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Bradley A. Areheart

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Disability Trouble

Bradley A. Areheart

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YALE LAW & POLICY REVIEW

Disability Trouble

Bradley A. Areheart*

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INTRODUCTION

Historically, disability has been seen as an essentially medical phenomenon. In particular, an individual's disability has typically been viewed as a personal, medical problem that requires an individualized, medical solution.¹ This viewpoint has been described as the medical model of disability ("medical model"), and it has long been the dominant paradigm for understanding disability in Western culture.²

To challenge the idea that disability is essentially medical and to emphasize its social construction, disability scholars coined and advanced the disablement/impairment binary ("disability binary").³ Within this binary, disablement is said to represent the socially constructed features of disability, while impairment denotes a disabled physiology.⁴ Yet, by relying on a dichotomy between social disablement and physiological impairment, the disability binary underscores the notion that disability has a natural, biological essence. Such a notion may stymie disability rights by reinforcing older, biologically determinist ways of thinking about disability.

Given that the disability binary now commands considerable theoretical attention in scholarly discussions of disability, it is appropriate and timely to critically reassess the disability binary's merits.⁵ The disability binary has received sparse critical attention, and no legal scholars have provided a systematic

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1. MARY JOHNSON, *MAKE THEM GO AWAY: CLINT EASTWOOD, CHRISTOPHER REEVE AND THE CASE AGAINST DISABILITY RIGHTS* 27 (2003).
 2. Bradley A. Areheart, *When Disability Isn't "Just Right": The Entrenchment of the Medical Model of Disability and the Goldilocks Dilemma*, 83 *IND. L.J.* 181, 185-87 (2008).
 3. See MICHAEL OLIVER, *POLITICS OF DISABLEMENT: A SOCIOLOGICAL APPROACH* 11 (1990) [hereinafter OLIVER, *POLITICS*] (distinguishing between impairment and disability) ("What is at stake here is the issue of causation, and whereas previous definitions were ultimately reducible to the individual and attributable to biological pathology, the [binary framework] locates the causes of disability squarely within society and social organization."); MICHAEL OLIVER, *UNDERSTANDING DISABILITY: FROM THEORY TO PRACTICE* 5, 28, 33, 35 (1996) [hereinafter OLIVER, *UNDERSTANDING DISABILITY*] (affirming the distinction between impairment and disability); see also TOM SHAKESPEARE, *DISABILITY RIGHTS AND WRONGS* 13 (2006) ("When the sociologist Michael Oliver became involved with social model theory in the early 1980s, the impairment/disability distinction was further reinforced at the core of the disability rights ideology.").
 4. OLIVER, *UNDERSTANDING DISABILITY*, *supra* note 3, at 35.
 5. Moira Gatens made a similar introductory observation about the gender/sex binary before proceeding to examine that binary's merits. MOIRA GATENS, *IMAGINARY BODIES: ETHICS, POWER AND CORPOREALITY* 4 (1996).

critique or examined the legal implications attendant to such a critique.⁶ The disability binary is thus ripe for more incisive examination.

While many legal articles have been focused on suggesting doctrinal changes to the Americans with Disabilities Act (ADA), this Article takes a step back to rethink the very meaning of disability. My thesis is that the “biological” impairment prong of the disability binary is itself socially constructed, and thus disability is more constructed than acknowledged to date. Accordingly, I make “disability trouble”—an allusion to Judith Butler’s *Gender Trouble*,⁷ which challenged the gender/sex binary of feminist scholarship—by questioning whether the disability binary is an accurate framework for understanding the meaning of disability. My argument proceeds as follows.

In Part I, I situate the disability binary within its scholarly context and identify the lack of legal scholarship that is critical of the social model of disability. I also explain why I have coined the term “disability trouble” to represent the result of my argument that impairment is socially constructed, and I clarify my use of certain disability terminology.

Part II offers a case for rethinking disability by paying particular attention to feminist work on the gender/sex binary. I first introduce the gender/sex binary and the feminist scholarship that emerged in its wake. I then explore the disability binary as an analogue to the gender/sex binary. To the extent that the two binaries are similar, feminist work on the gender/sex binary may be instructive and provide a roadmap for disability scholars attempting to rethink the disability binary.

In Part III, I argue that impairment, though theorized as biologically asocial, is indeed a social concept. I first explain why impairment is best understood as diagnosis. I then focus on two aspects of diagnosis—the creation of diagnoses and the acts of diagnosis—to show that specific impairments (ranging from sensory impairments to intellectual impairments to mental illnesses) have been, and continue to be, socially constructed in significant ways. In particular, I show how the very creation of diagnoses is often spurred along by political, social, and financial incentives. I also illustrate how the process of assigning a particular diagnosis to a particular individual is inseparable from

6. For critiques of the disability binary outside of the law literature, see generally SHAKESPEARE, *supra* note 3 (critiquing the social model); Shelley Tremain, *On the Government of Disability: Foucault, Power, and the Subject of Impairment*, in THE DISABILITY STUDIES READER 185 (Lennard J. Davis ed., 2d ed. 2006) (providing a Foucauldian critique of the term “impairment”); and the essays in DISABILITY/POSTMODERNITY (Mairian Corker & Tom Shakespeare eds., 2002).

7. JUDITH BUTLER, GENDER TROUBLE: FEMINISM AND THE SUBVERSION OF IDENTITY (2006) [hereinafter BUTLER, GENDER TROUBLE]. *Gender Trouble* was originally published in 1990, JUDITH BUTLER, GENDER TROUBLE: FEMINISM AND THE SUBVERSION OF IDENTITY (1990), and was republished as a Routledge classic in 2006. See also JUDITH BUTLER, UNDOING GENDER 42-43 (2004) [hereinafter BUTLER, UNDOING GENDER] (“[When] one refers to ‘gender trouble’ . . . one is . . . suggesting that gender has a way of moving beyond that naturalized binary.”).

certain social and interactional phenomena, meaning that end diagnoses are also socially constructed. Here, I contend that any allegedly biological root of impairment is contested and refracted by social interests.

