-oriented conversations into dialog with interdisciplinary critical theory. In the US, interdisciplinary transgender studies scholarship currently feels very far away from direct engagement with national-level policy and law. The reason I could not come to Linköping in 2009 was because I was at a conference on somatechnics,³ which is a relatively new concept that demonstrates the mutually inextricable nature of embodiment (*soma*) and technology (*techne*): it is a neologism, a new made-up word, that replaces the additive logic of the "and" in the framing of the body/technology relationship, by mashing them up and refusing to acknowledge a clear separation between technology and the body. The body is "always already technologized," in this way of thinking; there is what might be called an "originary technicity" of the human. That is to say, it is wrong to think about technology as a prosthesis, as something that gets added to a natural body that has already been formed, instead of realizing that technology and our bodies have grown up together, so to speak: that in a literal sense the hand emerges over evolutionary time in relationship to the ability of some stones to flake and chip, rather than the hand forming "on its own," as it were, and then "discovering" some object in nature that was serendipitously fitted to it. The body is likewise "always already technologized" to the extent that language – an immersive technology for enfolding abstraction, symbolization, and representation into the experience of the world – is always already there for us now, structuring how we grasp and manipulate the world of experience. For the human there is no before technology, no outside of technology, either diachronically or synchronically. There are only varying, mutable

assemblages of body, tool, environment, and other – in which one tool's body is another body's tool.

This ontological assertion about the relationship between embodiment and technology has clear ethical and political implications for trans people, because it is often through the assertion of unnaturalness that our dignity, our common humanity, our ability to live, is stripped from us. Others sometimes want to think of our medicalized transitions, or our cross-gender dressing practices, as technological enhancements or prosthetic additions that simply add an artificial element to our natural bodies, and they dismiss us or condemn us on these grounds. We are not natural. To say that we humans – trans or otherwise – have never been natural, or that our nature is always already technologized, is a very powerful way to undercut this moral argument against us.

I mention all this not only to help promulgate and disseminate the concept of somatechnics, but also to note that this line of thinking is becoming increasingly well established in some pockets of the Scandinavia academy, partly through Ulrika Dahl's uptake of it to reframe feminist debates about the "unnaturalness" of high femme styles and subjectivities, and through the conference on somatechnics she organized last month in Stockholm,⁴ co-sponsored by the Norwegian-based Thought as Action Network, many members of which presented at last month's conference, and many of whom gave the concept of somatechnics quite a rigorous interrogation. But it is also becoming established here at Linköping University in particular, partly through its affinities with Jami Weinstein's Zoontology Research Team, and partly through the presence at the university of philosopher Margrit Shildrick, who has been involved in the conversations about somatechnics since their inception about 10 years ago at Macquarie University in Australia. I am very interested in working with Margrit, and with Nina Lykke, to bring a somatechnics conference here to Linköping next year because there is such a good opportunity right now, in northern Europe, to bring this kind of activist intellectual engagement to bear on questions of law and policy as they relate to trans issues, as well as on other forms of social oppression based on bodily difference, and I would be honored to be part of that conversation.⁵

My talk today is called "Trans Health is Queer (And Queer Health Isn't Normal)", which is a deliberately provocative title. What I am aiming for is the idea that the problem lies not with queerness, but with normalcy. The title arose in response to something that provoked me, something I learned about the Gender Management Services (GeMS) Clinic at Boston Children's Hospital, which is one of the leading hospital-based programs in the United States for providing medical services to young gender-transitioning people (Hurley 2012). What I encountered was a summary of intake interview outcomes for applicants to the program, which listed the reason why certain applicants – 90 out of several hundred – had been deemed ineligible. Most were too young, some were too old; a few lived too far away to make regular treatment feasible, some were already receiving satisfactory treatment elsewhere, and some had health insurance that denied coverage. But 12 applicants were turned down for what the GeMS program called being "self-identified 'queer' or 'questioning'".

