

BENDING GENDER:

Disability Justice, Abolitionist Queer Theory, and ADA Claims For Gender Dysphoria

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The trans rights movement is engaged in an internal debate over whether trans people diagnosed with gender dysphoria should bring claims under the Americans with Disabilities Act (ADA). Some have argued the ADA is a good vehicle for those with gender dysphoria to access medical needs, while others contend that because gender identity should not be pathologized and the state should not be the arbiter for who can access care, trans plaintiffs should not raise ADA claims.

This Essay defends the ADA as a viable path for trans plaintiffs in prison to seek accommodations based on gender dysphoria, applying a critical autoethnographic lens. First, it presents survey data of the views of trans people incarcerated in Massachusetts on bringing ADA claims for gender dysphoria. Second, it summarizes the history of gender dysphoria in the Diagnostic and Statistical Manual (DSM) and its recent legal interpretation under the ADA. Third, applying the lenses of queer and Crip theory, the Essay argues that trans people should raise ADA claims as necessary to fulfill their medical needs under our current regime as striving toward a Disability Justice future. Finally, it considers counterarguments raised by trans movement litigators and scholars.

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INTRODUCTION

A. *Overview*

The Fourth Circuit’s recent ruling in *Williams v. Kincaid*¹ affirmed that trans² people who experience gender dysphoria (GD) are protected under the Americans with Disabilities Act³ (ADA).⁴ Trans people can now bring ADA claims based on our GD diagnoses. This prompts the question for trans litigants and their advocates: Should we?⁵ Are there any downsides to bringing

1. 45 F.4th 759 (4th Cir. 2022).

2. I use the term “trans” to capture transgender, transsexual, gender nonconforming, gender nonbinary, and other non-cisgender individuals. Cf. JULIA SERANO, WHIPPING GIRL: A TRANSEXUAL WOMAN ON SEXISM AND THE SCAPEGOATING OF FEMININITY 350–51 (2d ed. 2016) (“The word[] ‘transgender’ . . . came into vogue during [the early 1990s] as [an] umbrella term[]: . . . ‘transgender’ was used to promote a coalition of distinct groups . . . not based on a presumed shared biology or set of beliefs, but on the fact that [they] faced similar forms of discrimination.”). According to the American Psychiatric Association, “[t]ransgender refers to the broad spectrum of individuals whose gender identity is different from their birth-assigned gender.” AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 511 (5th ed., text rev. 2022) [hereinafter DSM-5-TR] (emphasis omitted).

3. Pub. L. No. 101–336, 104 Stat. 327 (codified as amended at 42 U.S.C. §§ 12101–12213 and 47 U.S.C. § 225).

4. See *Williams*, 45 F.4th at 766–74.

5. See Dean Spade, Commentary, *Resisting Medicine, Re/modeling Gender*, 18

an ADA claim on behalf of trans people with GD? How should we approach that question as trans movement lawyers?

I invoke the first person because I consider myself part of the cadre of trans rights advocates who face these questions, which pose real dilemmas as we strive to capture the nuances of gender in our work, knowing that the courts may never fully grasp our identities. Indeed, “queering” gender and sexuality would directly refuse any such capture.⁶

Nevertheless, I argue in favor of bringing ADA claims for incarcerated trans people with GD.⁷ I specify this group to narrow the scope of this Essay and because my work has focused on supporting trans people seeking gender-affirming care while incarcerated. The Essay is centered on trans people on the inside because the stakes are so high for them. “A shocking 47% of Black transgender people, and more than one in five (21%) transgender women of all ethnicities, are incarcerated during their lifetimes.”⁸ Further, centering an incarcerated trans person’s experience can and should provide important insights for the free world.⁹ And disability law is particularly relevant in the prison context, where “people with disabilities . . . face a heightened risk of violence and harassment.”¹⁰

BERKELEY WOMEN’S L.J. 15, 36 (2003) (“I think it is important that trans people be a part of conversations about how legal claims are pursued by attorneys, and that attorneys working on such claims understand themselves to be determining not just the rights of a single plaintiff, but impacting a broad set of gender transgressive people who may differ from the plaintiff in question in essential ways.”).

6. See Zaria El-Fil, *Claiming Alterity: Black, Gender, and Queer Resistance to Classification* (“[Q]ueerness is a rebellion refusing enclosure.”), in *SURVIVING THE FUTURE: ABOLITIONIST QUEER STRATEGIES* 42, 44 (Scott Branson et al. eds., 2023) [hereinafter *SURVIVING THE FUTURE*]; see also *id.* (“‘[Q]ueer’ . . . is not necessarily synonymous with ‘LGBTQIA+’ as an identity; rather, it is a zone of instability, a ‘doing for and toward the future.’ It is a refusal of the present with an aim toward futurity.” (quoting JOSÉ ESTEBAN MUÑOZ, *CRUISING UTOPIA: THE THEN AND THERE OF QUEER FUTURITY* 1 (2009))); *id.* at 45 (“[Q]ueer isn’t another identity to be placed into neat social categories but, rather, an opposition to the manageable limits of identity. It is the ‘total rejection of the regime of the Normal.’” (quoting MARY NARDINI GANG, *TOWARD THE QUEEREST INSURRECTION* 3 (2014), <https://theanarchistlibrary.org/library/mary-nardini-gang-toward-the-queerest-insurrection.pdf> [<https://perma.cc/X8SJ-KUYG>])).

7. This legal theory was first successful in an employment case; then its premise was extended to prisons’ obligations. See, e.g., Kevin Barry & Jennifer Levi, *Blatt v. Cabela’s Retail, Inc. and a New Path for Transgender Rights*, 127 YALE L.J.F. 373, 390–91 (2017).

8. SOMJEN FRAZER ET AL., *LAMBDA LEGAL & BLACK & PINK NAT’L, PROTECTED AND SERVED? 2022 COMMUNITY SURVEY OF LGBTQ+ PEOPLE AND PEOPLE LIVING WITH HIV’S EXPERIENCES WITH THE CRIMINAL LEGAL SYSTEM* 47 (2022) (citation omitted).

9. See D Dangaran, *Abolition as Lodestar: Rethinking Prison Reform from a Trans Perspective*, 44 HARV. J.L. & GENDER 161, 214 (2021) (“By centering trans people who are policed on a regular basis and who exist in and out of the prison system, and by letting them set the agenda, the LGBTQ rights movement will be able to shift toward a transformative justice model over time.” (footnote omitted)); Elizabeth M. Iglesias & Francisco Valdes, *Religion, Gender, Sexuality, Race and Class in Coalitional Theory: A Critical and Self-Critical Analysis of LatCrit Social Justice Agendas*, 19 CHICANO-LATINO L. REV. 503, 516 (1998) (“This technique of ‘looking to the bottom’ to inform anti-subordination theory makes sense because ‘the bottom’ is where subordination is most harshly inflicted and most acutely felt.”).

10. Jamelia N. Morgan, *Reflections on Representing Incarcerated People with*

B. *Doctrinal Incentive*

An ADA claim requires plaintiffs to satisfy a lower legal standard than the Eighth Amendment. Title II of the ADA requires plaintiffs to show that they were subject to discrimination “by reason of” their disability.¹¹ A claim can be premised on intentional discrimination, the failure to make a reasonable accommodation, or disparate impact.¹² Liability for failure to provide a reasonable accommodation does not require a showing of intentional discrimination.¹³ This is an easier pleading standard to meet, by far, compared to the Eighth Amendment deliberate indifference standard, which requires plaintiffs to show that prison officials knew of and disregarded an excessive risk to the health or safety of the plaintiff.¹⁴ Even when deliberate indifference is a factor for pursuing compensatory damages under the ADA, the ADA standard is easier to meet than that of the Eighth Amendment.¹⁵ Litigators therefore have strong reasons to pursue ADA claims if possible.

GD is marked by “clinically significant distress or impairment in social, occupational, or other important areas of functioning” that arises from the “marked incongruence” between a transgender person’s sex assigned at birth and their gender identity or gender expression.¹⁶ Some reasonable accommodations a person with GD might pursue include hygiene items, laser hair removal, clothing and undergarments, access to equal programs and services, separate shower time, proper pronoun and name usage, strip searches by guards of a preferred gender, and housing transfer.¹⁷ These accommodations can be life-saving for people who are misgendered and harassed daily, living in a facility segregated based on sex parts rather than gender identity.

C. *Positionality Statement / Autoethnographic Method*

I aim to foster a dialogue among abolitionist trans rights lawyers and advocates. Trans people working as lawyers on this issue have a personal stake in the claims. In light of that truth, I take an autoethnographic approach in this Essay,¹⁸ highlighting my experience engaging with the history of trans pathologization.

Disabilities: Ableism in Prison Reform Litigation, 96 DENVER L. REV. 973, 978 (2019) (footnote omitted).

11. 42 U.S.C. § 12132.

12. See, e.g., *Sosa v. Mass. Dep’t of Corr.*, 80 F.4th 15, 30–31 (1st Cir. 2023).

13. See *id.* at 31.

14. See *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

15. See *Durham v. Kelley*, 82 F.4th 217, 229 (3d Cir. 2023) (comparing the deliberate indifference standards under the Eighth Amendment and the ADA).

16. DSM-5-TR, *supra* note 2, at 513.

17. See, e.g., *Doe v. Mass. Dep’t of Corr.*, Civil Action No. 17–12255, 2018 WL 2994403, at *1, *4–8 (D. Mass. June 14, 2018) (determining plaintiff’s requested gender-affirming items were reasonable accommodations under the ADA).

18. See generally Senthurun Raj, *Legally Affective: Mapping the Emotional Grammar of LGBT Rights in Law School*, 31 FEMINIST LEGAL STUD. 191, 199–203 (2023) (providing examples of autoethnography in LGBT legal studies); Leon Anderson, *Analytic Autoethnography*, 35 J. CONTEMP. ETHNOGRAPHY 373, 383–85 (2006) (describing the impact of having a “highly visible social actor within the written text,” *id.* at 384).

The self should not be hidden away; feigning authorial neutrality does a disservice to the addition of my lived experience to a rigorous analysis of these issues.

I have written about the importance of social location before.¹⁹ Here, I acknowledge that while I am trans, I have not been diagnosed with GD, nor have I sought forms of care that would require such a diagnosis. I do experience dysphoria regarding my facial hair, leg hair, chest, and sex parts. Similarly, up to this point in my life I have not identified as a person with a disability, though I have felt comfortable saying that I'm neurodivergent, having been told by my therapist (a social worker) that she believes some diagnoses that might match my experiences include anxiety, post-traumatic stress disorder (PTSD), and mild attention-deficit/hyperactivity disorder (ADHD).²⁰

I think it is morally incumbent upon lawyers to contend with our positionality. Like it or not, we lawyers pose a risk to the rest of the trans community: we may participate in the boundary setting of trans people's rights just as much as the courts and medical professionals do. By playing with "the master's tools," though we do not seek to uphold cissexism or ableism, we might inadvertently lose sight of the larger vision: "[T]o bring about genuine change."²¹

D. *Summary of Argument*

This Essay covers a lot of ground, contributing in two main ways to a discussion that has taken place for over thirty years.

In Part I, I present the results of a survey conducted by Black and Pink Massachusetts, a grassroots organization that supports incarcerated LGBTQ people.²² Thirty-seven trans, transgender, nonbinary, genderqueer, or intersex people in Massachusetts prisons responded to three questions regarding ADA claims for trans people with GD.²³ The results inform Massachusetts lawyers and advocates of the preferences of the local incarcerated trans community and provide insights for those in other jurisdictions, as well.

Part II summarizes the history of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and provides an autoethnographic reflection on my experience reading the DSM. I detail the legislative history that led to the

19. See Danganan, *supra* note 9, at 167–68.

20. See *Neurodivergent*, CLEVELAND CLINIC (June 2, 2022), <https://my.clevelandclinic.org/health/symptoms/23154-neurodivergent> [<https://perma.cc/CG8T-U69D>]. But cf. Katie Eyer, *Claiming Disability*, 101 B.U. L. REV. 547, 551–54, 564–68 (2021) (troubling the common act of refusing to self-identify as disabled despite having conditions that would qualify one as disabled).