Finally, in Part IV, I examine the various implications of making disability trouble. Understanding disability as having a substantially social origin leads naturally to the conclusion that society ought to take greater responsibility in combating disability discrimination. Such an understanding also has implications for health law policy and the recently amended ADA: A broad, shifting, and more constructed sense of disability invites certain normative outcomes, which might warrant law reform, stasis, or some combination of the two.

I. THE DISABILITY BINARY AND TERMINOLOGY

Disability has long been understood as a simple consequence of biology. Because this perspective encourages “biological determinism”⁸ and ignores the role of culture in disabling people, disability advocates developed the social model of disability (“social model”) as a response. The social model has been called the “the big idea” of the disability movement.⁹ It reframed disability as being in part a social construct by distinguishing social disablement from physiological impairment.¹⁰ Disablement—in contrast to impairment—was “all the things that impose restrictions on disabled people; ranging from individual prejudice to institutional discrimination, from inaccessible public buildings to

8. My use of the term “biological determinism” is intended to denote the idea that our genetic makeup determines and makes inevitable our development as people with certain traits and opportunities.

9. SHAKESPEARE, *supra* note 3, at 29.

10. A key moment in the social model’s intellectual and political history occurred in 1976, when the Union of the Physically Impaired Against Segregation (UPIAS) published its *Fundamental Principles of Disability*. UPIAS’s differentiation between impairment and disability would later form the basis of what Michael Oliver coined “the social model of disability.” UNION OF THE PHYSICALLY IMPAIRED AGAINST SEGREGATION (UPIAS), *FUNDAMENTAL PRINCIPLES OF DISABILITY* (1976); see OLIVER, *UNDERSTANDING DISABILITY*, *supra* note 3, at 1-2 (“I should say at this point that the original simple idea underpinning my work was not my original idea but was an idea that I came across in encountering *Fundamental Principles of Disability* for the first time.” (citation omitted)); *id.* at 28 (affirming the impairment/disability distinction in *Fundamental Principles of Disability* as being “valid to this day”); see also Tom Shakespeare, *The Social Model of Disability*, in *THE DISABILITY STUDIES READER*, *supra* note 6, at 197, 197 (“While the problems of disabled people have been explained historically in terms of divine punishment, karma or moral failing, and post-Enlightenment in terms of biological deficit, the disability movement has focused attention onto social oppression, cultural discourse, and environmental barriers.”); *id.* at 198-99 (explaining that the “redefinition of disability itself” is what sets the social model apart from other socio-political approaches to disability).

unusable transport systems, from segregated education to excluding work arrangements, and so on.”¹¹

Separating disability into its biological and social components has thus been the linchpin for a social model of disability.¹² Indeed, Michael Oliver, who is widely credited with formalizing and establishing the social model in Western academia,¹³ emphasized disability’s social nature precisely by distinguishing disablement from impairment.¹⁴ He explained that disablement has “nothing to do with the body.”¹⁵ Impairment, however, is “nothing less than a description of the physical body.”¹⁶ Oliver thus used the disability binary to emphasize the

11. OLIVER, UNDERSTANDING DISABILITY, *supra* note 3, at 33. One of the most common illustrations for understanding disability as a social construct are the architectural barriers faced by wheelchair users. Adam Samaha has stated: “It is one thing to be unable to walk. It is quite another matter to be unable to enter a building unassisted because the architect preferred stairs to ramps.” Adam Samaha, *What Good Is the Social Model of Disability?*, 74 U. CHI. L. REV. 1251, 1258-59 (2007). In such a situation, a person is disabled—or made to feel disabled—at least in part by factors outside of the person’s own body. Such factors may, under the social model, include physical, institutional, and attitudinal barriers. Areheart, *supra* note 2, at 188.

Tom Shakespeare has explained that one key to understanding the social model is viewing it as a series of dichotomies: impairment is distinguished from disability (or what I call “disablement,” *see infra* note 41), thereby creating the disability binary; the social model is distinguished from the medical model of disability; and disabled people are distinguished from non-disabled people. Shakespeare, *supra* note 10, at 198-99. Furthermore, under the disability binary, impairment is individual and private, while disablement is structural and public. *Id.* at 198. In this way, impairment might be seen as a remnant of the medical model of disability, a paradigm that historically has focused on the impact of an individual’s own physical or mental impairments rather than on factors that reside outside of the person’s body.

12. COLIN BARNES & GEOFF MERCER, DISABILITY 65 (2003); MARK RAPLEY, THE SOCIAL CONSTRUCTION OF INTELLECTUAL DISABILITY 62 (2004) (noting that the “fractioning of a monolithic ‘disability’ into notions of a (physical or mental) *impairment*, with concomitant *disability* caused by social barriers” is “central” to the social model).

13. Samaha, *supra* note 11, at 1251-52 (noting that although the social model’s causation story has been around since the 1970s, it was Michael Oliver who launched the social model in Western academia in 1990); *see also* RAPLEY, *supra* note 12, at 62 (“[T]he social model as a formal statement of social scientific theory is usually held to originate in the work of Mike Oliver . . .”).

14. *See supra* note 3.