TABLE 1 Consecutive Inquiries by Intake Social Worker

Reason	n (%) of the 90 Inquiries Deemed Ineligible
Too young	34 (37.8)
Too old	18 (20.0)
Insurance denied coverage at hospital	9 (10.0)
Self-identified "queer" or "questioning"	12 (13.3)
In stable treatment elsewhere	6 (6.7)
Too distant to travel	11 (12.2)

Image courtesy of Natasha Hurley, University of Alberta

That startled me. Not because I do not recognize that some people – including children – can express gender atypical characteristics, or have a gendered subjectivity that is not congruent with gender stereotypes, and yet not want medical treatment to change their bodies or their social or legal identities. Not because I do not see very good reasons for sorting out gender-different people who want medicalized body-modification services from gender-different people who do not. Not because I have any problem with people who are "questioning" being asked to come

back later when they are more sure about what they want, especially when it involves irreversible medical procedures. What did startle me, though, and what I reflexively resisted, was the hard, sharp, clear line being drawn, in a new way, by an institutionalized medical power, between being "queer" and being "trans." Trans, for me, has always been queer, and the threat I perceived to the disarticulation and disambiguation of those terms motivated the string of thoughts that I am trying to lay out for you now.

Let me first hasten to add that I recognize both the good work and good intentions of the GeMS clinical staff, and let me go on record as supporting early childhood gender-transitioning for those individuals who at a young age clearly express a gender identity that is not congruent with their assigned sex and social role. I was one of those children, and I know that had a door been opened for me to follow that path, I would have done so without hesitation. But let me also add that had I been given the opportunity to transition early, I know, looking back, that something else of value would have been lost – namely my perspectives on life drawn from the experience of discordance between sex, assigned social role, and gender identity. The feelings associated with such experiences are often quite painful, as many of us here today know, and thus it is difficult sometimes to see the value in them. But I do value them – not because they are painful, but because they have allowed me to see life askance, in a critical way that I know has made it possible for me to love life and its infinite variety more deeply than I think I would have known how to do otherwise. I value my transness and my gender-queerness. It is that queer sense of difference that, perhaps needlessly, I worry could be lost somehow, and that I recognize, retrospectively, as being one of the things that I most like about myself.

What startled me when I saw it in the report from the GeMS Clinic, even though I knew in theory that it would be there, was the presence – seemingly so benign, so helpful, so caring – of an institutional medical power that insinuates itself ever more intimately into the administration of our embodied lives, and which, in the name of promoting health, reducing the pain and suffering of children, and creating a desired con-

gruence between embodiment and subjectivity, minimizes or eliminates some potentially viable expressions of life while nurturing and cultivating others. It is the power that sorts, classifies, and intervenes, producing bodies in accordance with norms through the correction of deviation. It is the power we exercise when we weed the garden or cull the herd, when we choose which bodies will continue living and which ones will become fertilizer for the others. It is the power that Michel Foucault has called "the biopolitical."⁶

I think the biopolitical framework is incredibly useful for thinking about trans issues. For those of you not familiar with it, a brief, sentence-long introduction: Foucault considers power within Eurocentric modernity to be organized around two poles – one pole that pays attention to the disciplining of individual bodies, and one pole that manages populations of bodies collectively. The trick of biopolitics is to see the ways that these poles are always connected to one another in concrete, material, and specific ways: that is, how particular ways of intervening in, or operating on, the bodily life of individuals are also techniques of managing aggregate populations. The recent gender recognition controversy in Sweden is a textbook illustration of biopolitics: in it you can trace how the particular bodies of gender discordant subjects had been compelled to submit to sterilization in order to reproduce the Swedish body politic, according to nationally specific norms and procedures, and how the changes in the treatments of individuals produces new forms of citizenship and belonging at the level of the population.

Within biopolitics, questions of health are central to the management of individual bodies and collective bodies politic, and the provision of health care itself becomes a technique of biopolitical intervention. Increasingly, the body of the rights-bearing subject within Eurocentric modernity is the body that can be defined as healthy, primarily through its submission to a regime of health surveillance and maintenance, within which the individual bears the responsibility for complying with the regime, and the cost for failing to do so, as in cases where smokers or the obese are in danger of losing access to health insurance because they represent unnecessary and eliminable risks for the systems. In fram-

ing today's conference through the conjoined terms "Trans Health" and "Human Rights," it seems to me that the organizers have directly engaged with the biopolitical paradigm. How, we must ask, are health and rights to be linked in relation to trans issues? Because it is not so simple as saying, for example, that one should not have to give up one's reproductive capacity in a coercive manner, in order to be recognized as a citizen-subject of the nation. The logic of biopolitics undergirds the entire concept of transgender health, to the extent that "healthy gender" is defined in relation to norms. We have to resist the idea of access to rights and the benefits of citizenship being based on the cultivation of or adherence to norms, including gender norms, or that the only acceptable, socially-sanctioned medical interventions are the ones that produce normalcy, rather than queerness.