21. AUDRE LORDE, *The Master's Tools Will Never Dismantle the Master's House*, in *SISTER OUTSIDER: ESSAYS AND SPEECHES* 110, 112 (Crossing Press rev. ed. 2007) (1984).

22. See *infra* Part I.

23. The questions were: (1) Under the ADA, a disability is "a physical or mental impairment that substantially limits one or more major life activities." Do you consider gender dysphoria to be a disability? (2) Do you think there is any stigma attached to gender dysphoria when it is considered a disability? (3) If you needed to and had the option, would you bring a disability legal claim for your gender dysphoria? Survey Questions, Black & Pink Mass. [hereinafter Survey Questions] (quoting Americans with Disabilities Act, 42 U.S.C. § 12102(1)(A)) (on file with the Harvard Law School Library).

exclusion of gender identity disorders from the ADA's protection.²⁴ Finally, I provide the legal basis for the ADA to cover GD.

In Part III, I make a normative argument that a Disability Justice framework could embrace trans people with GD as disabled in a way that would benefit all of society.²⁵ And in Part IV, I contend with counterarguments raised by prison litigator A.D. Lewis during a panel discussion on this issue.²⁶ Scholars have explored the normative pros and cons of bringing the claim, after establishing its legal viability.²⁷ This Essay contributes to that discussion using abolitionist queer theory,²⁸ Crip theory,²⁹ and the instructive approaches of movement lawyering.³⁰

I. SURVEYING THE INCARCERATED TRANS COMMUNITY

In December 2022, Black and Pink Massachusetts and Rights Behind Bars jointly administered via mail a survey to 176 inside members of Black and Pink Massachusetts.³¹ Thirty-seven respondents identified as trans, transgender, nonbinary, genderqueer, or intersex.³² The group of thirty-seven was asked to answer a set of questions specific to them.³³ I included three open-ended questions regarding the ADA to inform our movement's legal strategy.³⁴ These

24. See *infra* Part II, pp. 247–58.

25. See *infra* Part III, pp. 258–62.

26. See *infra* Part IV, pp. 262–70.

27. See, e.g., Ali Szemanski, *When Trans Rights Are Disability Rights: The Promises and Perils of Seeking Gender Dysphoria Coverage Under the Americans with Disabilities Act*, 43 HARV. J.L. & GENDER 137, 159–68 (2020); Namrata Verghese, *The Promise of Disability Rights Protections for Trans Prisoners*, 21 DUKEMINIER AWARDS J. SEXUAL ORIENTATION & GENDER IDENTITY L. 291, 315–39 (2022); cf. Kevin M. Barry, *Disabilityqueer: Federal Disability Rights Protection for Transgender People*, 16 YALE HUM. RTS. & DEV. L.J. 1, 35–49 (2013).

28. I use the term “abolitionist queer theory” to juxtapose the history of “abolition” with that of “queer,” as have other writers before me. Cf. ANGELA Y. DAVIS ET AL., *ABOLITION. FEMINISM. NOW.* 2 (2022).

29. “[C]rip theory is more contestatory than disability studies, more willing to explore the potential risks and exclusions of identity politics while simultaneously and ‘perhaps paradoxically’ recognizing ‘the generative role identity has played in the disability rights movement.’” ALISON KAHER, *FEMINIST, QUEER, CRIP* 15 (2013) (quoting ROBERT MCRUER, *CRIP THEORY: CULTURAL SIGNS OF QUEERNESS AND DISABILITY* 35 (2006)) (citing Carrie Sandahl, *Queering the Crip or Crippling the Queer: Intersections of Queer and Crip Identities in Solo Autobiographical Performance*, 9 GLQ: J. LESBIAN & GAY STUD. 25, 53 n.1 (2003)).

30. I use the terms “abolition,” “queer,” “Crip,” and “movement lawyering” as “words to help forge a politics.” See KAHER, *SUPRA* note 29, at 15 (quoting ELI CLARE, *EXILE AND PRIDE: DISABILITY, QUEERNESS, AND LIBERATION* 70 (1999)).

31. See Survey Questions, *supra* note 23.

32. See Survey Results, Black & Pink Mass. [hereinafter Survey Results] (on file with the Harvard Law School Library).

33. See Survey Questions, *supra* note 23.

34. *Id.*; see Jules Lobel, *Participatory Litigation: A New Framework for Impact Lawyering*, 74 STAN. L. REV. 87, 121–22 (2022) (discussing the significance of allowing plaintiffs in a class action to join in deciding on claims); see also Gabriel Arkles et al., *The Role of Lawyers in Trans Liberation: Building a Transformative Movement for Social Change*, 8 SEATTLE J. SOC. JUST. 579, 611–19 (2010) (articulating a vision for the role lawyers

questions are represented in the table below. Black and Pink Massachusetts volunteers coded the responses into “yes,” “no,” and “other.” I have also represented in Table 2 a subgroup of twenty respondents who had been diagnosed with GD.

Table 1: Survey Results for All Trans and Intersex Respondents (n=37)

Question	Yes	No	Other	No Reply
Q1. Under the ADA, a disability is “a physical or mental impairment that substantially limits one or more major life activities.” Do you consider gender dysphoria to be a disability?	21	4	6	6
Q2. Do you think there is any stigma attached to gender dysphoria when it is considered a disability?	21	3	6	7
Q3. If you needed to and had the option, would you bring a disability legal claim for your gender dysphoria?	26	1	3	7

Table 2: Survey Results for Respondents Diagnosed with GD (n=20)

Question	Yes	No	Other	No Reply
Q1. Under the ADA, a disability is “a physical or mental impairment that substantially limits one or more major life activities.” Do you consider gender dysphoria to be a disability?	13	3	3	1
Q2. Do you think there is any stigma attached to gender dysphoria when it is considered a disability?	15	3	2	0
Q3. If you needed to and had the option, would you bring a disability legal claim for your gender dysphoria?	17	1	2	0

The key takeaway from this survey is that many incarcerated trans people are ready to move forward with ADA claims. Advocates therefore need to seriously engage with the claims.

A. *Do You Consider Gender Dysphoria to Be a Disability?*

In response to this question, 57% of the trans and intersex respondents, 68% of those trans and intersex respondents who answered this question, and 65% of respondents with GD diagnoses answered yes³⁵:

“We live in a constant distress with our own identity and our born sex.”
“Gender dysphoria affects you mentally and the way you see and identify yourself. It affects your mood on a daily basis. It is a serious condition that must be treated.”
“Yes, [GD] is a disability. It put me at a disadvantage with other people.”
“[GD] limits what a person can do physically in a society that is still very trans[phobic] and homophobic as well as the impact that takes place mentally and emotionally because until a gender dysphoric person[‘]s body

might play in movements).

35. See Survey Results, *supra* note 32.

physically matches what their brain is telling the[m] it should be[,] distress and turmoil will be a constant in that person[']s life.”

“Yes! [B]ecause [I] can’t get gender affirming bottom surgery while in here. I can’t get make up [or] earring[s, or] dress as I could on the streets. I don’t feel comfortable in my skin/body.”

“[B]ased on societ[y’s] long denial of acceptance [of trans people], the psychological effect of coming out or exposure, harassment, and embarrassment prevents us from expression (first and foremost), which is a life function. Without it, we become depressed or in my case severely anxious causing us to not be able to function at work/school or publicly. Even causes other issues such as high blood pressure, migraines, and other physical medical problems.”³⁶

In short, these responses show that trans people are experts on their own experiences and that they can tie GD to various impairments to their lives on the inside.

B. *Do You Think There Is Any Stigma Attached to Gender Dysphoria When It Is Considered a Disability?*³⁷

In response to this question, 57% of trans and intersex respondents, 70% of those trans and intersex people who answered the question, and 75% of respondents with GD answered yes.³⁸

Some responses focused on the additional stigma that might come from GD being classified as a disability:

“I believe it is like any other disability and there will always be a stigma attached because people [will] either covet or ridicule what they don’t live with or understand.”

“Yes, most clinicians and providers mostly agree gender dysphoria is not a disability.”³⁹

“Yes. It was hard for me to get diagnosed by a [Bureau of Prisons] psychologist and I had to ask to be evaluated multiple times.”

“Certainly, as many people have said to me, ‘isn’t dysphoria mean you[’re] crazy’ or ‘don’t people with dysphoria cut off their balls’ and other similar statements. They do not realize those are a few of the actions of some people, with or without dysphoria, and that the dysphoria is the emotional or mental state of discomfort caused from lack of social acceptance or expectations.”

36. *Id.*

37. Many respondents opined on the stigma that GD itself carries. *See id.* Qualitative interviews would be helpful for future research so that the interviewer could differentiate stigma caused by GD, stigma caused by being trans, and the additional stigma that being labeled a person with a disability might bring.

38. *See* Survey Results, *supra* note 32.

39. This respondent indicated that they *did* believe that GD is a disability (yes to question 1) and that they would want to bring an ADA claim if given the opportunity (yes to question 3). *Id.*

“Yes, people think you’re crazy and need med instead of just being who you are.”⁴⁰

Other responses discussed the stigma that the respondents faced for being trans or for having a GD diagnosis:

”I believe people attack trans men + females for just being them so it is a disability.”

“Yes! [S]ociety claims this is a choice to be a girl/woman/female the stigma is that there is something wrong with us. [F]eeling wrong in our body when we were clearly born in male or female bodies.”

“Other people think that we are different or lower than the ‘norm.’ A lot of people refuse to accept me as transgender because I was born in a male body. That it is against ‘God’s Will’ to change my body to how I see/feel it is supposed to be.”

“[Y]es I feel most people see GD as a lifestyle choice. It’s not. It is a deep rooted issue that can tear an individual apart from the inside. It took me 37 years to be able to look in a mirror and start feeling good about who I am.”

“I think people do not know what a trans person goes through in a given day and yes, there is stigma attached to gender dysphoria. I have been told that if [I] am transgender I am more likely to be looked at for civil commitment because it is a mental abnormality.”

“Staff is under the[] impression that those with gender dysphoria is a game played just to get the benefits of items regular inmates are not entitled to.”

“I believe there’s a stigma in any gender dysphoria but [the Massachusetts Department of Corrections] doesn’t see it for us.”⁴¹

Someone who responded “no” provided an elaborate response:

”No I don’t believe it to be a stigma because a person doesn’t choose to be trans or [gender nonconforming] and because it[‘]s something people can[‘]t control[.] [S]o if there is a stigma it[‘]s on the person who feels it is to sort out their issues and figure out why they feel that way[.]”⁴²

In a quip that perfectly captures the normative conundrum one respondent said simply:

“Depends on your definition of ‘stigma.’”⁴³

“[P]risons routinely violate the rights of people with disabilities,”⁴⁴ so these respondents could be familiar with the harmful effects of that stigma. Of the thirty-seven trans respondents, twenty-eight indicated that they had a disability, and only one listed GD as that disability.⁴⁵ Thus, twenty-seven of the thirty-seven respondents had other disabilities.⁴⁶

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

44. Morgan, *supra* note 10, at 978.

45. See Survey Results, *supra* note 32.

46. See *id.*

C. *If You Needed to and Had the Option, Would You Bring a Disability Legal Claim for Your Gender Dysphoria?*

In response to this question, 70% of trans and intersex respondents, 87% of those trans and intersex people who answered the question, and 85% of respondents with GD answered yes.⁴⁷

The written responses were quite enthusiastic. One person noted that they had filed such a claim on their own, and that it was pending.⁴⁸ Others stated how an ADA claim would help their circumstances:

”Yes! I would because we are denied access to products that other females [in] prisons are allowed and we are residents under [MA] law not prisoners being incar[cerated] not being able to live fully female is severe mental torture for me.”