15. OLIVER, UNDERSTANDING DISABILITY, *supra* note 3, at 35.

16. *Id.*

constructed nature of disability. The disability binary has since been considered key to the social model.¹⁷

The social model's constructionist account offers several benefits for disability advocates: (1) It dispels uncritical assumptions that a disadvantage resulting from disability is natural or necessary;¹⁸ (2) it explains how social conditions contribute to disability disadvantage (which implies that such disadvantage can be changed through political struggle);¹⁹ and (3) it liberates disabled persons by shifting the attention from an individual's physical or mental deficits to the ways in which society includes or excludes them.²⁰ The social model has been discussed widely both as it pertains to the meaning of disability and as a justification for certain policy and legal prescriptions, and it has become a fixture in legal disability scholarship.²¹

One major drawback of the social model is that it has not been substantially developed, revised, or rethought since the 1970s.²² Other social movement ideologies such as feminism have developed and transformed substantially over

17. *Id.* at 28 (noting that the disability binary “remains valid to this day”); RAPLEY, *supra* note 12, at 62; Samaha, *supra* note 11, at 1257 (“Key to the social model is a distinction between personal impairments and disability.”).

18. Samaha, *supra* note 11, at 1253.

19. *Id.* at 1255; *see also* SHAKESPEARE, *supra* note 3, at 30.

20. SHAKESPEARE, *supra* note 3, at 29-30.

21. Samaha, *supra* note 11, at 1268 (noting that Mary Crossley “helped import the social model into legal scholarship”); *see* Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 653-59 (1999) [hereinafter Crossley, *Disability Kaleidoscope*]; *see also* Carlos A. Ball, *Looking for Theory in All the Rights Places: Feminist and Communitarian Elements of Disability Discrimination Law*, 66 OHIO ST. L.J. 105, 130-31 (2005) (noting that the social model defines disability as a social construct and that this viewpoint has become “quite pervasive in the legal academic literature”); Mary Crossley, *Reasonable Accommodation as Part and Parcel of the Antidiscrimination Project*, 35 RUTGERS L.J. 861, 875-77 (2004) [hereinafter Crossley, *Reasonable Accommodation*] (noting that work on the social model “has gained the attention of the legal academy”).

22. SHAKESPEARE, *supra* note 3, at 33-34; *see also* Mairian Corker & Tom Shakespeare, *Mapping the Terrain, in* DISABILITY/POSTMODERNITY, *supra* note 6, at 1 (noting that disability studies have “suffered from a theoretical deficit”); Shakespeare, *supra* note 10, at 199 (“Many leading advocates of the social model approach maintain that the essential insights developed by UPIAS in the 1970s still remain accurate and valid three decades later.”); *id.* at 202 (“While acknowledging the benefits of the social model in launching the disability movement, promoting a positive disability identity, and mandating civil rights legislation and barrier removal, it is my belief that the social model has now become a barrier to further progress.”).

time—responding to criticism and changing circumstances.²³ But social disability theory has clung to a strict reading of its founding assumptions.²⁴

One possible explanation for this lack of criticality is that disability has been theorized largely by advocates.²⁵ The social model, for example, was forged by disability rights advocates with policy preferences already in mind.²⁶ It provided intellectual justification for the predetermined goals of the disability rights movement.²⁷ Later, as leaders of the disability rights movement became academics, “the social model became an intellectual export. It moved from interest group device to scholar’s tool.”²⁸ Adam Samaha similarly shows that the terms of the social model have found their way into legal scholarship, often accompanied by the uncritical and misguided assumption that the social model necessarily has normative consequences.²⁹ Indeed, most legal scholars have not been critical of the social science literature on disability, simply citing the social model as implicit support for policy and legal positions.³⁰ Legal scholars have

23. SHAKESPEARE, *supra* note 3, at 33-34.

24. *Id.* at 34.

25. *See infra* notes 26-28.

26. Samaha, *supra* note 11, at 1254 (noting that disability rights advocates forged the social model “alongside a political platform”); *id.* at 1255 (“[T]he social model was generated within a disability rights movement with policy objectives.”); *id.* at 1280-82 (“Similar notions were percolating elsewhere, but a social model of disability was driven to the forefront by a movement of disabled people dissatisfied with existing institutions and policies. Participants sought to define disability, and thus the movement, in accord with their experience and objectives. . . . Given this history, it is not surprising that original proponents of the social model supported social reconstruction to ameliorate disadvantage. This goal was the inspiration for the model in the first place.” (footnote omitted)).

27. *Id.* at 1282 (noting that the social model was “an accoutrement” to the disability rights movement); *id.* at 1269 (noting that the regular connection between the social model and policy “might follow from affiliation with the disability rights movement”).

28. *Id.* at 1283 (footnote omitted).

29. *See id.* at 1267-69 (noting that legal scholars have regularly and mistakenly claimed that the social model provides a normative basis for making disability policy).

30. *See id.* at 1267 (noting that in the law literature, “prescriptions for environmental restructuring regularly follow discussions of the social model”); *id.* at 1278 (arguing that, in spite of such literature, the social model provides no normative basis for judgment and policymaking); *see also* Michael Ashley Stein, *Disability Human Rights*, 95 CALIF. L. REV. 75, 91-93 (2007) (noting several limitations of the social model).

certainly written about the social model, and have taken account of its centrality to disability scholarship,³¹ but few have been critical of the social model.³²

While the social model has provided a useful vocabulary for theorizing disability, its terms merit greater scrutiny. The social model—by relying on a binary division between social disablement and physiological impairment—unwittingly underscores the notion that disability has a biological essence. In other words, although the social model was formulated to indicate disability’s constructed nature, it inadvertently reifies the idea that disability is built in part upon non-social, biological, and essential facts.³³ Part III will examine whether disability is rightly seen (through the lens of the disability binary) as being predicated upon an essentially biological foundation.

In this Article, I argue that impairment is actually substantially socially constructed and thereby make “disability trouble.” I have coined this phrase as an allusion to Judith Butler’s *Gender Trouble*,³⁴ a seminal contribution to feminist scholarship that challenged the gender/sex binary.³⁵ The gender/sex binary

31. See *supra* note 21. Even where U.S. scholars have not expressly adopted the social model, “the overarching orientation” of U.S. disability scholars is “social and cultural, not medical or individualist.” SHAKESPEARE, *supra* note 3, at 25.