So should we be against health, and against rights? Perhaps. There is a way that I am against both, even as I am of course for both. To acknowledge Michel Foucault's influential formulations once again: where there is power, there is resistance; but also, whenever we say yes to life, we say yes to power. We cannot really extricate ourselves from these contradictory situations. Rather, we have to constantly be on the lookout, in an ever-shifting terrain, for emergent threats of coercion as well as new opportunities for freedom.

To paraphrase Jonathan Metzl's introductory remarks in the recent anthology *Against Health: How Health Became the New Morality* (Metzl and Kirkland 2010), there is nothing wrong with being in good health. Like him, I am neither a nihilist with a death wish, nor a science-denier: I believe in the germ theory of infectious disease and have tremendous respect for the power of antibiotics; I endorse getting vaccinated, and wearing bike and motorcycle helmets, seat belts, and sunscreen. I do, however, also believe that much of what we call "illness" is produced by disparities in income and access to health, disparities often rooted in racial discrimination, and, like Metzl, I think that merely calling for the equitable redistribution of health care resources is insufficient for addressing the problem at hand. We also have to challenge our assumptions about what constitutes health. As Metzl notes: "Health is a

desired state of being, but it is also a prescribed state and an ideological position.”(Metzl and Kirkland 2010, 2) It is an increasingly compulsory state of being that is increasingly difficult to maintain, as well as a state of being that is saturated with moral judgment. I think we have to be against any concept of health that limits it to risk avoidance behavior coupled with moral censure of people who, for whatever reason, are not in constant compliance with a regulatory regime that claims to aim to maximize the desired good called health. We have to realize that compliance is a technique, not an end in itself – and that a mind frame that idealizes compliant behavior is not necessarily healthy. Sometimes resistance is necessary, especially for queer people, who are sometimes treated like a disease in the social body. Sometimes we have to insist that what might be considered unhealthy by others is actually life-affirming and good for us. What I ultimately want to discuss is the relationship between health and norms, and to insist that an anti-normative queerness can be a very healthy thing indeed.

This brings me, at last, to one of the central words in the title of my talk today: queer. What do I mean by “queer?” What I certainly do not mean is any definition of queer that makes it essentially a five-letter synonym for gay and lesbian. Queer, for me, is something else, something bigger. It is a generationally and geographically specific term, one that took shape almost a quarter-century ago in the US, when I was younger (and thinner, and healthier than I am today) and just coming out into a larger community of sexually diverse and gender-diverse people in San Francisco. It was a term that, prior to the early 1990s, used to have very negative feelings associated with it, and which was used only in a pejorative sense. Then, around 1990, it became a word that took on positive associations, and that named a new kind of community, and that came to stand in for the potential in all of us, and all of society, to turn in unexpected directions, and thereby transform the world, in hopefully better and deeply significant ways. How that word, *queer*, gained that capacity has something to do with health, and with the history of the AIDS epidemic.