“Yes, the Department of Correction[s] does not help us, and a lot of the other inmates make fun of us or do not want us in the given cell block, and [the Department of Corrections] doesn’t look out for us if we can not live in a given cell block because inmates do not want us there.”

“People with gender dysphoria especially in prison are misdiagnosed and purposefully delayed in treatment, education, and health care. It takes transgender people 3 times longer to get medical needs met and even harder to be treated as a human.”⁴⁹

This type of stigma on people with GD is critical for litigators to consider, whether working in the prison context or not. Trans people’s health needs do not start and stop with gender-affirming care; though accessing such care is often hindered, trans people also face health disparities in many other ways, as well.⁵⁰

Overall, respondents are being neglected, and they are ready to bring legal action—including ADA claims—to get the care they need. This type of survey can and should be replicated in other jurisdictions. A movement-lawyering approach should seek more input than that of a single client; by including legal strategy questions in surveys like the Lambda Legal Inside Report 2022 (which did not include any such questions),⁵¹ movement lawyers can get a sense of the community’s perspective on legal strategy.

47. *See id.*

48. *See id.*

49. *Id.*

50. For instance, in the 2015 U.S. Trans Survey, “[22%] of respondents rated their health as ‘fair’ or ‘poor,’ compared with 18% of the U.S. population,” and “[39%] of respondents were currently experiencing serious psychological distress, nearly eight times the rate in the U.S. population (5%).” SANDY E. JAMES ET AL., NAT’L CTR. FOR TRANSGENDER EQUAL., *THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY* 103 (2016).

51. *See generally* FRAZER ET AL., *supra* note 8.

II. THE EVOLVING UNDERSTANDING OF GENDER DYSPHORIA

I feel that not properly treating [GD] is a form of medical malpractice. A person should not have to prove to anyone who they are. I understand that medical/mental health professionals need to be sure about a patient but I fought to prove myself for over 8 years.

—Anonymous Survey Respondent⁵²

This Part summarizes the history of the gender-related disorders in the DSM, then provides a brief autoethnographic note of my experience of reading the DSM. The American Psychiatric Association (APA) issues the DSM, a handbook used as the authoritative guide for the clinical diagnosis of mental disorders.⁵³ This Part then provides a brief history of the ADA and a summary of the legal interpretation of the ADA's coverage of GD.

Congress passed the ADA as “a comprehensive civil rights law that prohibits discrimination based on disability in a range of areas,”⁵⁴ including prisons.⁵⁵ Congress excluded gender identity disorders from the ADA's coverage when it passed the ADA in 1990.⁵⁶ We must understand the gatekeepers' terms in the cissexist, heteropatriarchal, and ableist society in which we are living if we are to survive and move toward thriving in a better world.

A. *The Pathologization of Trans Identities*

When the ADA was passed in 1990, it incorporated definitions of various gender identity disorders that were established in the 1987 version of the DSM.⁵⁷ This section traces how those DSM definitions have changed in meaningful ways for the ADA claim for GD.

1. *DSM-III-R*.—Western psychiatry has evolved its understandings of trans identities over time.⁵⁸ Though congresspeople may have been influenced by archaic conceptions of trans people, the ADA was written with reference to a particular set of definitions. In 1987, the APA issued the DSM-III-R,⁵⁹ which categorized a few diagnoses under the subclass “gender identity disorders,” including “Gender Identity Disorder of Childhood,”⁶⁰ “Transsexualism,”

52. See Survey Results, *supra* note 32.

53. See DSM-5-TR, *supra* note 2, at xxiii.

54. Barry, *supra* note 27, at 7.

55. Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206, 209 (1998) (“[T]he ADA plainly covers state institutions *without* any exception that could cast the coverage of prisons into doubt.”).

56. Barry, *supra* note 27, at 9.

57. *Id.* at 11.

58. “‘Transsexual’ was not coined until 1949, ‘transgender’ not until 1971, and ‘trans’ . . . not until 1996.” Stephen Whittle, *A Brief History of Transgender Issues*, THE GUARDIAN (June 2, 2010, 6:49 AM), <https://www.theguardian.com/lifeandstyle/2010/jun/02/brief-history-transgender-issues> [<https://perma.cc/E22P-H8ZM>]. For a discussion of the earlier psychological conception of “gender inversion,” see ANNA LVOVSKY, VICE PATROL: COPS, COURTS, AND THE STRUGGLE OVER URBAN GAY LIFE BEFORE STONEWALL 68–71 (2021).

59. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed., rev. 1987) [hereinafter DSM-III-R].

60. Childhood GD and adult GD necessitate separate conversations. See Kari E.

“Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT), and “Gender Identity Disorder Not Otherwise Specified”⁶¹:

The essential feature of the disorders included in this subclass is an incongruence between assigned sex (i.e., the sex that is recorded on the birth certificate) and gender identity. Gender identity is the sense of knowing to which sex one belongs, that is, the awareness that “I am a male,” or “I am a female.”⁶²

This definition of “gender identity” reinforced the gender binary.⁶³ As trans scholar Julia Serano argues, this binary presents an “oppositional sexism”—“the belief that female and male are rigid, mutually exclusive categories, each possessing a unique and nonoverlapping set of attributes, aptitudes, abilities, and desires.”⁶⁴ The implications of this binary become evident when analyzing the diagnoses.

(a) *Transsexualism*.—DSM-III-R defined “transsexualism” by its “essential features”: “a persistent discomfort and sense of inappropriateness about one’s assigned sex in a person who has reached puberty” and a “persistent preoccupation, for at least two years, with getting rid of one’s primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.”⁶⁵ “Invariably,” the APA noted, “there is the wish to live as a member of the other sex.”⁶⁶ To Serano’s point, “the other sex” presupposes that there are only two sexes.

The diagnostic features of transsexualism applied an “oppositional sex” view of clothing, appearance, and mannerisms.⁶⁷ The diagnoses were written from a cisgender perspective, in that they presumed the existence of only two sexes.⁶⁸

Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 COLUM. J. GENDER & L. 88, 106 (2002). I do not discuss Gender Identity Disorder (GID) of Childhood because this Essay focuses on adults seeking gender-affirming care in carceral settings. For a discussion of gender-affirming care that children might pursue, see Jennifer Levi & Kevin Barry, “*Made to Feel Broken*”: Ending Conversion Practices and Saving Transgender Lives, 136 HARV. L. REV. 1112, 1121–22 (2023) (book review).

61. See DSM-III-R, *supra* note 59, at 71–78.

62. *Id.* at 71.

63. Cf. J.S. Welsh, *Assimilation, Expansion, and Ambivalence: Strategic Fault Lines in the Pro-Trans Legal Movement*, 110 CALIF. L. REV. 1447, 1459 (2022) (acknowledging that there is “a broad array of people, ideas, and identifications that seek to undermine binary notions of sex and gender”).

64. SERANO, *supra* note 2, at 13.

65. DSM-III-R, *supra* note 59, at 74.

66. *Id.*

67. See *id.* (“People with this disorder usually complain that they are uncomfortable wearing the clothes of their assigned sex and therefore dress in clothes of the other sex. Often they engage in activities that in our culture tend to be associated with the other sex.”).

68. See *id.* (“[E]ven after sex reassignment, many people still have some physical features of their originally assigned sex that the alert observer can recognize.”).

Finally, DSM-III-R included a cultural section. The APA described how “the Hijra of India and the corresponding group in Burma may have conditions that, according to this manual, would be diagnosed as male-to-female Transsexualism. The Hijra, however, traditionally undergo castration, not hormonal and surgical feminization (creation of a vagina).”⁶⁹ I will return to this example below.

(b) *GIDAANT*.—DSM-III-R contained another disorder that I had never heard of: Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (*GIDAANT*).⁷⁰ As I explain below, reading about this diagnosis was a dysphoric experience for me:

The essential features of [*GIDAANT*] are a persistent or recurrent discomfort and sense of inappropriateness about one’s assigned sex, and persistent or recurrent cross-dressing in the role of the other sex, either in fantasy or in actuality, in a person who has reached puberty. . . . [T] here is no persistent preoccupation (for at least two years) with getting rid of one’s primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.⁷¹

DSM-III-R hyperfixated on cross-dressing as the primary tell of this disorder, fixing the gender binary rigidly into place.⁷² Once again revealing a cissexist gaze, DSM-III-R stated that “[t]he degree to which the cross-dressed person appears as a member of the other sex varies, depending on mannerisms, body habitus, and cross-dressing skill.”⁷³ And without accounting for any form of gender expression besides clothing, DSM-III-R stated that “[w]hen not cross-dressed, the person usually appears as an unremarkable member of his or her assigned sex.”⁷⁴ “Cross-dressing” was framed as a remedy to the associated mental health impairments.⁷⁵

The APA differentiated this diagnosis from “Transvestic Fetishism,” wherein an individual cross-dresses “for the purpose of sexual excitement.”⁷⁶ But the APA also said that people with this disorder include “homosexuals who cross-dress” and “female impersonators.”⁷⁷ Here, DSM-III-R betrayed an archaic view of homosexuals as gender inverts and deviants—female impersonators who may or may not have been sexually aroused by the clothing.⁷⁸

69. *Id.*

70. *See id.* at 76–77.

71. *Id.* at 76.

72. *See id.*

73. *Id.*

74. *Id.*

75. *See id.* (“Anxiety and depression are common, but are often attenuated when the person is cross-dressing.”).

76. *Id.* at 77.

77. *Id.* at 76.

78. *See* Lvovsky, *supra* note 58, at 29 (discussing the post-Prohibition years as “a time when . . . liquor officials commonly conflated homosexuality and gender inversion as twin sides of the same pathology, using *fag*, *fairy*, and *female impersonator* as synonyms separated only by their varying vulgarity”).

2. *DSM-IV-TR*.—The DSM was revised in 1994.⁷⁹ DSM-IV removed three gender-related diagnoses, including “Transsexualism,” and replaced them with “Gender Identity Disorder” (GID).⁸⁰ A textual revision was issued in 2000, titled DSM-IV-TR.⁸¹

DSM-IV-TR stated that “Gender Identity Disorders are characterized by strong and persistent cross-gender identification accompanied by persistent discomfort with one’s assigned sex.”⁸² The APA defined “gender identity” as “an individual’s self-perception as male or female” and characterized the disorder by the person’s “strong and persistent feelings of discomfort with one’s assigned sex, the desire to possess the body of the other sex, and the desire to be regarded by others as a member of the other sex.”⁸³

The GID definition did not focus on reproductive sex parts the way the transsexualism definition did in DSM-III-R.⁸⁴ But the driving binaristic assumption that trans people are trying to function in society *as* “the other sex” negates the individuality of each trans person’s selfhood and reinforces the idea that trans people’s gender is less “real” than that of cisgender people.

DSM-IV-TR stated that “[d]istress or disability in individuals with [GID] is manifested differently across the life cycle.”⁸⁵ Though the definition mentioned distress, trans identity itself is the aberrance.

3. *DSM-5-TR*.—The APA revised the DSM in 2013, creating the DSM-5.⁸⁶ DSM-5 removed GID and replaced it with a new, significantly modified GD diagnosis.⁸⁷ The APA issued a text revision, the DSM-5-TR, in 2022, which states that “[GD] as a general descriptive term refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.”⁸⁸

At the outset, this definition does important work in bifurcating “distress” from the “incongruence” trans people feel, and pathologizing only the former. DSM-5-TR states that the “distress . . . *may* accompany”⁸⁹ that incongruence, and explains that while “not all individuals will experience distress from incongruence, many are distressed if the desired physical interventions

79. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994) [hereinafter DSM-IV].

80. *Id.* at 785; *see also* Kevin M. Barry & Jennifer L. Levi, *The Future of Disability Rights Protections for Transgender People*, 35 *TOURO L. REV.* 25, 37 n.57 (2019) (explaining the history of “transsexualism” in the DSM).

81. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000) [hereinafter DSM-IV-TR].

82. *Id.* at 535 (emphasis omitted).

83. *Id.* (emphasis omitted).

84. *Compare id.*, with DSM-III-R, *supra* note 59, at 74.

85. DSM-IV-TR, *supra* note 81, at 577.

86. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013).

87. *See id.* at 814–15.

88. DSM-5-TR, *supra* note 2, at 511.

89. *Id.* (emphasis added).

using hormones and/or surgery are not available.”⁹⁰ DSM-5-TR “focuses on dysphoria as the clinical problem, not identity per se.”⁹¹ This significant shift accomplished many trans activists’ goals, removing the pathologization of trans gender identity from the DSM altogether. Gone, too, is the omnipresent sex binary found throughout previous versions.⁹²

Critically, the language of causation has been removed entirely. Where DSM-IV-TR said GID is a “disturbance [that] *causes* clinically significant distress or impairment,”⁹³ DSM-5-TR states that GD is a “condition [that] *is associated with* clinically significant distress or impairment.”⁹⁴ Similarly, DSM-5-TR states that “[GD] manifests itself differently in different age groups.”⁹⁵ The equivalent sentence in DSM-IV-TR said: “Distress or disability in individuals with Gender Identity Disorder is manifested differently across the life cycle.”⁹⁶ This shift in language, though subtle, shows that the distress—which is GD—occurs *in* individuals *with* GID as conceptualized by DSM-IV-TR, but, by comparison, GD is *both* the diagnosis and the manifestation in DSM-5-TR. This difference is of the utmost importance for the legal interpretation of DSM-5-TR under the ADA. In short, with GD the distress *is* the disability, whereas GID considered anyone whose gender identity did not match their sex assigned at birth as inherently ill.

Despite these positive changes, DSM-5-TR still upholds the sex binary in other places. In the only diagnostic criterion that compares the current sex parts of a trans person with their desired sex parts, DSM-5-TR reveals its authors’ assumption that sex parts *belong* to a specific sex assigned at birth.⁹⁷ This forced sex/gender distinction—allowing gender to include non-binary representation but not granting the same fluidity to sex—ignores that “[t]hroughout history, great women have had penises and great men have had vaginas.”⁹⁸ Some trans women have penises and never wish to change that. So a trans woman with GD who decides to surgically remove her penis *does not necessarily* desire the “primary and/or secondary sex characteristics” of a woman, unless “woman” can only mean “cis woman.”⁹⁹ The category “woman” does

90. *Id.* at 512.

91. *Id.*

92. *But cf.* Shannon Minter & Martine Rothblatt, Report from the Workshop, Health and Insurance Law (July 6, 1996), in PROC. FROM THE FIFTH INT’L CONF. ON TRANSGENDER L. & EMP. POL’Y 69, 71–73 (1996) <https://www.digitaltransgenderarchive.net/files/h702q650b> [<https://perma.cc/VV36-7A9B>] (calling for a complete end to diagnosing any part of trans identity in the realm of mental health and suggesting a shift to the medical model); Spade, *supra* note 5, at 30–32 (arguing for complete “de-medicalization”).

93. DSM-IV-TR, *supra* note 81, at 581 (emphasis added).

94. DSM-5-TR, *supra* note 2, at 513 (emphasis added).

95. *Id.*

96. DSM-IV-TR, *supra* note 81, at 577.

97. See DSM-5-TR, *supra* note 2, at 513 (noting “[a] strong desire for the primary and/or secondary sex characteristics of the other gender” as a manifestation of GD).

98. Minter & Rothblatt, *supra* note 92, at 73.

99. See SERANO, *supra* note 2, at 11 (“No qualifications should be placed on the term ‘trans woman’ based on a person’s ability to ‘pass’ as female, her hormone levels, or the state

not belong to cisgender women, and the category “man” does not belong to cisgender men.¹⁰⁰

Recall that DSM-III-R said quite conclusively that Hijra identity in India “would be diagnosed as male-to-female Transsexualism.”¹⁰¹ DSM-5-TR differs, stating that “[t]he equivalent of gender dysphoria has . . . been reported in [other] cultural contexts” that have gender identity categories beyond the sex binary, though “[i]t is unclear . . . whether the diagnostic criteria for gender dysphoria would be met with these individuals.”¹⁰² This update is an important lesson to those who subject third-gender individuals to scrutiny under Western biomedical standards.¹⁰³ We should not forget that these diagnostic terms, which lawyers ask courts to wrestle with, are borne of “gendered settler norms and restrictions.”¹⁰⁴ Such norms “of the outside world are reproduced inside jails and prisons.”¹⁰⁵

B. *My Visceral Experience of the DSM*

It was disorienting and dysphoric to read these diagnostic criteria. As I read sections of the GIDAANT diagnosis, specifically, I stood up and paced around my office, washed my hands, stretched, and felt near tears. I have never before read something approximating my gender identity through such a pathologizing frame. The experience is difficult to put into words. For years in high school and college, I had read texts and watched films that made me consider whether I was, to use the terms of DSM-III-R, “transsexual.” I concluded I was not because I did not feel the need to remove my sex parts. As an assigned male at birth person, I do not wear women’s clothing because of “transvestic fetishism,” but because the clothing is aesthetically pleasing and helps people to avoid gendering me as a man, including by not clinging around my groin. I could see myself in every part of the diagnostic criteria of GIDAANT. And as doing so, I could feel myself coping with the anxiety of seeing some partial truths of my gender framed as a clinical disorder. Professor Dean Spade puts it plainly: “[T]rans people do not want to be seen as ‘disabled.’”¹⁰⁶

of her genitals—after all, it is downright sexist to reduce any woman (trans or otherwise) down to her mere body parts or to require her to live up to certain societally dictated ideals regarding appearance.”).

100. Cf. Welsh, *supra* note 63, at 1461 (“Many activists in [the queer expansionist] current reject the binary model of trans identity and the conceptual coherence of sex, gender, and genitals. Others aim to destabilize the notion of switching sex or gender within a binary system . . .” (footnote omitted)).

101. DSM-III-R, *supra* note 59, at 74.

102. DSM-5-TR, *supra* note 2, at 518.

103. See E Ornelas, *Telling “Our Stories”: Black and Indigenous Abolitionists (De) Narrativizing the Carceral State*, in SURVIVING THE FUTURE, *supra* note 6, at 20, 28 (“[J]ails and prisons . . . subject Native individuals who identify as queer, trans, gender nonconforming, and/or Two Spirit to the cisheteropatriarchal whims of non-Native police, corrections officers, wardens, doctors, counselors, etc.”); El-Fil, *supra* note 6, at 47.

104. Ornelas, *supra* note 103, at 28.

105. *Id.*

106. Spade, *supra* note 5, at 34.

I would suggest a correction: trans people do not want to be pathologized.¹⁰⁷ Diagnostic labels can cause us harm in this transphobic society.¹⁰⁸ The social model of disability understands that the pathologization that takes place in and by society creates the disabling effect.¹⁰⁹ I think a major component of what I was grappling with lies in the fact that I feel and have tried to acknowledge my able-bodied privilege for much of my life. To begin to realize that how I perceive my body while living in society has some disabling effects is a disorienting paradigm shift.

I include this affective response with a nod to all the readers who were told by their professors that there is no room for emotion in the law school classroom, which, I worry, extends to the profession writ large. I strongly disagree. Emotions provide information and an opportunity for growth. My racing thoughts walked me right into the web in which I see our legal movement stuck right now. In my heightened state, I thought: “My gender could not be in the DSM. My identity and core parts of my gender expression—what made me *me*—couldn’t possibly be a disability.”

Given my dysphoric reaction to the GIDAANT diagnostic criteria and the advocacy to remove transsexualism from the DSM, I can really feel the stakes of the issue. It would seem far too convenient, but not at all consistent, for trans advocates to want our identities and experiences to be covered by the ADA, *where they are legally considered disabilities*, but not pathologized by the DSM, *where they are clinically determined to be disabilities*.

But the world before DSM-5 posed a more complex ontological challenge than we face today. Today’s ADA claim requires us only to view GD as disabling. I can support that approach much more readily now that my gender identity itself has been depathologized. And I urge others to, as well.

C. *The ADA’s Exclusion of Gender Identity Disorders*

1. *Initial Passage of the Exclusion.*—The ADA defines a disability as “(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.”¹¹⁰ This definition is informed by the social model of disability, “which holds that it is society’s negative reactions to our medical conditions—not the conditions themselves—that cause disability.”¹¹¹

Congress removed transvestism, transsexualism, and gender identity disorders not resulting from physical impairments from the protection of the ADA.¹¹² This exclusion was introduced by a small handful of legislators

107. Thank you, Nikk Wasserman, for this brilliant point.

108. See Kelsey Mumford et al., *What the Past Suggests About When a Diagnostic Label Is Oppressive*, 25 AMA J. ETHICS 446, 448 (2023).

109. Kevin M. Barry et al., *A Bare Desire to Harm: Transgender People and the Equal Protection Clause*, 57 B.C. L. REV. 507, 513 (2016).

110. 42 U.S.C. § 12102(1).

111. Barry et al., *supra* note 109, at 513.

112. 42 U.S.C. § 12211(b)(1).

cherry-picking exceptions to the ADA from DSM-III-R.¹¹³ Late-breaking amendments by Senators William Armstrong and Jesse Helms were made with statements on the record of disdain regarding “sexually deviant behavior”¹¹⁴ with “a moral content to them.”¹¹⁵

2. *ADA Amendments Act of 2008*.—Congress passed the ADA Amendments Act of 2008¹¹⁶ (ADAAA) after the Supreme Court “narrowed the broad scope of protection intended to be afforded by the ADA, thus eliminating protection for many individuals whom Congress intended to protect.”¹¹⁷ Congress sought to “reinstat[e] a broad scope of protection to be available under the ADA.”¹¹⁸ As amended, the ADA’s definition of disability “shall be construed broadly in favor of expansive coverage to the maximum extent permitted by the terms of the ADA.”¹¹⁹

Yet Congress “ignored activists’ calls to jettison the exclusion, despite other legal changes evincing an acknowledgment of the discrimination faced by the trans community, changes in medical opinion about [gender identity disorders], and increased activism for trans inclusion.”¹²⁰ Activists had been calling for the removal of gender identity disorder from the ADA since at least the mid-1990s.¹²¹ Congress ignored “a national trans[] lobby calling for an end to the exclusion” because the ADAAA was intended to “restor[e,] not expand[,] congressional intent.”¹²² “Congress clearly intended to exclude [gender identity disorders] [and [t]ranssexualism[] from protection when it passed the ADA in 1990,” so the intended goals of the ADAAA would not apply.¹²³ In response, the activist movement splintered and “disability rights advocates” compromised, making “the strategic decision to leave [the issue of trans exclusion] for another day.”¹²⁴

The transphobia from Congress and disability rights advocates has since been critiqued by scholars.¹²⁵ Scholars have continued to call for Congress to remove the exclusion. For example, Associate Dean Kevin Barry argues for a “modest bill” that would remove “‘gender identity disorders not resulting from physical impairments’ and ‘transsexualism’ from the” list of the ADA’s

113. See Barry, *supra* note 27, at 23–26; Barry et al., *supra* note 109, at 530–40.

114. 135 CONG. REC. S19,870 (daily ed. Sept. 7, 1989) (statement of Sen. Jesse Helms).

115. *Id.* at S19,853 (statement of Sen. William Armstrong).

116. Pub. L. No. 110–325, 122 Stat. 3553 (codified in scattered sections of 29 and 42 U.S.C.).

117. 42 U.S.C.A. § 12101(a)(4) (West 2009).

118. *Id.* § 12101(b)(1).

119. 29 C.F.R. § 1630.1(c)(4) (2023).

