

Gender and disability, along with race, class, nationality, and sexuality, are constitutive features of the ways in which our fully integrated selves—what Margaret Price (2011) calls “bodyminds”—are lived and known. Gender has emerged as a key site of disability critique in four general areas: (1) sex, impairment, and the “realness” of the body; (2) the medicalization of gender; (3) the mutually reinforcing structures of gender and disability oppression; and (4) the reconfiguration of gender through disability experience. Thus, if disability theorists hope to understand and critique norms of bodily appearance and bodymind functioning, as well as offer meaningful alternative conceptions of the world and being, they must attend to how gender structures and is structured by those norms. Similarly, feminist and queer theorists cannot develop adequate accounts of gender without attending to the entanglement of the meaning and materialization of gender and disability.

Just as disability theorists have distinguished between impairment and disability, feminist theorists have distinguished between sex and gender. Sex refers to the chromosomal, anatomical, and physiological characteristics that mark the body as male, female, or intersex. Gender, by contrast, refers to socially, culturally, and historically contingent norms of appearance, bodily comportment, behavior, and desire that define what it means to be masculine, and thus a man, and feminine, and thus a woman. In this picture, those who queer gender norms, such as butches, femmes,

trans-identified people, and other gender-transgressive people, fall along a gender continuum. Feminist and disability theorists have worked diligently to show how gender and disability are socially and culturally produced in order to combat the naturalization and regulation of “woman,” nonnormative gender, and disability. In oppressive contexts, naturalized conceptions of gender and disability operate to rationalize and normalize injustice against women, gender-transgressive people, and disabled people.

One consequence of sex-gender and impairment-disability distinctions is the relegation of sex and impairment to the body. Some feminist and disability theorists are concerned about the extent to which those distinctions lead to a devaluation of the material body, in particular purportedly real physical dimensions of gender and disability (Alaimo and Hekman 2008; Siebers 2008a, 2008b). In defense of a “materialist turn” in feminism, Stacy Alaimo and Susan Hekman contend that focusing on ideology or representation alone neglects attention to, among other things, bodily pain and diseases that affect women’s “real” bodies (2008, 3–4, 6). For them, understanding the body and nature as produced by interactions between the material and the discursive (7) enables a more constructive critical attention to bodily conditions, like pregnancy, that must be acknowledged as sex-linked to a certain extent in order to understand them and provide access to the best care possible. This recent feminist turn to “the material” has a corollary in some disability discussions about pain and impairment. For example, Tobin Siebers argues for a realism about the disabled body that attends to the body’s agency and the “real” embodied lives of disabled people (2008b, 67–68).

Other feminist, queer, and disability theorists question the assumption that sex and impairment are mere facts of bodily materiality (Hall 2005, 2009; Kafer 2013;

Salamon 2010). As Gayle Salamon (2010) and Alison Kafer (2013) point out, it is difficult, if not impossible, to know what impairment and sex mean or how they are inhabited independent of the social and cultural context in which bodies are lived and assigned meaning. In addition, assuming the facticity of sex naturalizes binary understandings of sex and gender, which is often made possible by ignoring the lived bodily experience of gender-transgressive people (Salamon 2010; Spade, "About Purportedly Gendered Body Parts"). Among other negative consequences, naturalizing binary sex and gender often results in pathologizing gender-transgressive people and inhibits their access to health care.

Feminist theorists have rigorously critiqued the heteronormative gender bias that informs the medicalization of gender (Fausto-Sterling 2000; Butler and Weed 2011). As Fausto-Sterling (2000, 3) argues, the medical model relies on a flawed view of nature, and biomedical knowledge about sex difference reveals much more about dominant gender beliefs than about nature. The medical model conceptualizes disability, transgender, and intersex as problems in need of cure/elimination. In the case of intersex, "cure" involves surgical creation of binary sex; in the case of transgender, "cure" has involved sex reassignment surgery to fix gender identity disorder (GID). While trans people who desire sex reassignment surgery and hormone replacement therapy may not perceive these procedures as a cure for "misaligned" sex and gender, they have been forced to submit to a GID diagnosis in order to receive permission to access the medical services they need to exercise gender autonomy. The most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, published in 2013, replaced GID with a new category, gender dysphoria (Beredjick 2012). The effects of this new diagnosis for gender-transgressive people remain to be