My colleague in the Gender and Women’s Studies Department at the

University of Arizona, Adam Geary, who does work on AIDS history, claims that a 1985 article in the *Gay Community News*, played a foundational role in "queer's" transformation from a negative condemnation of difference to a positive description of difference (Geary 2012). That article was Cindy Patton's "The Heterosexual AIDS Panic: A Queer Paradigm" (Patton 1985). A few reminders about the early history of AIDS, drawn from Patton's article and Geary's historicization of it. First detected in 1981, the immune-deficiency syndrome initially appeared in a handful of marginalized populations, colloquially called the 5H's: *h*omosexual men, *H*aitians, *h*emophiliacs, *h*eroin-users, and *h*ookers. By 1985, approximately 60 of the 8000 cases then reported occurred in seemingly white heterosexual individuals who could not be linked to one of the 5H populations, and this set off a panic, with increasing calls for quarantine of suspect groups and other similarly harsh measures. The "heterosexual panic" that began around 1985 was rooted in the assumption that supposedly "normal" people were somehow coming into contact with and being infected by "risk-bearing" populations. Patton's point was that many different kinds of difference – racial, sexual, geographical, genetic – were all being lumped together through the operations of homophobia, sexism, racism, classism, ableism, anti-immigrant discrimination, and so on and so forth as a conglomerate "other" juxtaposed against a putatively "normal" white heterosexuality, that had to defend itself and police its borders to ward off infection. This idea of an embattled white normality that had to erect a *cordon sanitaire* also involved the idea of policing and surveillance: the only way for infection to spread among a putatively normal population was if some members were secretly crossing the line – visiting prostitutes, shooting drugs, secretly being gay, or engaging in promiscuous bisexual behavior – behaviors that needed to be brought to light and rooted out of the general population.

Patton used what she called a "queer paradigm" to explain this particular understanding of AIDS risk and transmission:

In order to fully grasp the articulation of sexism and racism within the homophobic view of AIDS, we have to understand the existence of a "queer paradigm" which links a wide range of stereotypes about sexuality. A suspicious fascination with hidden but powerful sexuality links Haitians, Africans, prostitutes, and gay men, and makes it possible for society to believe that "normal" heterosexuals only get AIDS when they venture into that danger zone. (Patton 1985, 2)

Patton is using the word *queer* to name a mixed category of people who have little in common with one another other than how normalcy places them in the same position of difference from the norm, based on some negative stereotype: that black sexuality is more primitive or less consensual than white sexual expression, that prostitutes lack good judgment, or IV drug users lack self control. It is important to note as well that Patton does not use the word *queer* in any affirmative sense – it still means something bad to her, it is what straights call those others whom they fear and dislike.

But within a few short years, some people started calling themselves *queer*, in a defiant and contestatory way, to claim membership in the very community of different differences that Patton sought to evoke with that word. That is, some people started to say they were *queers* to name their difference from what was considered normal; if they were white to name their solidarity with anti-racism; if they were men to name their solidarity with feminism; if they were able-bodied to name their solidarity with disability activism; if they were comfortably middle-class to name their solidarity with the poor, and if they were citizens to name their solidarity with the diasporic, the migrant, the unsettled, and the undocumented. *Queer* came to name a political stance that signaled resistance to the idea of a coercive normativity, as much as it came to name a disparate community composed of those marginalized and oppressed by heterosexist norms. *Queer* simply was not normal.

The summer of 1990 witnessed an important event in the history of *queer's* affective transformation from negative to positive, with publication of "Queers Read This" (Anonymous 1990), a broadside written

anonymously by several authors who was involved with AIDS activism. Within days of its distribution at the 1990 Gay Pride march in New York, it sparked the formation of Queer Nation groups across the United States. I want to read one portion of that manifesto to remind us all today, as the conditions of agency within health management systems shift in unprecedented ways, of the continuing importance, and transformative power, of anger and resistance. As an "anonymous queer" wrote in 1990:

I'm angry. I'm angry for being condemned to death by strangers saying, "You deserve to die" and "AIDS is the cure." [...] Angry as I listen to a man tell me that after changing his will five times he's running out of people to leave things to. All of his best friends are dead. Angry when I stand in a sea of quilt panels, or go to a candlelight march or attend yet another memorial service. I will not march silently with a fucking candle and I want to take that goddamned quilt and wrap myself in it and furiously rend it and my hair and curse every god religion ever created. I refuse to accept a creation that cuts people down in the third decade of their life. It is cruel and vile and meaningless and everything I have in me rails against the absurdity and I raise my face to the clouds and a ragged laugh that sounds more demonic than joyous erupts from my throat and tears stream down my face and if this disease doesn't kill me, I may just die of frustration. [...] And I'm angry when the newspapers call us "victims" and sound alarms that "it" might soon spread to the "general population." And I want to scream "Who the fuck am I?" [...] And I'm angry at straight people who sit smugly wrapped in their self-protective coat of monogamy and heterosexuality confident that this disease has nothing to do with them because "it" only happens to "them." And the teenage boys who upon spotting my Silence=Death button begin chanting "Faggots gonna die" and I wonder, who taught them this? Enveloped in fury and fear, I remain silent while my button mocks me every step of the way. [...] What else can you expect from a faggot? I'm angry. (Anonymous 1990)