120. Szemanski, *supra* note 27, at 149.

121. See Minter & Rothblatt, *supra* note 92, at 71–73; see also SERANO, *supra* note 2, at 157–160.

122. Barry, *supra* note 27, at 31 (emphasis omitted).

123. *Id.* at 31–32.

124. *Id.* at 32.

125. See *id.* at 33; KAUFER, *supra* note 29, at 153 (arguing that an “expansive approach to disability politics . . . means challenging the . . . transphobia that lurk[s] within the disability rights movement”).

exclusions.¹²⁶ In contrast, Professor Jeannette Cox has suggested the provisions could be removed as a part of the Equality Act.¹²⁷

3. *Legal Interpretations Since DSM-5*.—A straightforward textual analysis shows that GD is a protected disability under the ADA and the definitions in DSM-5-TR.¹²⁸ Other articles have expounded on the legal viability of this claim.¹²⁹ And in January 2024, the United States Department of Justice issued a statement of interest in a case I am litigating against the Georgia Department of Corrections, stating the United States’s position that “[g]ender dysphoria” does not fall within the . . . ‘gender identity disorder’ or ‘transsexualism’” exclusions under the ADA.¹³⁰

As stated above, the Fourth Circuit recently held that GD has come to mean something different than the excluded gender identity disorders.¹³¹ No other circuit court has yet to reach the issue. District courts have found GD is not excluded under two theories.¹³² A court might hold that GD is not GID and thus falls outside of the ADA exclusion.¹³³ Or a court might find that GD is a gender identity disorder, and yet hold that “a physical etiology underlying gender dysphoria may exist to place the condition outside of the exclusion,”¹³⁴ as a gender identity disorder resulting from physical impairments.¹³⁵

Courts have held that recent medical research demonstrates that “GD diagnoses have a physical etiology, namely, hormonal and genetic drivers contributing to the in utero development of dysphoria.”¹³⁶ Even the United States “Department of Justice has agreed that this emerging research renders the inference that gender dysphoria has a physical basis sufficiently plausible to survive

126. Barry, *supra* note 27, at 33.

127. See Jeannette Cox, *Disability Law and Gender Identity Discrimination*, 81 U. PITT. L. REV. 315, 348 (2019).

128. See, e.g., Kevin M. Barry, *Challenging Transition-Related Care Exclusions Through Disability Rights Law*, 23 UDC/DCSL L. REV. 97, 107–08 (2020).

129. See, e.g., Szemanski, *supra* note 27, at 144–59; Verghese, *supra* note 27, at 298–315; Barry & Levi, *supra* note 80, at 42–52.

130. Statement of Interest of the United States at 8, *Doe v. Ga. Dep’t of Corr.*, No. 23-cv-5578 (N.D. Ga. Jan. 8, 2023), ECF No. 69.

131. See *Williams v. Kincaid*, 45 F.4th 759, 766–69 (4th Cir. 2022).

132. See *Doe v. Pa. Dep’t of Corr.*, No. 20-cv-00023, 2021 WL 1583556, at *8–9 (W.D. Pa. Feb. 19, 2021) (summarizing the split).

133. See, e.g., *Doe v. Mass. Dep’t of Corr.*, No. 17–12255, 2018 WL 2994403, at *1, *6 (D. Mass. June 14, 2018); *Tay v. Dennison*, No. 19-cv-00501, 2020 WL 2100761, at *3 (S.D. Ill. May 1, 2020); *Shorter v. Barr*, No. 19cv108, 2020 WL 1942785, at *9 (N.D. Fla. Mar. 13, 2020). But see *Parker v. Strawser Constr., Inc.*, 307 F. Supp. 3d 744, 753–54 (S.D. Ohio 2018).

134. *Doe v. Pa. Dep’t of Corr.*, 2021 WL 1583556, at *9. The Fourth Circuit has so held. See *Williams*, 45 F.4th at 772.

135. 42 U.S.C. § 12211(b)(1).

136. *Doe v. Mass. Dep’t of Corr.*, 2018 WL 2994403, at *6; see also Lauren Hare et al., *Androgen Receptor Repeat Length Polymorphism Associated with Male-to-Female Transsexualism*, 65 BIOLOGICAL PSYCHIATRY 93, 95 (2009); D.F. Swaab, *Sexual Differentiation of the Human Brain: Relevance for Gender Identity, Transsexualism and Sexual Orientation*, 19 GYNECOLOGICAL ENDOCRINOLOGY 301, 303–05 (2004).

a motion to dismiss.”¹³⁷ Thus, trans plaintiffs have a strong argument that GD qualifies as a disability under the ADA.¹³⁸

Finding the “case present[ed] a question of great national importance,” despite the lack of a circuit split, Justice Alito issued a dissent from the denial of certiorari in the Fourth Circuit’s case.¹³⁹ Justice Alito laid out the two rationales jointly advanced by the plaintiff and adopted in the alternative by the Fourth Circuit: (1) that GD is not a gender identity disorder, as that term is now obsolete; and (2) that the plaintiff alleged her GD resulted from a physical impairment because she has a “physical need for hormonal treatment,” without which she experiences physical distress.¹⁴⁰

Justice Alito found GID and GD to be interchangeable, or at least that the term “gender identity disorders” as used in the ADA is a “catch-all category” that includes GD.¹⁴¹ And he rejected the physical-impairment conclusion by the Fourth Circuit because the Fourth Circuit did “not meaningfully distinguish physical impairments from ‘mental impairment[s],’ which the ADA recognizes as a distinct category.”¹⁴²

Justice Alito cited a district court opinion that found that the “majority” of federal cases have concluded that the ADA excludes gender identity disorders that substantially limit a major life activity.¹⁴³ That district court cited only four cases in support of its proposition, three of which did not reach the precise issue.¹⁴⁴ The District of Arizona could not have reached the issue because it was decided before DSM-5 was published in 2013.¹⁴⁵ Similarly, the plaintiffs in the Middle District of Georgia and the Western District of Wisconsin were diagnosed with GID, not GD.¹⁴⁶ The Eastern District of Wisconsin issued the only decision of the four that supports Justice Alito’s view¹⁴⁷—standing against the Fourth Circuit Court of Appeals,¹⁴⁸ the District of Colorado,¹⁴⁹ the District

137. *Williams*, 45 F.4th at 771 (citing Statement of Interest of the United States of America at 1–2, *Blatt v. Cabela’s Retail, Inc.*, No. 14-cv-4822 (E.D. Pa. Nov. 16, 2015)).

138. *See id.*; *see also Doe v. Mass. Dep’t of Corr.*, 2018 WL 2994403, at *6.

139. *Kincaid v. Williams*, 143 S. Ct. 2414, 2414 (2023) (Alito, J., dissenting from the denial of certiorari). *See generally* SUP. CT. R. 10.

140. *Kincaid*, 143 S. Ct. at 2416 (Alito, J., dissenting from the denial of certiorari).

141. *See id.* at 2417.

142. *Id.* at 2418 (quoting 42 U.S.C. §§ 12102(1)(A), 12211(b)(1) (alteration added)).

143. *See id.* at 2419 n.3 (quoting *Parker v. Stawser Constr., Inc.*, 307 F. Supp. 3d 744, 754 (S.D. Ohio 2018)).

144. *Parker*, 307 F. Supp. 3d at 754 (citing *Gulley-Fernandez v. Wis. Dep’t of Corr.*, No. 15-cv-995, 2015 WL 7777997, at *2 (E.D. Wis. Dec. 1, 2015); *Mitchell v. Wall*, No. 15-cv-108, 2015 WL 10936775, at *1 (W.D. Wis. Aug. 6, 2015); *Diamond v. Allen*, No. 14-cv-124, 2014 WL 6461730, at *4 (M.D. Ga. Nov. 17, 2014); *Kastl v. Maricopa Cnty. Cmty. Coll. Dist.*, No. Civ.02–1531, 2004 WL 2008954, at *4 (D. Ariz. June 3, 2004)).

145. *See Kastl*, 2004 WL 2008954, at *1.

146. *See Diamond*, 2014 WL 6461730, at *4; *Mitchell*, 2015 WL 10936775, at *1.

147. And only barely. A pro se litigant was before the court on a petition to proceed in forma pauperis and the court issued its finding on the ADA exclusion with no reasoning. *Gulley-Fernandez*, 2015 WL 7777997, at *1–3.

148. *Williams v. Kincaid*, 45 F.4th 759, 763 (4th Cir. 2022).

149. *Griffith v. El Paso County*, No. 21-cv-00387, 2023 WL 2242503, at *17 (D. Colo.

of Massachusetts,¹⁵⁰ the Eastern District of Pennsylvania,¹⁵¹ three different judges on the Southern District of Illinois,¹⁵² the Northern District of Florida,¹⁵³ and the District of Idaho.¹⁵⁴ Justice Alito relied on an outdated case that did not analyze the issue properly and neglected to provide an independent tally.¹⁵⁵

If the recent trend is any indication, this viable legal theory will continue to be tested across the federal courts, a circuit split will possibly emerge, and the Supreme Court might take up the issue again. I accept the claim as valid for the reasons set forth thus far, and now move to exploring the normative question: Should litigants bring ADA claims for GD?

III. “LIKE ANY OTHER DISABILITY”

I believe [GD] is like any other disability and there will always be a stigma attached because people [will] either covet or ridicule what they don't live with or understand.

—Anonymous Survey Respondent¹⁵⁶

Is the inclusion of GD in the DSM transphobic? Is resistance to a disability framework ableist? Is there a clear answer to these questions or should we rather “[l]ive the questions now?”¹⁵⁷ I feel confident that our movement is asking the right questions.¹⁵⁸ By “living” those questions, we might shed our egoic defenses.

Feb. 27, 2023) (rejecting the reasoning of a previous case in the same district because the court found *Williams* persuasive).

150. *Doe v. Mass. Dep't of Corr.*, No. 17-12255, 2018 WL 2994403, at *1, *6 (D. Mass. June 14, 2018).

151. *Blatt v. Cabela's Retail, Inc.*, No. 14-cv-4822, 2017 WL 2178123, at *3 (E.D. Pa. May 18, 2017).

152. *Tay v. Dennison*, No. 19-cv-00501, 2020 WL 2100761, at *3 (S.D. Ill. May 1, 2020); *Venson v. Gregson*, No. 18-cv-2185, 2021 WL 673371, at *2-3 (S.D. Ill. Feb. 22, 2021); *Iglesias v. True*, 403 F. Supp. 3d 680, 687-88 (S.D. Ill. 2019).

153. *Shorter v. Barr*, No. 19cv108, 2020 WL 1942785, at *10 (N.D. Fla. Mar. 13, 2020).

154. *Edmo v. Idaho Dep't of Corr.*, No. 17-cv-00151, 2018 WL 2745898, at *7-8 (D. Idaho June 7, 2018).

155. I found further cases that foreclose an ADA claim for GD, but Justice Alito did not cite them. *See Lange v. Houston County*, 608 F. Supp. 3d 1340, 1360-63 (M.D. Ga. 2022); *Duncan v. Jack Henry & Assocs., Inc.*, 617 F. Supp. 3d 1011, 1056-57 (W.D. Mo. 2022) (holding “gender identity disorders” encompasses GD, *id.* at 1057); *Doe v. Northrop Grumman Sys. Corp.*, 418 F. Supp. 3d 921, 929-30 (N.D. Ala. 2019) (same). Even taking these cases into account, however, the vast majority of lower courts, as cited above, have sided with the viability of an ADA claim for GD.

156. *See* Survey Results, *supra* note 32; *see also supra* p. 244.

157. RAINER MARIA RILKE, LETTERS TO A YOUNG POET 27 (M.D. Herter Norton trans., W.W. Norton & Co., Inc. 2004) (1934) (emphasis omitted).

158. *See* Spade, *supra* note 5, at 32 (“The most pressing and controversial area in trans law bringing up these issues currently is the question of whether and when disability discrimination claims should be used to address instances of gender identity discrimination.”).