32. See Samaha, *supra* note 11, at 1253 (arguing that legal scholars have failed to question the social model). Adam Samaha’s article on the social model suggests that one explanation for the lack of critical work on the social model by legal scholars: their apparent belief that the model necessarily entails a normative orientation. *Id.* at 1267–68. The social model may thus have a “herding” effect on scholars analyzing disability. *Id.* at 1269.

To be fair, at least some critical scholarship on disability has recently come from within the legal academy, with legal scholars questioning the normative meaning of disability and analyzing models of disability previously resident within the humanities. See Areheart, *supra* note 2 (writing on the entrenchment of the medical model of disability in the media and federal court jurisprudence); Samaha, *supra* note 11 (arguing that the social model of disability is, properly understood, addressed toward causation and has no necessary normative implications); Michael Ashley Stein & Penelope J.S. Stein, *Beyond Disability Civil Rights*, 58 HASTINGS L.J. 1203 (2006) (arguing for a disability human rights paradigm). Still, this work is young and far from developed. RAPLEY, *supra* note 12, at 66 (noting the limits of early “second wave” approaches).

33. RAPLEY, *supra* note 12, at 66 (noting that impairment and disablement, under the social model, are paradoxically “reified as structurally given things”). In this way, impairment might be seen as a remnant of the medical model of disability, which posits biology as an essential characteristic of the disabled individual. *Id.*

34. See *supra* note 7.

35. Toril Moi notes that Butler’s scholarship, including *Gender Trouble*, was “by far the most important work on sex and gender in the 1990s.” TORIL MOI, *What is a Woman?*, in *WHAT IS A WOMAN? AND OTHER ESSAYS* 3, 45 (2001); see also ALISON STONE, *AN INTRODUCTION TO FEMINIST PHILOSOPHY* 61 (2007) (“[Butler’s] *Gender Trouble* . . . is one of the most important and influential books in contemporary feminist philosophy.”).

states that sex is physiological, while gender is socially constructed.³⁶ One of Butler's concerns was that the gender/sex binary, by effectively designating sex as non-social, left room for biological determinism.³⁷ I am similarly concerned that the disability binary, by designating impairment as non-social, has left room for biological essentialism. Accordingly, I seek to make disability trouble by suggesting that (1) the meaning of disability is not fixed and has a way of transcending the disablement/impairment binary; and (2) disability is more social and less biologically laden than previously theorized.³⁸

I am not invoking Butler's popular theory that gender is performative by, for example, building a case that disablement is merely a stylized repetition of acts that, over time, produce the appearance of substance.³⁹ My argument instead focuses on appropriating Butler's claim that biological sex is just as culturally constructed as social gender, and applying it to the disability context.⁴⁰ Just as gender trouble became a rallying cry for scholars seeking to rethink sex and gender, it is my hope that disability trouble evokes and invites new ideas about the meaning of disability.

Before proceeding, it bears noting that while many social model theorists use the term "disability" instead of "disablement" to refer to disability that is socially constructed, I have used "disablement" for two reasons. First, this is the term used most often by Michael Oliver, who formalized and popularized the disability binary within disability studies. Second, there is an analytic benefit to using "disablement" to denote disability that is constructed socially: Doing so preserves "disability" as a holistic term that encompasses both impairment and disablement. In other words, using "disablement" to refer to the socially constructed component of the disability binary avoids confusion over whether "disability" is being discussed generally or as part of a dichotomy. Here, I have endeavored to use "disability" exclusively as a non-dichotomous, holistic term. However, it is important to note that many of my sources equivocally use "disability" as both a holistic term and as the dichotomous counterpart to "impairment" within the disability binary.⁴¹

36. STONE, *supra* note 35, at 30-34.

37. BUTLER, GENDER TROUBLE, *supra* note 7, at 9 ("The presumption of a binary gender system implicitly retains the belief in a mimetic relation of gender to sex whereby gender mirrors sex or is otherwise restricted by it.").

38. This use of "disability trouble" parallels Judith Butler's use of the phrase "gender trouble." BUTLER, UNDOING GENDER, *supra* note 7, at 42-43 ("[When] one refers to 'gender trouble' . . . one is . . . suggesting that gender has a way of moving beyond [the] naturalized [gender/sex] binary.").

39. BUTLER, GENDER TROUBLE, *supra* note 7, at 45.

40. *Id.* at 9-10.

41. It is thus imperative to discern how such scholars are using the term "disability" in order to avoid confusion.

II. THE GENDER/SEX BINARY AS ANALOGUE

The disability and gender/sex binaries have intuitive similarities, and to the extent that the binaries are analogous to each other, feminist work on the gender/sex binary may be instructive for disability scholars attempting to rethink the disability binary.⁴² Before evaluating the strength of the analogy, however, it may be useful to first examine feminist scholarship on the gender/sex binary.⁴³ In particular, recalling the gender/sex binary's trajectory over the last forty years may help chart a path for future disability scholarship.⁴⁴

Though many people use "sex" and "gender" interchangeably, feminists have distinguished between the terms since the late 1960s,⁴⁵ when they appropriated the term "gender" to emphasize the socially constructed nature of sex and counter the viewpoint that biology is destiny.⁴⁶ This distinction made theoretical sense for psychologists attempting to explain transsexuality.⁴⁷ Feminists also found the distinction useful since it allowed them to argue that perceptions

42. A few disability scholars have previously noted the connection between the gender/sex and disability binaries, but without much examination. See Samaha, *supra* note 11, at 1257 (noting this connection in passing); Shelley Tremain, *On the Subject of Impairment*, in *DISABILITY/POSTMODERNITY*, *supra* note 6, at 32, 41 (same).

43. For scholarly exposition on the gender/sex binary within the law literature, see, for example, Mary Anne C. Case, *Disaggregating Gender from Sex and Sexual Orientation: The Effeminate Man in the Law and Feminist Jurisprudence*, 105 *YALE L.J.* 1 (1995); Katherine M. Franke, *The Central Mistake of Sex Discrimination Law: The Disaggregation of Sex from Gender*, 144 *U. PA. L. REV.* 1 (1995).