Now, this is where I come into the story. In 1990, I was a seemingly mild-mannered PhD student in history at UC Berkeley, but unknown to most of my academic colleagues, I identified as transgender, and I was angry too – not about AIDS specifically, but about the way I perceived the gatekeeping role of the psychomedical establishment, and the way I hated the necessity of taking on a pathologizing label in order to live my body in the manner that living my body felt healthy to me. I found in the concept of queerness a political mode of address for these feelings, and I became one of the founding members of a group called Transgender Nation, which grew out of the San Francisco chapter of Queer Nation. I saw in queerness a way to reframe trans issues. And now you will have to indulge me, because I have reached the age where reminiscing about things I did when I was young starts to take on the patina of history, and where nostalgia can pass for analysis, while I share an excerpt from piece called "Transgender Rage Against the Psychiatric Establishment," which I delivered at a protest at the annual meeting of the American Psychiatric Association in 1993:

We of the Transgender Nation have this to say to the American Psychiatric Association: We are a gender minority suffering from medical and psychiatric colonization. You are our oppressors – you are not our helpers. We are not a disease. We are not an emotional disorder. We are not crazy. We should not be in your *Diagnostic and Statistical Manual*. We demand removal from your sick list. And we demand as well the kind of quality health care for our particular medical needs that every human being deserves as an inalienable right.

As queer people, we transsexuals and other gender minorities draw inspiration from the lesbian and gay liberation movement that emerged after the Stonewall riots. We cannot forget, however, like others sometimes do, that Stonewall began as an act of transgender solidarity when street queens came to the aid of a female-to-male cross-dresser – a "passing woman" – who was resisting arrest. We protest the transphobia we encounter in the queer community that has coopted our uprising and made it the symbol of a less radical cause. But we take heart from

the fact that homosexuality was considered a mental illness by the APA until 1973, until determined, militant, political activism succeeded in overturning the stigmatization and pathologization of many queer lives.

As radical anthropologist Gayle Rubin has noted, gay liberation merely paved the way for a broader movement: "Sexualities keep marching out of the pages of the *Diagnostic and Statistical Manual* and on to the pages of social history. At present, several other groups are trying to emulate the successes of homosexuals. Bisexuals, sadomasochists, individuals who prefer cross-generational encounters, transsexuals, and transvestites are all in various states of community formation and identity acquisition." And, I would add, we are in various stages of revolt. As transgender activists, we believe, in the words of our stone butch comrade Leslie Feinberg, that transgender liberation is a movement whose time has come. (Stryker 1993)

I know that the debate over transgender pathologization/inclusion in the DSM and the *International Classification of Diseases* (ICD) has moved along in interesting ways since then, with many good arguments being advanced for why remaining in the ICD in particular might be a good idea, in terms of access to health care for the those segments of the transgender population least able to access care otherwise. I would no longer suggest the depathologization of homosexuality as the best analogy for how trans people should engage with the medical establishment. I think a far better model is a feminist framework drawn from the reproductive rights movement: like people seeking abortions, transgender people need services for a nonpathological condition, which is often stigmatized by others, which not every body needs, and for which the goal is competent, safe, and legal care rather than no care or dangerous care. But I still want to insist that it is not wrong to be angry about stigmatization, or about being excluded from rationality, and that it can in fact be quite healthy to turn, affectively and politically, away from the idea that our hopes and dreams are best fulfilled by proper medical treatment – however much we want that – and to turn toward other conversations, essentially political conversations about the cultivation of difference.