I am grateful that I had such a visceral reaction to GIDAANT.¹⁵⁹ I will never forget feeling that dysphoric response to reading about my specific type of gender identity disorder-no-longer. For the most part, I am not barred from participating equally, and, importantly, I rarely need to navigate state-imposed barriers to my gender expression.¹⁶⁰ But in moments when my conditions—anxiety, PTSD, ADHD, and even occasional GD—prevent me from participating equally, I can usually ask for support from my coworkers or my peers. I can access clothing and hygiene products that affirm my gender. In these ways, I can accommodate my GD needs. I feel my heart racing and my palms getting sweaty at that realization. I am living with disabilities, and am reasonably accommodated, for the most part. That self-realization is truly all the Disability Justice movement asks us to work toward accepting.¹⁶¹

Disability is a social construct.¹⁶² Like any construct, it can be bent and remade.¹⁶³ What might it mean for a trans person who might not meet DSM-5's criteria of GD to claim being disabled? What would it look like for them to find "brilliance and pride" in that identity, as they might their trans identity?¹⁶⁴

With the ADA, disability advocates set a solid floor for disability rights. Despite the ADA's exclusions of gender identity disorders, the ADA provided me with a paradigm shift for considering what accessibility for people with GD might entail.¹⁶⁵ So the ADA may spark conversations for us to have in community—in loving struggle and tearful long nights and awkward pauses.

159. See *supra* pp. 249–50.

160. Spade, *supra* note 5, at 34 ("[D]isabled people are capable of equal participation, but are currently barred from participating equally by artificial conditions that privilege one type of body or mind and exclude others." (emphasis added)).

161. See *What Is Disability Justice?*, SINS INVALID (June 16, 2020), <https://www.sinsinvalid.org/news-1/2020/6/16/what-is-disability-justice> [<https://perma.cc/Y5LK-QL6V>] ("A disability justice framework understands that . . . [a]ll bodies have strengths and needs that must be met.").

162. See Cindy LaCom, *Ableist Colonizations: Reframing Disability Studies in Multicultural Studies*, in *AMERICAN MULTICULTURAL STUDIES: DIVERSITY OF RACE, ETHNICITY, GENDER AND SEXUALITY* 53, 56 (Sherrow O. Pinder ed., 2012) ("A foundational argument in disability studies is that disability is a cultural construct and that 'knowledge about disability is socially produced.'" (quoting SIMI LINTON, *CLAIMING DISABILITY: KNOWLEDGE AND IDENTITY* 4 (1998))); see also DAVIS ET AL., *supra* note 28, at 68; Jannine Williams & Sharon Mavin, *Disability as Constructed Difference: A Literature Review and Research Agenda for Management and Organization Studies*, 14 INT'L J. MGMT. REVS. 159, 167, 171, 172 (2012); Liat Ben-Moshe, *Alternatives to (Disability) Incarceration*, in *DISABILITY INCARCERATED: IMPRISONMENT AND DISABILITY IN THE UNITED STATES AND CANADA* 255, 264 (Liat Ben-Moshe et al. eds., 2014) [hereinafter *DISABILITY INCARCERATED*].

163. See ALICE WONG, *DISABILITY VISIBILITY: FIRST-PERSON STORIES FROM THE TWENTY-FIRST CENTURY* xxii (2020) ("Disability is mutable and ever-evolving. . . . Disability is pain, struggle, brilliance, abundance, and joy.")

164. See *id.*; cf. KAHER, *supra* note 29, at 45 ("I think the inability to value queer lives is related to the inability to imagine disabled lives. . . . Not wanting to cultivate queerness . . . is intertwined with fears about cultivating disability."). For an enriching discussion of queer theory as applied to ADA claims for GD, see Verghese, *supra* note 27, at 315–27.

165. I thank Ido Katri for pointing this out.

For refusing to “delimit understandings of ‘disability’ to physical and cognitive difference” just “might constitute an act of resistance.”¹⁶⁶

We know our ideal world is “not yet here.”¹⁶⁷ Nevertheless, might “we at least begin to contemplate a world in which . . . ‘normalcy’ exists along . . . a continuum we understand as liminal and in which we work to become comfortable with that liminality, perhaps even to celebrate it rather than attempting to regulate and ‘manage’ difference?”¹⁶⁸ How can we dismantle the institutions we’re struggling to survive in while also building something beautiful and worthy of holding on to? Who has the spoons to do all of that?¹⁶⁹

Some answers might lie in the urgent necessity to take care of our community members experiencing preventable harm in state and federal custody. Through my work, I have learned that in prison, people with GD are highly regulated because of their differences. They struggle to access necessary medical care, they are subject to daily forms of gender-based violence including harassment and assault, and they are housed in torturous conditions that exacerbate their mental health conditions. “Prisons are spaces where people get disabled, or more disabled.”¹⁷⁰

So I use all available tools—including ADA claims—on behalf of those who are currently “more disabled” because of oppressive systems.¹⁷¹ As a prison litigator, I’m learning that “[t]he harshness of prison life disables people,” and that “[d]isability is also a byproduct of the correctional system’s obsessive infatuation with security and control.”¹⁷² My clients diagnosed with GD have experienced those disabling effects and have not shied away from ADA claims whatsoever. On the contrary, they encourage me to raise ADA claims in their demand letters and legal filings, and they file ADA administrative grievances, which are sometimes an alternative to the traditional administrative remedy procedure.

So where do we go from here? We must learn from our comrades in the Disability Justice movement.¹⁷³ They tell us that “[i]t’s radical to imagine that

166. LaCom, *supra* note 162, at 62.

167. MUÑOZ, *supra* note 6, at 1; *see also* LaCom, *supra* note 162, at 63.

168. LaCom, *supra* note 162, at 63.

169. *See* Fortesa Latifi, *Spoon Theory: What It Is and How I Use It to Manage Chronic Illness*, WASH. POST (Jan. 14, 2023 6:00 A.M.), <https://www.washingtonpost.com/wellness/2023/01/14/spoon-theory-chronic-illness-spoonie> [<https://perma.cc/4J5X-L96H>].

170. *See* LEAH LAKSHMI PIEPZNA-SAMARASINHA, *THE FUTURE IS DISABLED: PROPHECIES, LOVE NOTES, AND MOURNING SONGS* 24 (2022).

171. *Id.*; *see* Morgan, *supra* note 10, at 989 (“Court filings are opportunities to resist ableism prevalent in carceral systems. By focusing on portraying clients as disabled not only because of medical diagnosis but also *because of* disabling prison and jails conditions, attorneys can move beyond disability discrimination and work towards challenging the more insidious, systematic ways that ableism propagates in carceral spaces.”).

172. Marta Russell & Jean Stewart, *Disablement, Prison, and Historical Segregation*, in *CAPITALISM & DISABILITY: SELECTED WRITINGS BY MARTA RUSSELL* 86, 94 (Keith Rosenthal ed., 2019).

173. *See* Natalie M. Chin, *Centering Disability Justice*, 71 SYRACUSE L. REV. 683, 736–48 (2021).

the future is disabled” and that “our power is the strongest when we employ a diversity of tactics on our own terms—tactics that build our strengths, that strike where the enemy is weak or has a gap.”¹⁷⁴ In my work, the “enemy” is the carceral state that refuses to let trans people live safely and express their gender while in state or federal custody.

Even as we fight using our disabled terms, we must remember that we are simultaneously “thinking and worlding from outside of our present governing system of meaning.”¹⁷⁵ We must “analyze [our] commitments to traditional symbolics of Western gender,”¹⁷⁶ including the thought that we are not disabled. We must bend gender and break the rules.¹⁷⁷ We must release “gender non-binary” and reclaim our faerie,¹⁷⁸ embrace our bakla.¹⁷⁹

I think trans people—especially trans lawyers and advocates—will need to radically change our collective self-image to embrace a Disability Justice future. This change can happen if we organize around universal accommodations, which means embracing that we are all living with disabilities in some way and that the words we ascribe to those disabilities are entirely socially constructed. In the prison context, that means people would access what they need in order to stay safe before hopefully returning to society.

There should be nothing to fear regarding our own nuanced identities; we can expand on our fully-fledged self-conceptions far away from the biomedical realm.¹⁸⁰ But we don our legalese medical “drag” and navigate these systems, code-switching, as we always have, when we receive the call. We follow in the footsteps of our ancestors—Black and indigenous queer and trans people, particularly—who have done this for decades.¹⁸¹

174. PIEPZNA-SAMARASINHA, *supra* note 170, at 21, 161.

175. El-Fil, *supra* note 6, at 51.

176. *Id.*

177. Cf. PIEPZNA-SAMARASINHA, *supra* note 170, at 32 (describing disabled people’s “unending crip majestic tradition of bending reality . . . [and] time to create crip lives that are beyond what anyone has told us was possible, all the time”).

178. D Dangaran, *Faerie Gender Realization*, MEDIUM (Apr. 2, 2020), <https://ddangaran.medium.com/faerie-gender-realization-d694856fd1e3> [https://perma.cc/52E3-W9G2] (explaining how queer history archival research led me to reclaim the term “faerie” as a gender identity and exploring ways I could live out that gender on my terms).

179. Jaime Oscar M. Salazar, *How “Bakla” Explains the Struggle for Queer Identity in the Philippines*, FOREIGN POL’Y (July 30, 2022, 6:00 AM), <https://foreignpolicy.com/2022/07/30/bakla-queer-identity-philippines> [https://perma.cc/W5MX-ZAZ5] (“Various translated as ‘drag queen,’ ‘gay,’ ‘hermaphrodite,’ ‘homosexual,’ ‘queer,’ ‘third sex,’ and ‘transgender,’ bakla shows how in the Philippines, as in many places around the world, gender and sexuality are imagined and lived out in connection with concepts and categories that Western lenses can’t fully account for.”).

180. Disability Justice teaches us that this is *necessary* because “Black genderedness [is] incompatible with white Western gender,” and so a “vision of a reimagined future will need to arise from Black LGBTQIA+ individuals who break with normativity in their historical positioning and embodiment and show us how to imagine otherwise.” El-Fil, *supra* note 6, at 51.

181. See G. Samantha Rosenthal, *Column: Gender-Affirming Care Has a Long History in the U.S., and Not Just for Transgender People*, MICH. ADVANCE (July 7, 2023, 3:51 AM),

If we are serious about working toward a better future, then we ought to wield the ADA as a tool for trans justice. The ADA helps get us to “a world where trans people could access life-sustaining healthcare without coverage bans or discriminatory and dehumanizing providers due to legal advocacy and enforcement,” such that “they would not face as many impossible choices—choices like going without healthcare at the expense of their physical and mental well-being, or seeking care by risking life, limb, and criminal sanction.”¹⁸² Until we reach that world, we need to convince the state to fulfill our rights using their rules, as we know what we need best. So let’s organize and train advocates to play by those rules and, even if “temporarily . . . [,] beat [the master] at his own game.”¹⁸³ Isn’t that what movement lawyers are for?

IV. CONSIDERING THE COUNTERARGUMENTS

Living in the wrong body is a worse prison than one with bars.

—Anonymous Survey Respondent¹⁸⁴

A. *Lavender Law Panel*

On July 25, 2023, I spoke on a panel held at the National LGBTQ+ Bar Association’s Lavender Law conference.¹⁸⁵ The panel, moderated and organized by U.S. Department of Justice attorney David Knight, was entitled “Overcoming Stigmas: Using ADA Litigation to Secure Transgender People’s Rights.”¹⁸⁶ The other panelists were Professor Jennifer Levi, Richard Saenz, and Brynne Madway.¹⁸⁷ I would estimate that around eighty lawyers and law students attended the session. In many ways, the panel and the attendees represented the modern trans rights movement.¹⁸⁸

After the panelists described the issue (like this Essay did in Part II), I presented the Black and Pink Massachusetts survey results—the same data

<https://michiganadvance.com/2023/07/07/gender-affirming-care-has-a-long-history-in-the-u-s-and-not-just-for-transgender-people> [<https://perma.cc/93D8-32GX>] (describing the common narratives trans people have adopted to attain gender-affirming care since the 1960s and 1970s); see also C. RILEY SNORTON, *BLACK ON BOTH SIDES: A RACIAL HISTORY OF TRANS IDENTITY* 24–27, 56–58, 74–84 (2017) (discussing the experiences of slaves whose bodies were surgically forced into conformity and who “cross-dressed” to escape captivity).