44. Rosemarie Garland-Thomson has lamented that many disability scholars are unversed in the related critical enterprises that have come before. Rosemarie Garland-Thomson, *Integrating Disability, Transforming Feminist Theory*, in *THE DISABILITY STUDIES READER*, *supra* note 6, at 257, 257. She notes that women's studies and race studies established a model in the academy for identity-based scholarship. *Id.* She observes, however, that disability scholars' general lack of knowledge of related disciplines has led to "a great deal of wheel reinventing." *Id.*

This work picks up on that critical observation. In particular, advances in feminist thought may well offer insights for disability given the intuitive similarities between certain aspects of feminist and disability scholarship.

45. *MOI*, *supra* note 35, at 3; *STONE*, *supra* note 35, at 31; Case, *supra* note 43, at 2 (noting that "the two terms have long had distinct meanings, with gender being to sex what masculine and feminine are to male and female").

46. *MOI*, *supra* note 35, at 5; Mari Mikkola, *Feminist Perspectives on Sex and Gender*, *STANFORD ENCYCLOPEDIA OF PHILOSOPHY* (2008), <http://plato.stanford.edu/archives/fall2008/entries/feminism-gender/>.

47. Mikkola, *supra* note 46. The gender/sex distinction achieved traction with the publication of Robert J. Stoller's book, *Sex and Gender*, in 1968. *GATENS*, *supra* note 5, at 5. Stoller's work instantly medicalized sex and situated gender as a purely psychological category. *MOI*, *supra* note 35, at 22-23.

and expectations of women are socially produced and thus subject to change.⁴⁸ The resulting insight was that one's biological sex does not determine one's social gender.⁴⁹

In 1990, however, Judith Butler made "gender trouble" by leading a chorus of feminist scholars who questioned and criticized the gender/sex binary.⁵⁰ Many questioned whether sex and gender were distinct in the first place, with some focusing on whether sex classification was solely a question of biology,⁵¹ and others focusing on whether gender was only social.⁵² In the wake of these deconstructive efforts, some feminists attempted to reconstruct what it meant to be a woman.⁵³ Such critiques not only enriched feminist thought on human

48. STONE, *supra* note 35, at 56; Mikkola, *supra* note 46. Feminists quickly seized upon Robert Stoller's work since it seemed to offer a "theoretical justification for the right to equality for all independently of sex." GATENS, *supra* note 5, at 6-7; see MOI, *supra* note 35, at 22-23 (noting that Stoller's ideas in *Sex and Gender* "were quickly appropriated by feminists").

49. STONE, *supra* note 35, at 31 ("[Feminists] valued the [sex/gender] distinction because it implied that gender expectations and ideas are products of culture and society, and so can be changed. This challenged the view, widely held at that time, that women's and men's biology causes them to have the social positions and statuses that they do."). Stone explains,

We can now be more precise about what it means to say that sex does not determine gender. Namely, when people form particular ideas about gender, or behave in typically masculine or feminine ways, or understand themselves as masculine or feminine, none of these activities is caused by features of those individuals' biology such as their hormone levels.

Id. at 34.

50. See MOI, *supra* note 35, at 3 (noting that from the late 1980s to the late 1990s, the gender/sex binary was subjected to "merciless critique" by Butler, Donna Haraway, and other poststructuralist theorists of sex and gender).

51. See *infra* Part III (canvassing feminists' resistance to the claim that sex is solely biological); see also ANNE FAUSTO-STERLING, MYTHS OF GENDER: BIOLOGICAL THEORIES ABOUT WOMEN AND MEN (1985) (analyzing scientific claims about women and men); GATENS, *supra* note 5, at 3-17 (questioning whether sex may be understood without reference to "imaginary bodies," meaning socially constructed notions of the body).

52. See, e.g., GATENS, *supra* note 5, at 13-14 (arguing that gender has an "intimate relation to biology-as-lived in a social and historical context"); MOI, *supra* note 35, at 29 ("To deny that biology grounds social norms is to deny that our sexed bodies produce *any* gender norms in whatever context."); RAIJA PROKHOVNIK, RATIONAL WOMAN: A FEMINIST CRITIQUE OF DICHOTOMY 138-41 (Manchester University Press 2002) (1999) (arguing that gender roles issue directly from biologically sexed bodies).

53. See, e.g., LINDA MARTIN ALCOFF, VISIBLE IDENTITIES: RACE, GENDER, AND THE SELF 148 (2006) (arguing that gender is "a position one occupies and from which one can act politically"); Sally Haslanger, *Future Genders? Future Races?*, 34 ANN. PROC. CENTER FOR PHILOSOPHIC EXCHANGE 4, 6-7 (2004) (arguing that gender is

sexuality, but also catalyzed civil rights through a resulting expansion of legal protections. One legal innovation to poststructural work on the gender/sex binary was four generations of sex stereotyping jurisprudence,⁵⁴ each of which was, as explained by Mary Anne Case, effectuated by a gradual expansion of Title VII to protect various permutations of gender and sex.⁵⁵ Work on the gender/sex binary has been “fundamental to the development of feminist thought.”⁵⁶

With this abbreviated history as a preface, it is now appropriate to consider whether the disability binary is similar enough to the gender/sex binary to glean insights from feminist criticisms and developments of the gender/sex binary. Is the disability binary much like the gender/sex binary and thus in a position to glean from prior feminist insights? Or is disability sufficiently different that disability theory should chart its own path?