seen. While many trans activists welcome the end of characterizing gender transgression as a disorder, they also wonder about the implications for legal advocacy because of the strategic use of the GID diagnosis in fighting discrimination against trans people (Beredjick 2012). Still, the introduction of gender dysphoria into the *DSM-5* does not signal an end to the medical regulation of gender.

In recognition of some degree of overlap between trans and disability experience, one can consider the successful, but fraught, use of state disability statutes in legal advocacy for trans rights. Like disability advocates, trans advocates can and have used state disability discrimination laws to locate the problems of exclusion and discrimination in the built and conceptual environment rather than in the bodies of trans people (Spade 2003, 32–33). Both disabled and trans people are stigmatized, a problem that can be addressed by changing dominant beliefs, attitudes, and environments, not by "curing"/eliminating nonnormative bodyminds.

Identifying the mutually reinforcing structures of gender and disability oppression involves understanding how other axes of identity, such as race, class, and sexuality, inform gender and disability. Spade's use of the Americans with Disabilities Act in legal advocacy for trans rights is often on behalf of poor people and people of color who have no health insurance and are most vulnerable to regulation of myriad state institutions such as prisons and foster care systems. Eugenics and "eugenic logic" (Garland-Thomson 2012) are also sites where gender, race, class, and sexuality oppression converge to the detriment of nonnormative bodyminds. Susan Burch and Hannah Joyner (2007) describe the life of Junius Wilson, an African American deaf man born in North Carolina in 1908 and imprisoned in 1925 in the then-named State Hospital for the Colored Insane, where he was sterilized and castrated. Burch and Joyner



explain how white racist mythologies of the black male rapist, along with Wilson's inability to communicate with others because of his deafness (and because others could not comprehend his Raleigh signing), were used by white state authorities to diagnose Wilson as a sexual pervert and prescribe sterilization and castration as a cure (2007, 47). Had Wilson been white, his experience would have been different. Historically, beliefs about gender have informed definitions of and treatments for mental disability. Thus, racialized, classed, and heteronormative gender regulation has been an important function of the diagnosis of mental disability (Carlson 2001, 2010; Price 2011).

In addition to making visible and analyzing the interrelatedness of gender, race, class, disability, sexuality, and other axes of identity, feminist queer disability theorists understand how disability experience can be a site for critical reconfigurations of gender. While some disability theorists argue for recognition of disabled people as "real men" and "real women," others have used disability as a critical resource through which to reimagine gender beyond heteronormative and able-bodied binaries. Embodying "normate" (Garland-Thomson 2011) gender, for example, requires having a body whose appearance and capacity are in conformity with dominant gender norms (Garland-Thomson 2011; James 2011; Mintz 2011; Serlin 2003). Naomi Finkelstein (2003, 311) describes feeling "emasculated" by fibromyalgia-rheumatoid arthritis while also understanding it as an experience that enables reconfiguring what it means to be butch. Being a "crip butch" reconfigures masculinity as openness to vulnerability and simultaneously exposes cracks in narrow gender norms (317). Similarly, Eli Clare (1999) writes about the complex process of trying to reclaim one's gendered disabled body, a process that involves negotiating categories like "woman" and "tomboy" that don't quite fit, as well as urban markers

of gender that leave no room for white, working-class, rural gender-transgressive experience.

While feminist insights about gender have been useful for disability theorists, disability studies, especially in its feminist, queer, and crip incarnations, promises to transform understandings of gender. Indeed, in its critique of heteronormative gender, feminist and queer disability studies crips gender (Sandahl 2003; McKuer 2006), creating an opening for the emergence of another world and more capacious, democratic ways of being in it.