182. Chinyere Ezie, *Dismantling the Discrimination-to-Incarceration Pipeline for Trans People of Color*, 19 UNIV. ST. THOMAS L.J. 276, 322 (2023).

183. LORDE, *supra* note 21, at 112.

184. See Survey Results, *supra* note 32.

185. See *The 2023 Lavender Law Conference & Career Fair: Program Schedule*, NAT’L LGBTQ+ BAR ASS’N, <https://lgbtqbar.mtiley.com/events/LavLaw23/Agenda.aspx> [<https://perma.cc/GY9V-Y2Z6>].

186. *Id.*

187. See *id.*

188. As co-chair of the National Trans Bar Association, I have created a number of spaces for trans lawyers to convene. Those interested in this topic are all across the country and gather in rare opportunities like Lavender Law to have important dialogues. There are few other opportunities for large-scale collaborations. Cf. Danganan, *supra* note 9, at 173 (discussing the LGBTQ roundtable).

shared in Part I.¹⁸⁹ I then seized the rare opportunity to juxtapose lawyers' views of legal strategy to those of incarcerated trans people. I asked the lawyers and law students gathered at our panel the same three questions we asked folks in the survey, reframing the third one to allow folks to consider themselves as an advocate instead of a plaintiff:

1. Under the ADA, a disability is "a physical or mental impairment that substantially limits one or more major life activities." Do you consider gender dysphoria to be a disability?
2. Do you think there is any stigma attached to gender dysphoria when it is considered a disability?
3. If you needed to and had the option, would you bring a disability legal claim for your gender dysphoria? Or, "Would you bring this claim for your client [if you are a lawyer], or if you are trans would you want to bring this claim for yourself?"

The room's responses trended in the same direction as the survey respondents, but the lawyers were more unanimous. With each question, I asked for a show of hands for yes and no. No one answered "no" on question one. On question two, nearly everyone said yes. I invited some audience members to share their comments on each of the points and got some interesting feedback. Regarding question two, one nonbinary person who is disabled said that there is a stigma that once something is a disability, it "should be cured" because the "expectation is toward able-bodiedness." Other scholars have agreed.¹⁹⁰ When we came to question three, again most said yes. But this time, I asked if anyone who disagreed with bringing the claim would like to share why.

Prison litigator A.D. Lewis stood up and gave a series of normative arguments against the claim. At a high level, he stated that he does not think lawyers should bring ADA claims for GD. He made a few distinct points that I've organized into four themes: (1) GD is completely controlled by doctors, the World Professional Association for Transgender Health (WPATH) is led by cis people, and "I don't trust medical providers"; (2) GD is not how a vast number of trans people identify ("GD describes what cis people make of me, not what I make of myself"); (3) GD in jails and prisons creates two systems—not trans enough to be crippled, and too trans and therefore too disabled to get coverage; (4) "I don't believe in the capacity of the courts."

Levi responded by saying that movement lawyers cannot lose sight of the history of the ADA or the DSM. Levi also pointed out that one way to expedite

189. *See supra* pp. 242–44.

190. *See, e.g.,* Jamelia Morgan, *Contesting the Carceral State with Disability Frames: Challenges and Possibilities*, 170 U. PA. L. REV. 1905, 1919–20 (2022) ("A Disability Justice approach recognizes that 'able-bodied supremacy has been formed in relation to intersecting systems of domination and exploitation,' and that it is impossible to 'comprehend ableism without grasping its interrelations with heteropatriarchy, white supremacy, colonialism and capitalism, each system co-creating an ideal bodymind built upon the exclusion and elimination of a subjugated 'other.'"" (alteration omitted) (quoting Patty Berne, *Disability Justice—A Working Draft*, SINS INVALID (June 10, 2015), <https://www.sinsinvalid.org/blog/disability-justice-a-working-draft-by-patty-berne> [<https://perma.cc/9EHV-SEPQ>])).

the release of trans people from prison is to bring a lawsuit for medical care that the facility is required to provide. Here, Levi alluded to the fact that facilities will often release trans plaintiffs seeking gender-affirming care to moot their claims.¹⁹¹ In that vein, bringing medical necessity suits can be, perhaps inadvertently, an abolitionist strategy and a “de-carceral intervention,” not simply a “carceral” or “non-carceral” one.¹⁹²

In response to Lewis, I said that his points, while extremely useful, seemed to be larger critiques of the role of lawyers in this cause altogether. If lawyers—particularly movement lawyers working with incarcerated trans people—are retained to help meet a client’s urgent health needs, should we really refrain from pursuing a claim that might bring that relief? What else should movement lawyers do with our skillset and position of privilege?¹⁹³

B. *Holding the Counterarguments*

“Addressing counterarguments,” through a classical law review format, does not truly capture what I intend to do with these deep and political questions.¹⁹⁴ So, to “hold” the counterarguments, I offer a reformulation of Lewis’s arguments with texts that resonated with what he posited, and respond to those points.

1. *Medical Gatekeepers*.—Lewis’s points formed an argumentatively dense critique of medical gatekeeping. Professor Dean Spade has also raised this critique—and others that Lewis raised.¹⁹⁵ Spade writes that “[t]he mostly

191. See, e.g., Tim Stelloh, *Transgender Inmate Suing Ga. Prison System Granted Surprise Early Release*, NBC NEWS (Aug. 31, 2015, 10:56 PM), <https://www.nbcnews.com/news/us-news/transgender-inmate-suing-ga-prison-system-granted-early-release-n419216> [<https://perma.cc/MH7D-U6Y6>].

192. Cf. Danganan, *supra* note 9, at 205–06 (categorizing gender-affirming care in prison as non-carceral interventions because accessing medical care did not move the person closer to being in the free world). This important point has made me rethink gender-affirming prison placements, which I had previously categorized as a carceral intervention. See *id.* at 202. Trans women seeking transfer to women’s facilities have been issued parole instead. See, e.g., James Factora, *For Years, Ashley Diamond Advocated from Inside a Men’s Prison. She’s Finally Free*, THEM (Aug. 15, 2022), <https://www.them.us/story/ashley-diamond-trans-prisoner-released-parole-advocacy> [<https://perma.cc/978C-2X6C>]. Such an outcome is an abolitionist success. But of course, there is a huge risk when bringing such claims that the trans person would not be released and would instead be subjected to heightened surveillance and different forms of violence in the women’s facility, which is what led me to categorize such an intervention as “carceral.” Perhaps my categorization is better conceived as pertaining to outcomes rather than interventions, given the remedy is sometimes out of the advocate’s control.

193. I thank Jules Welsh for pointing out that our debate maps onto that of the idealist-expansionist (Lewis) and ambivalent-utilitarian in their article. See Welsh, *supra* note 63, at 1459–68.

194. Cf. KAUFER, *supra* note 29, at 150 (“[T]he *benefits* of coalition politics are bound up in the *difficulties* of such politics. Disagreement pushes us to recognize and acknowledge our own assumptions and the boundaries we draw around our own work; without such disagreement, and the ways it compels us to reexamine our positions, we can too easily skim over our own exclusions and their effects.”).

195. See Spade, *supra* note 5, at 32.

unexplored territory remains in the realm of de-medicalization, where trans rights are recognized but will not hinge upon surgical status or medical evidence.”¹⁹⁶ He acknowledges that trans attorneys and advocates are “wresting with the fact that, to some extent, the medicalization of trans identity was at one time a progressive step toward dignity and equality [because] it was preferable to total illegitimacy and criminality.”¹⁹⁷ But “even as we rely on it to argue that trans people should be protected from discrimination and allowed to legally change our genders, we proceed with caution and work to reduce the gatekeeping powers of medical experts over us.”¹⁹⁸ Lewis argued that even if we had the best case law, trans people would still not be getting necessary care because of the neglect of medical providers. Spade agrees.¹⁹⁹

Lewis also asserted that WPATH is led by cis people. Similarly, Serano offers a helpful critique of cissexism in medical and psychiatric establishments, defining cissexism as “the tendency to hold transsexual genders to a different standard than cissexual ones,” and arguing that it “runs rampant” in the general public, in universities, and in the medical and mental health professions.²⁰⁰ Further, Serano argues that cis mental health professionals should “focus their energies on correcting the huge disparity that exists between cissexual and transsexual access to gender-related healthcare,” condemning medical gatekeepers for the lack of insurance coverage for gender-affirming care in trans patients even when the same surgeries are covered for cissexual patients.²⁰¹ She also critiques the Harry Benjamin International Gender Dysphoria Association (HBIGDA), now known as WPATH,²⁰² as being “inherently cissexist, as it requires trans people to accommodate and appease the gender presumptions of individual therapists (who potentially harbor traditional sexist, oppositional sexist, and/or cissexist biases) in order to have our identified genders recognized.”²⁰³

Although the call for trans autonomy is well taken, the WPATH Standards of Care should not be so quickly cast aside. The newest version of the WPATH Standards of Care Guidelines “w[as] developed by global professionals in medicine, psychology, law, social work, counseling, psychotherapy, family studies, sociology, anthropology, sexology, speech and voice therapy, and other related fields.”²⁰⁴ They address “health and wellbeing of transgender people in

196. *Id.* at 30.

197. *Id.* at 31–32.

198. *Id.* at 32.

199. *Id.* at 28–29 (explaining that forcing trans people “to produce narratives of struggle around those identities that mirror the diagnostic criteria . . . can be dehumanizing, traumatic, or impossible to complete”).

200. SERANO, *supra* note 2, at 156.

201. *Id.* at 157.

202. *Mission and Vision*, WPATH, <https://www.wpath.org/about/mission-and-vision> [<https://perma.cc/NLG2-2D8V>].

203. SERANO, *supra* note 2, at 157–58.

204. *World Professional Association for Transgender Health, Standards of Care for Transgender and Gender Diverse People, Version 8 Frequently Asked Questions*, WPATH,

a very broad sense.”²⁰⁵ And because “[e]very major U.S. medical and mental health organization” supports the “access to age-appropriate, individualized gender-affirming care” outlined in the WPATH guidelines,²⁰⁶ they can be very persuasive in court.²⁰⁷

Spade ends his analysis of medical gatekeepers by pointing out some inherent contradictions in the work of trans advocates: “I believe in the necessity of litigation and policy work to alleviate immediate crises in the lives of trans people, but I also know that organizing and cultural work have been central to this movement since its inception.”²⁰⁸ As Professor Alison Kafer summarizes, “Spade carefully maps the implications” of litigation within the medical model, “challenging ableism within trans communities while detailing the risks of disability identification.”²⁰⁹ In other words, Spade holds the position that trans rights should not depend on the mental health establishment’s diagnosis of gender-identity disorder.²¹⁰ But pragmatically, “because ‘many trans people’s lives are entangled with medical establishments,’ their best hope is a medical diagnosis and the recognition and access to services it entails.”²¹¹

Litigating medical civil rights need not “threaten” trans autonomy; we’ll still be organizing, looking to our queer trans horizons, and utilizing other “source[s] of support” on that journey besides the “master’s [court]house.”²¹² Trans advocates need to ensure we embrace the autonomy of disabled people within our community who want to access civil rights laws. Denying ADA protection for GD is, in this regard, denying disabled people autonomy to make decisions for themselves.