Both sex and impairment have historically been seen as mere questions of biology. In this context, gender and disablement were terms fashioned by advocates with political objectives in mind and for similar purposes: to counter biological determinism and secure the civil rights of women and people with disabilities.⁵⁷ Indeed, the binaries present a natural parallel. Sex is much like impairment, with both terms said to represent biological traits. Similarly, gender is like disablement, with both terms representing socially constructed traits.⁵⁸

Moving beyond these more obvious parallels, the biological component of each binary has particular salience in a way that has little import for other identity groups (including those based on race or national origin). Generally

a matter of occupying either a subordinate or a privileged social position); Natalie Stoljar, *Essence, Identity and the Concept of Woman*, 23 *PHILOSOPHICAL TOPICS* 261, 283-84 (1995) (identifying four clusters that help organize the concept of “woman”).

54. Case, *supra* note 43, at 37-41.

55. See *id.* at 37 (“The [U.S. Supreme] Court, as it was faced with increasingly subtle and complex barriers to the equality of the sexes, has gradually broadened its conception of impermissible sex stereotyping, lumping together under the same general heading several related but conceptually distinguishable phenomena.”).

56. STONE, *supra* note 35, at 30.

57. See SHAKESPEARE, *supra* note 3, at 29 (“The redefinition of disability in the social model parallels the feminist movement’s redefinition of women’s experience in the early 1970s.”); Samaha, *supra* note 11, at 1280-82 (arguing that the terms of the social model were fashioned by disability advocates with policy objectives in mind).

58. None of the analysis comparing the gender/sex and disability binaries (and, at some level, women and disability) is intended to obscure the intersectional fact that these concepts are interrelated for women with disabilities. Scholarship at the intersection of disability and women is emerging and making a valuable contribution to understanding disability. See, e.g., *GENDERING DISABILITY* (Bonnie G. Smith & Beth Hutchinson eds., 2004).

speaking, some biological characteristics act as impediments to equality and must be accounted for when crafting policy.⁵⁹ Such characteristics are uniquely present in both women and people with disabilities. For example, feminists have accounted for women's biological capacity to bear children via the Pregnancy Discrimination Act,⁶⁰ and disability advocates have accounted for disabled physiology via the ADA's access and accommodation requirements.⁶¹

Interestingly, different legal treatment may both further and hinder equality. Taking account of biological differences can help foster equality of opportunity. However, given many Americans' strong ideological bent toward formal equality, differential treatment is often perceived as special treatment. And such treatment can birth or sustain stereotypes that militate against genuine equality. This is a distinct challenge shared by both women and people with disabilities.

Despite their many similarities, there are a few differences between the binaries worth noting. First, there may be a difference in the types of barriers identified by advocates. In particular, some have argued that while nothing is intrinsically problematic about being a woman—remove social discrimination and most females will flourish—the barriers disabled people face are more complex.⁶² Such barriers are said to involve both discrimination and some measure of intrinsic limitations.⁶³ As an example, some limitations would exist for a visually impaired person even if all physical, institutional, and attitudinal barriers could be eliminated. The limited ability to see would persist and limit that individual's capacity to function in a world where most people have more sight.

Yet this argument underestimates the intrinsic barriers women face. Women have *some* limitations built into their physical stature. Most of these have to do with physical strength and size, but there are also myriad contingencies associated with the capacity to reproduce. Thus, while there may be some differences between the barriers faced by women and people with disabilities, the difference is less pronounced than has been acknowledged.

A second difference is that while gender may be chosen, disablement is rarely volitional. Feminists have championed the claim that sex does not determine gender; one may choose a gender that does not conform to traditional sex

59. In other words, the law must sometimes treat people differently to achieve equality. See, for example, Jessica L. Roberts, *An Area of Refuge: Due Process Analysis and Emergency Evacuation for People with Disabilities*, 13 VA. J. SOC. POL'Y & L. 127 (2005), for an analysis of equal protection jurisprudence for people with disabilities.

60. Pregnancy Discrimination Act of 1978, 42 U.S.C. § 2000e(k) (2006).

61. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended at 42 U.S.C. §§ 12101-213 (2006 & Supp. 2010)).

62. *E.g.*, Shakespeare, *supra* note 10, at 202.

63. *Id.*

roles.⁶⁴ The matter of escaping biology is not simple in the context of either binary, but volition is a particularly complex phenomenon for disabled persons. While one diagnosed with a debilitating disease may choose her/his attitude in internalizing a condition, some impairments seem unavoidably disabling.

Third, the gender/sex binary has a certain neutrality that is absent for the disability binary in that the gender/sex binary refers to ways of identifying a person, whereas the disability binary refers to ways in which a person is limited or impaired. Here, the word “impairment” has a particularly negative connotation that its counterpart in the analogy (“sex”) does not have. While the disability binary does seem less culturally neutral than the gender/sex binary, both binaries still represent efforts to describe or characterize groups of people.

Although differences between the two binaries and their constituents do exist, the binaries are still sufficiently similar to merit comparison. The most important elements of the analogy between the disability and gender/sex binaries still hold: (1) Each binary is predicated on a nature/culture split wherein one component of the binary represents that which is natural and biological and the other represents that which is socially constructed; and (2) each binary was fashioned to further the same objective—illuminating the socially constructed nature of what it means to be a woman, in the case of the gender/sex binary, or disabled, in the case of the disability binary. In sum, the disability binary is sufficiently like the gender/sex binary to warrant examination into areas that feminists have tread.

III. DISABILITY TROUBLE: THE CONSTRUCTION OF IMPAIRMENT

As noted above, feminists took various approaches to troubling the gender/sex binary.⁶⁵ Analogizing from these contributions, there are at least three questions one might ask in troubling the disability binary: (1) is impairment only biological?; (2) is disablement only social?; and (3) if the disability binary is rejected as an inadequate construct for understanding disability, how might we better reconstruct the meaning of disability? Because the meaning of impairment has been undertheorized,⁶⁶ and because the meaning of impairment also

64. E.g., BUTLER, *GENDER TROUBLE*, *supra* note 7, at 9 (“When the constructed status of gender is theorized as radically independent of sex, gender itself becomes a free-floating artifice, with the consequence that *man* and *masculine* might just as easily signify a female body as a male one, and *woman* and *feminine* a male body as easily as a female one.”).