This, for me, is what transgender studies within the academy have always been about: creating a different kind of conversation about transgender issues, one that exceeds and reframes medicalization.⁷ The rise of transgender studies within the academy is directly linked to the queer moment of the early 1990s. To assert the emergence of transgender studies as a field only in the 1990s rests on a set of assumptions that permit a differentiation between one kind of work on "transgender phenomena" and another, for there had of course been a great deal of academic, scholarly, and scientific work on various forms of gender variance long before the 1990s. What changed in the early 1990s was the relatively sudden appearance of new possibilities for thinking about, talking about, encountering, and living transgender bodies and lives. These changes derived in part from new political alliances forged during the AIDS crisis, which brought sexual and gender identity politics into a different sort of engagement with the biomedical and pharmaceutical establishments. They emerged as well from shifting generational perspectives on gender, identity, embodiment, and social roles as the first post-baby-boomers came into adulthood; from new strategies for managing bodies and populations within the neoliberal world order that became hegemonic in the aftermath of the Soviet collapse; from the increasingly broad dissemination of poststructuralist and performative theories of subjectivity and embodiment within academe, which allowed a different kind of sense to be made of transgender phenomena; from new forms of media and communication that fostered new social and communal forms; and from *fin-de-mille* futurist fantasies of technologically enhanced life in the impending 21st century.

The convergent effect of such contingencies was that self-identified trans people found new ways to enter into conversation with others about the objective and subjective conditions of gendered embodiment, rather than remaining mere objects of knowledge in the discourses of others about them, or continuing to speak in constrained autobiographical modes that, for the most part, narrated diagnostic categories from first-person perspectives. Psychopathology, in other words, was no longer the dominant mode of trans coherence and intelligibility.

It is interesting for me to look back and re-examine some of my early work in transgender studies from the perspective of health and rights. I have never trusted much in rights – for example, racial minorities have been granted civil rights in the United States since the 1960s, but there is still discrimination based on racist attitudes. While winning rights for trans people is undoubtedly necessary, changing feelings and perceptions is equally important. This, more than legal activism, has been the focus of my own work. And I have felt particularly drawn to working on the most difficult kinds of feelings – the abject ones rooted in the attribution of monstrosity and unnaturalness to people like me, and their queer transformation into new sources of power and insight. Maybe that is why I feel especially wary of any notion of health or health care that would erase, or not value, the dark power of queer difference and incongruence.

I want to share another passage from something I wrote back in 1993, when I was involved with Transgender Nation, which came directly out of that group's politics. "My Words to Victor Frankenstein Above the Village of Chamounix: Performing Transgender Rage" (Stryker 1994), used a reading of the moment in Mary Shelley's celebrated novel, in which the monster first speaks back to its maker, to launch a similar first-person monologue on the relationship between transsexuality and medical science:

The transsexual body is an unnatural body. It is the product of medical science. It is a technological construction. It is flesh torn apart and sewn together again in a shape other than that in which it was born. In these circumstances, I find a deep affinity between myself as a transsexual woman and the monster in Mary Shelley's *Frankenstein*. Like the monster, I am too often perceived as less than fully human due to the means of my embodiment. [...] The affront you humans take at being called a "creature" results from the threat the term poses to your status as "lords of creation," beings elevated above mere material existence. As in the case of being called "it," being called a "creature" suggests the lack or loss of a superior personhood. I find no shame, however, in acknowledging

my egalitarian relationship with non-human material Being; everything emerges from the same matrix of possibilities. "Monster" is derived from the Latin noun *monstrum*, "divine portent," itself formed on the root of the verb *monere*, "to warn." It came to refer to living things of anomalous shape or structure, or to fabulous creatures like the sphinx who were composed of strikingly incongruous parts, because the ancients considered the appearance of such beings to be a sign of some impending supernatural event. Monsters, like angels, functioned as messengers and heralds of the extraordinary. They served to announce impending revelation, saying, in effect, "Pay attention; something of profound importance is happening."