2. *Self-Identification / Informed Consent.*—Lewis made two points regarding self-identification. First, Lewis said: GD is not how a vast number of trans people identify. In line with this point, Spade argues: “Despite the disclaimer in the diagnosis description that this is not to be confused with normal gender non-conformity found in tomboys and sissies, no real line is drawn between ‘normal’ gender non-conformity and gender non-conformity which constitutes GID.”²¹³

Lewis also argued: “GD describes what cis people make of me, not what I make of myself.” Serano similarly posits that gatekeepers do not require cis

<https://www.wpath.org/media/cms/Documents/SOC%20v8/SOC-8%20FAQs%20-%20WEBSITE2.pdf> [https://perma.cc/K55L-QSKW].

205. *Id.*

206. *Id.*

207. *See, e.g.,* *Edmo v. Corizon, Inc.*, 935 F.3d 757, 788 n.16 (9th Cir. 2019) (calling the WPATH Guidelines “the gold standard on this issue”).

208. Spade, *supra* note 5, at 37.

209. KAER, *SUPRA* note 29, at 125.

210. *See id.* (quoting Spade, *supra* note 5, at 35).

211. *Id.* (quoting Spade, *supra* note 5, at 35).

212. LORDE, *supra* note 21, at 112.

213. Spade, *supra* note 5, at 24.

people to be pathologized before getting body modification surgery, whereas trans people need a then-GID diagnosis.²¹⁴

Serano makes a strong argument for self-identification as an alternative to the gatekeeper model.²¹⁵ Serano points out that medical gatekeepers “ignore the obvious fact that gender dissonance has always been a ‘self-diagnosed’ condition: There are no visible signs or tests for it; only the trans person can feel and describe it.”²¹⁶ Psychiatrists play the role of a veracity check, asking trans individuals probing questions about childhood and sexual desire. Serano argues that calling gender variance a mental illness and giving psychiatrists this power of gatekeeping trans identities “enables cissexual and cisgender prejudice against us.”²¹⁷

Lewis, Spade, and Serano propose that another model of healthcare be applied to gender-affirming care: the informed consent model.²¹⁸ This model sidesteps the psychiatrist as gatekeeper, but, in almost every instance, replaces the psychiatrist with another state or medical-industrial complex actor. Because the healthcare needs that people demand under ADA claims are either medical or provided by the administrative state, the gatekeeper will not be entirely removed through informed consent. We have seen these issues arise, for example, in the abuse of informed consent standards for those seeking abortion.²¹⁹ So this model does not fully resolve the problems raised by the gatekeeper critique, at least in accessing medical care. Transphobic doctors will still not provide surgery to the patient asking for it, and pro-trans doctors will likely be stymied by insurance companies (or prison systems) that are anti-trans and have the ability to deny coverage.

3. *Soft Policing*.—Lewis made nuanced points about the ways prisons would bifurcate the trans community if a GD frame were adopted. Lewis stated that GD is a metaphor; it’s not actually a disability.²²⁰ People can be

214. SERANO, *supra* note 2, at 156–57.

215. *Id.* at 158–60 (“[T]he process of socially and legally changing one’s sex should be entirely uncoupled from medicine and psychiatry . . .” *Id.* at 158.).

216. *Id.* at 159.

217. *Id.* at 160.

218. See Timothy Cavanaugh et al., *Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients*, 18 AMA J. ETHICS 1147, 1147 (2016) (arguing that “an informed consent approach to care [is] more patient-centered and respectful of the patient’s sense of agency” than the WPATH standard model of care); Florence Ashley, *Surgical Informed Consent and Recognizing a Perioperative Duty to Disclose in Transgender Health Care*, 13 MCGILL J.L. & HEALTH 73, 79–85 (2020) (explaining the informed consent models for gender-affirming care currently at use in Quebec through an autoethnographic approach); Ido Katri, *Transitions in Sex Reclassification Law*, 70 UCLA L. REV. 636, 683–90 (2023) (detailing self-identification examples in U.S. law).

219. See Ian Vandewalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violation of Medical Ethics*, 19 MICH. J. GENDER & L. 1, 4–8 (2012).

220. Cf. Doron Dorfman, *Disability as Metaphor in American Law*, 170 U. PA. L. REV. 1757, 1788, 1798–1800 (2022) (problematizing the Fourth Circuit’s use of disability as a metaphor because of the perilous “consequences for the disability community,” *id.* at 1788, that flow from the fact that “the court once again enshrined the connection between impairment and disability status under antidiscrimination law,” *id.* at 1799).

trans enough but not disabled, or people can be too disabled to get healthcare coverage.²²¹

I juxtapose this critique to the points raised by Mariame Kaba and Andrea Ritchie, who argue that “[t]he state’s police power is . . . located in the social welfare and medical systems,” such that medical professionals are “soft police” who can deny medical interventions.²²² Such soft policing includes “the denial of gender-affirming medical care, benefits, and access to social spaces” by medical institutions.²²³ The “current goal of the ‘treatment’ model is to discipline people into narrow confines of ‘acceptable’ ways of being and acting—a police project enacted by cops, prison guards, and health professionals.”²²⁴ Thus, the medical-industrial complex “polic[es] the line between ‘normal’ and ‘not,’” as such standards have existed since the late eighteenth century, in order to “polic[e] individuals’ health in the interests of economic productivity.”²²⁵

This critique of the medical model does not apply to the ADA, which applies the social model.²²⁶ Looking to the survey respondents, we can see precisely why GD is better understood when viewed through the social model,²²⁷ not purely a treatment model. Recall that respondents identified GD as a disability because it “put [them] at a disadvantage with other people,” and “limits what a person can do physically in a society that is still very trans[phobic] and homophobic.”²²⁸ Another respondent said “there will always be a stigma attached because people [will] either covet or ridicule what they don’t live with or understand.”²²⁹ The distress often occurs, then, at the point where individuals’ characteristics clash with societal structures and attitudes. In this way, GD denotes a social ostracization that already is occurring, rather than creating a dividing line itself.

Moreover, to receive protection under the ADA, a plaintiff does not need a medical diagnosis, or the showing of medical necessity, or even a psychiatric evaluation.²³⁰ The broad legal definition lends itself to the view that disability

221. Cf. Rabia Belt & Doron Dorfman, *Reweighing Medical Civil Rights*, 72 STAN. L. REV. ONLINE 176, 184 (2020) (arguing that uninsured and poor trans people who cannot get diagnosed are left without antidiscrimination protection).

222. MARIAME KABA & ANDREA J. RITCHIE, NO MORE POLICE: A CASE FOR ABOLITION 140–41 (2022).

223. *Id.* at 147.

224. *Id.* at 156.

225. *Id.* at 164 (footnotes omitted).

226. See Barry et al., *supra* note 109, at 513, 580–81.

227. See Rhoda Olkin, *Conceptualizing Disability: Three Models of Disability*, AM. PSYCHIATRIC ASS’N (Mar. 29, 2022), <https://www.apa.org/ed/precollege/psychology-teacher-network/introductory-psychology/disability-models> [<https://perma.cc/R68U-S6QM>].

228. Survey Responses, *supra* note 32.

229. *Id.*

230. Again, the ADA defined disability as “(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.” 42 U.S.C. § 12102(1). The ADAAA “made it easier for plaintiffs to show that an impairment ‘substantially limits

is a protected characteristic rather than a protected class.²³¹ This characteristic is so broad that everyone could be protected—particularly under the “regarded as” prong—because we all have impairments of some form or another. Anyone who would be limited but for treatment is also protected. Being covered by ADA therefore should not be seen as stigmatizing. Rather, the ADA is a big step toward the Disability Justice future that advocates are striving for.

4. *The Role of the Courts.*—Finally, Lewis verbalized a distrust of the role courts might play in securing the rights of trans people. For Lewis, it did not matter if the Fourth Circuit case currently supplies favorable precedent; the courts, systemically, would never be the forum wherein we would achieve true liberation, so these are small, temporary gains.

I disagree. I think the courts do have some role to play in advancing justice.²³² Spade highlights “that most of the successful legal claims for trans equality have come through strategic use of the medical model of transsexuality.”²³³ But Spade cautions that the legal trans rights struggle “has been dominated by judicial decisions which would not recognize gender transition at all, and would not allow gender change no matter what medical evidence was presented.”²³⁴ So Lewis and Spade would agree that putting our faith in judicial institutions is short sighted.

But I don’t think the trans rights movement should stop there. Litigation is necessary for meeting the immediate medical needs of some of the most vulnerable people within our communities, including those in prison.²³⁵ An absolutist approach that (1) casts the entire legal profession as simply not radical enough to create the *ultimate* change we are seeking in a long-term liberatory queer trans revolution and therefore (2) dismisses any intervention we can make in the meantime neglects our actual, individual wins and erases our collective power in the movement for trans liberation.²³⁶

The work Lewis and I do is path-dependent, and I am far from content with the current conceptualization of GD in DSM-5, even if it has greatly improved since the 1990s. But if we want to contend with the hegemony of the heterosexist and cissexist social welfare system and the extremely punitive

one or more major life activities.” *Tesone v. Empire Mktg. Strategies*, 942 F.3d 979, 994–95 (10th Cir. 2019) (quoting 42 U.S.C. § 12102(1)(A)) (citing 29 C.F.R. §§ 1630.2(j)(1)(i), (iii)).

231. See *supra* note 230 and accompanying text. I thank Seran Gee for this language and this point.

232. See, e.g., Jules Lobel, *Courts as Forums for Protest*, 52 UCLA L. REV. 477, 483–90 (2004) (arguing that activists can bring litigation for public awareness, debate, and creating social change).

233. Spade, *supra* note 5, at 30.

234. *Id.*

235. See *id.* at 37.

236. See, e.g., Arkles et al., *supra* note 34, at 611 (“While agenda-setting by lawyers can lead to the replication of patterns of elitism and the reinforcement of systems of oppression, we *do* believe that legal work is a necessary and critical way to support movements for social justice. We must recognize the limitations of the legal system and learn to use that to the advantage of the oppressed.”).

criminal justice system, then we cannot simply fold.²³⁷ As I think about how we can be pragmatic about our role in supporting trans people who are suffering under state control, while facing the reality of the current legal landscape, I cannot fathom outright rejecting the ADA as a mechanism for positive change. Lawyers face an uphill battle for securing incarcerated trans people's medical needs through Eighth Amendment²³⁸ and ADA claims alike. And when the ADA standards are easier to meet than other potential constitutional claims, refusing to raise these arguments would be to the serious detriment of our clients.²³⁹

CONCLUSION

The APA ended the pathologization of trans gender identities. The ADA has not been modernized to align with this shift, so federal courts have determined whether GD is a qualifying disability. The courts overwhelmingly say it is. Even as I hold the counterarguments raised by my colleagues in this movement, I ultimately believe people with GD ought to allow ourselves to embrace the ADA. I think this is the call of the Disability Justice movement. Trans people *already are* part of the wonderfully diverse disabled community changing and growing together, moving forward.

We are far from our Disability Justice future that embraces total self-determination for all. For that precise reason, we are far from a world in which medical and legal involvement in trans lives is unnecessary. We must make our tools work for our communities because we want to preserve our trans lives and livelihoods. I plan to continue to do that for my clients for years to come.

237. Cf. Paul Butler, *The System Is Working the Way It Is Supposed To: The Limits of Criminal Justice Reform*, 104 GEO. L.J. 1419, 1425 (2016) (grappling with the tension that “[i]n some cases, . . . even short-term limited reform is better than the alternative of not disturbing the status quo” while “[a]t the same time, . . . attempts to reform the system might actually hinder the more substantial transformation American criminal justice needs”); *id.* at 1471 (“My suggestion, then, is not that the Movement for Black Lives abandon the law; rather, activists should have a coherent perspective about what the law can and cannot do in terms of achieving the movement’s ultimate goals.”).

238. See generally Dangan, *supra* note 9, at 178–84 (outlining the fraught legal landscape for Eighth Amendment claims for gender-affirming care).

239. See *supra* p. 239.