65. See *supra* notes 50-53 and accompanying text.

66. While social modelists have focused on the meaning of disablement, impairment has been sorely neglected. BARNES & MERCER, *supra* note 12, at 67; Carol Thomas & Mairian Corker, *A Journey Around the Social Model*, in *DISABILITY/POSTMODERNITY*, *supra* note 6, at 18, 24; see also Dan Goodley & Mark Rapley, *Changing the Subject: Postmodernity and People with ‘Learning Difficulties’*, in *DISABILITY/POSTMODERNITY*, *supra* note 6, at 127, 139 (noting that “impairment is up for grabs in the discursive world”). One reason for this neglect is obvious: The

affects the answers to the second and third questions, I limit my analysis in this Article to the first question.

In the context of the gender/sex binary, feminists similarly questioned whether sex was only biological;⁶⁷ they were concerned that the sex component of the binary indicated there was an underlying biological essence associated with being a woman.⁶⁸ To rebut this inference, feminists took various approaches. Butler discussed “girling,” the stylized reiteration that one is a “girl” by various authorities at various points in a person’s life to reinforce the “naturalized effect” of sex.⁶⁹ Some scholars similarly argued strict sexual dimorphism could be seen as a contemporary phenomenon.⁷⁰ Others explored how biological processes unique to women may be so severely colored by medical interventions, as well as social preconceptions, that it is impossible to disaggregate biology from sociology or intelligibly claim that sex precedes gender.⁷¹ Additionally, scholars noted that gendered habits and traits relating to diet, stress, and activity can alter hormone levels and at least some sex characteristics.⁷² Feminists

social model was expressly formulated to address social disablement, which was merely contrasted with physiological impairment. Indeed, Oliver expressed his belief that a theory of impairment should be developed separately from a theory of disablement. OLIVER, *UNDERSTANDING DISABILITY*, *supra* note 3, at 42. While some disability scholars have recently focused on impairment as an important aspect of a disabled person’s phenomenology, my project is different and more theoretical: I explore impairment as a product of diagnosis to show how impairment—traditionally understood as the objectively biological component of disability—is still often socially constructed.

67. Mikkola, *supra* note 46.

68. *Id.*

69. JUDITH BUTLER, *BODIES THAT MATTER: ON THE DISCURSIVE LIMITS OF “SEX”* 7-8 (1993).

70. See PROKHOVNIK, *supra* note 52, at 131 (arguing that strict sexual dimorphism “was consolidated only in the twentieth century with the entrenchment of a biological notion of a natural sex difference based on the presence of X and Y chromosomes, which was taken as providing explanatory force”). The point advanced by scholars like Prokhovnik is not that, historically, there was no distinction between males and females, but rather that the biological distinctions that existed were more varied and less militantly enforced. *Id.* at 130-32; see also Case, *supra* note 43, at 15 n.35 (explaining that chromosomal taxonomy has complicated sexual dimorphism in recent years).

71. See, e.g., PROKHOVNIK, *supra* note 52, at 130 (“The physiological dimension of sex is not isolable from the network of social conventions and practices which influence the meaning of sex.”); *id.* at 135 (explaining how natural drives—such as motherhood and sexuality—are mediated through social practices).

72. See e.g., STONE, *supra* note 35, at 35 (noting research that suggests sexual dimorphism is exaggerated in western industrial societies due to social forces and mating practices); *id.* at 80 (noting that exercise may reduce the size of female

resisted the idea that sex is non-social in part because social forces affect biology and medical disciplines (which, in turn, claim to speak authoritatively about biology).

Returning to the disability framework, is impairment solely biological? Put another way, is impairment devoid of social input? Oliver and other social modelists like him would seem to answer this question in the affirmative. As Oliver stated, impairment is “nothing less than a description of the [disabled person’s] physical body.”⁷³ Contemporary disability scholars have consistently recognized that this biology-centered definition of impairment is fundamental to the social model.⁷⁴ Such a definition of impairment raises the critical question of who is disabled in the first place. What or who determines whether someone is disabled?

A. *Impairment as Diagnosis*

In answering the question of how a person comes to be considered disabled, the issue of diagnosis immediately emerges since the disabled person’s body is described as impaired principally through medical diagnoses. Diagnosis is a core element for structuring and understanding disability. Indeed, without diagnoses, many disabilities would not be understood as such by either the person diagnosed or by others. Moreover, most disabled persons interface with medical professionals who diagnose them throughout their lives, whereas sex and diagnosis typically converge only at the time of birth (when the sex of a child is pronounced by medical professionals). And medical diagnoses are often difficult to escape, given that medical (and especially psychiatric) records seem to have unusually long shelf lives.⁷⁵ In short, impairments, understood as the physical traits associated with disabilities, seem to be little more than diagnosis. Thus, in answering the question of how a person comes to be considered disabled, we may pose a second, closely related question: Is the diagnosis of impairments based solely on biology?

breasts and hips or male gonads, and that diet may cause children to start puberty early or cause women to stop menstruating altogether).

73. OLIVER, UNDERSTANDING DISABILITY, *supra* note 3, at 35.

74. Areheart, *supra* note 2, at 188 (identifying the impairment/disablement distinction as foundational to the social model); Crossley, *Disability Kaleidoscope*, *supra* note 21, at 657 (contrasting “bodily impairments” with “disability” under the social model); Shakespeare, *supra* note 10, at 197 (noting the dichotomy between biological impairment and social disability as key to the social model).