Hearken unto me, fellow creatures. I who have dwelt in a form unmatched with my desire, I whose flesh has become an assemblage of incongruous anatomical parts, I who achieve the similitude of a natural body only through an unnatural process, I offer you this warning: the Nature you bedevil me with is a lie. Do not trust it to protect you from what I represent, for it is a fabrication that cloaks the groundlessness of the privilege you seek to maintain for yourself at my expense. You are as constructed as me; the same anarchic Womb has birthed us both. I call upon you to investigate your nature as I have been compelled to confront mine. I challenge you to risk abjection and flourish as well as have I. Heed my words, and you may well discover the seams and sutures in yourself. (Stryker 1994)

I would like to conclude by suggesting that a queer view of health can be found in that early piece of work: *queerness* can be thought of as the disruptive potential for the emergence of new and different modes of life, and *health* can be thought of as a practice that cultivates and expands the opportunities for that lush exuberance of possible becomings to take root and thrive. This is also what I would call an environmental or ecological view of health: one that prioritizes the maintenance, restoration, or creation of contexts in which life in all its urgent queer variety can push forth. Queer health is more a wilderness than a garden.

But what about rights? Just as I am not necessarily against health, I

am not necessarily against rights. We need to improve the life-chances of the gender-different by any means necessary, and seeking rights is one powerful way of doing this (see Spade 2011). But I want to end with the thought that rights are a means, not an end in themselves. The clear articulation of a right is like a tuning fork, a mechanism that allows many voices to begin to vibrate together on the same frequency. But it is not the song, and it is not the dance. Rights have to be articulated in the context of movements, and in the vigorous exercise of free and unconventional speech and other forms of creative self-expression. As we all work to create a world in which trans people have more opportunities to thrive, we should keep in mind that a queer notion of trans health teaches us that health *per se* should not be conflated or confused with the regulation of health. We always have to keep in mind the matter of whose "whose body" we are talking about, and whose health, according to what norms and standards, and for what ends. Is my body for me to live, or is it the property of the state? Whose right is it to decide how this body best should live? I say it is my body, and my right to decide. And sometimes, I am just not normal. There is a strong desire for normalcy in large parts of this community, and that is understandable – we have been outcasts. I think there is no problem with wanting to be valued and accepted by neighbors, colleagues, friends, and family. But I think there is a problem with normal. And there is a problem with predicating the value of your life and way of being in the world on whether or not you adhere to a norm. Transgender is queer. Queer is not normal. Normality is not health. Queer health is not normal, and trans health is queer.

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NOTES

1. Originally delivered as the keynote address at the conference "Trans Rights as Human Rights: The Implications for Trans Health (Care)", Linköping University, May 8, 2012.
2. *Transgender Studies and Theories: Building up the Field in a Nordic Context*, November 18-20, 2009, Department of Gender Studies, Linköping University, Sweden. Selected proceedings subsequently published in *Graduate Journal of Social Science* (2010).
3. *(Re)Figuring Sex: Somatechnical (Re)Visions*, November 20-21, 2009, Sydney Me-

chanics School of Arts. See Pugliese and Stryker (2009), and Sullivan and Murray (2009), for extended discussions of the history, definitions, and varied uses of somatechnics. See also the journal *Somatechnics*, which Edinburgh University Press began publishing in 2011.

4. *Somatechnical Figurations: Kinship, Bodies, Affects: An International Symposium* at Södertörn University April 12–14, 2012, organized by Ulrika Dahl and Jenny Sundén. See also the special issue of *Somatechnics* (2013).
5. *The Missing Links: The Somatechnics of Decolonization* conference took place June 17–19, 2013, Linköping University, Sweden.
6. See the following works by Michel Foucault, some available in several editions, with translations in various languages published in various years: *History of Sexuality, Volume 1; Society Must Be Defended; Security, Territory, Population; The Government of Self and Others*.
7. The following few paragraphs are forthcoming in Susan Stryker and Aren Aizura, "Introduction: Transgender Studies 2.0" (Stryker and Aizura 2013).

SAMMANFATTNING

Denna artikel, ursprungligen presenterad som ett av inledningsanförändena på konferensen *Trans Rights as Human Rights* på Linköpings universitet 2012, analyserar relationen mellan rättighetsdiskurser och hälsodiskurser i förhållande till transpersoner. Författaren berör en rad olika frågor (transidentifierade barn, aidsepidemin) och granskar en rad olika metodologier (queerteori, vetenskaps- och teknikstudier, posthumanistiskt tänkande) för att kontextualisera sitt argument att vi måste betrakta hälsa inte bara som en form av delaktighet i biopolitiska regimer för hälsohantering, utan också mer som ett föreställande av vildhet, av oväntade tillblivelsesätt.