75. In *Madness, Distress, and Postmodernity*, Anne Wilson and Peter Beresford document their status as “psychiatric system survivors” and demonstrate how medical and psychiatric records may restrict future life opportunities, understandings, and rights. Anne Wilson & Peter Beresford, *Madness, Distress and Postmodernity: Putting the Record Straight*, in DISABILITY/POSTMODERNITY, *supra* note 6, at 143.

My argument in this Part is that diagnosis involves more than non-social biology. Rather, diagnosis is a social concept in at least two tangible ways. First, acceptable categories of diagnoses are created by a variety of non-medical factors and take form as interested parties interact. The very existence of many impairments is thus largely contingent upon political and social factors. Second, the actual process of diagnosing an individual includes various social inputs that assist the medical professional in concluding that a person has a particular impairment. Examining the creation of diagnoses and the acts of diagnosis through the lens of specific impairments illuminates the constructed and contested nature of impairment.

In one sense, the claim that impairment is socially constructed may be seen as a tautology, a particularized restatement of the idea that every aspect of a person's identity is constructed and shaped by culture.⁷⁶ This often leads to poststructural scholarship on the body that reaches "fantastic levels of abstraction" without discussing the specific ways in which the body is politically and historically situated.⁷⁷ My argument is not so general: I am not simply interested in proving that the impaired body *is* produced, but also in: (1) showing *how* the impaired body is produced; and (2) identifying the interests served by its production. To do so, I focus on the role of social factors, which influence both the very creation of particular diagnoses as well as whether people are classified as possessing those particular diagnoses.⁷⁸

While it is arguably possible to separate raw biology from its cultural accoutrements,⁷⁹ biology is most salient when understood through its social lens. The idea that socially constructed things are not real (and, therefore, that it is necessary to preserve some sense of non-social biology) is merely a red herring: The physical body, inseparable from the trappings of culture, is most real and worthy of consideration as a whole. This Article thus creates disability trouble by building a case against the presumption of a raw, "unadulterated biological core."⁸⁰ As explored below, the acts of creating and applying diagnoses, ubiquitous in describing biological symptoms, are "always contingent upon social factors."⁸¹ Any "biological core" is thus always already adulterated.⁸²

76. Charles E. Rosenberg, *Introduction*, in *FRAMING DISEASE: STUDIES IN CULTURAL HISTORY*, at xiii, xiv (Charles E. Rosenberg & Janet Golden eds., 1997).

77. *MOI*, *supra* note 35, at 31, 52.

78. See ROBERT A. ARONOWITZ, *MAKING SENSE OF ILLNESS: SCIENCE, SOCIETY, AND DISEASE* 176 (1998).

79. See IAN HACKING, *THE SOCIAL CONSTRUCTION OF WHAT?* (1999).

80. ARONOWITZ, *supra* note 78, at 171.

81. *Id.*

82. Cf. BUTLER, *GENDER TROUBLE*, *supra* note 7, at 9-10 (suggesting that sex "was always already gender").

B. *The Creation of Diagnoses*

It may be tempting to assume that diagnoses are divined from nature, that they are a “self-evident reflection of biological and epidemiological facts.”⁸³ Indeed, this seems to be the default, unreflective view. Yet, in a very real sense, an impairment does not exist until we agree that it does—until it is created.⁸⁴ For example, a child who 100 years ago might have been described as a “bad student” might today be described as having dyscalculia (a learning disorder associated with comprehending mathematics) or dysgraphia (a deficiency in the ability to write). Similarly, a person who at one time might have been seen as a “glutton” might now be understood as having bulimia nervosa. Such diagnoses thus exist as a confluence of both biological and cultural factors. Despite the modern tendency to see new diagnoses as the natural result of cumulative scientific progress, this Section will show that the creation of diagnoses is often a multi-factored process spurred along by political negotiation, financial incentives, and/or social judgments and norms.

1. Mental Illness

Mental illness is a keen example of how diagnoses can be constructed when key interests among medical scientists, doctors, patients, and businesses align. For example, the creation of Chronic Fatigue Syndrome—despite its non-specific pathology—was beneficial for a variety of social groups. Medical scientists received credit for discovering a new condition, clinicians found a diagnostic solution to idiosyncratic suffering, patients received relief from uncertainty and the promise of effective therapy, and businesses (especially insurance and pharmaceutical companies) saw the prospect of additional revenue.⁸⁵ The “discovery” of Chronic Fatigue Syndrome can thus be seen as resulting from a confluence of key social factors and interests.⁸⁶

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the authoritative manual of the American Psychiatric Association (APA), provides a window into how the creation of diagnoses is both politically and economically driven. The *DSM* plays a critical gatekeeping role in determining which mental illnesses are valid for insurance and clinical purposes. Each time a new edition

83. ARONOWITZ, *supra* note 78, at 58. Professor Aronowitz argues that such an approach is flawed. He points to the creation of Lyme disease as an example of a diagnosis built “implicitly and incrementally from a number of interacting factors,” and not as a necessary result of analyzing objective biological facts. *Id.*

84. Rosenberg, *supra* note 76, at xiii.

85. See ARONOWITZ, *supra* note 78, at 36.

86. *Id.* at 179.

of the *DSM* is forthcoming, expert panels are established to meet and deliberate about which diagnoses should be included and excluded.⁸⁷

Currently, with a new iteration of the *DSM* forthcoming in 2012, heated battles have already begun, involving various political and legal interests. For example, many transgendered persons are already fighting the current diagnostic categories of Gender Identity Disorder and Transvestite Fetishism.⁸⁸ Binge Eating,⁸⁹ Internet Addiction,⁹⁰ and Parental Alienation Syndrome⁹¹ are also tentative diagnostic categories likely to engender great controversy.

Such battles over whether a diagnostic category ought to exist in the first place are legion. Past examples include the exclusion of homosexuality,⁹² the inclusion of Post-Traumatic Stress Disorder,⁹³ and the proposal and rejection of the gender-biased Self-Defeating Personality Disorder.⁹⁴ Each of these aforementioned decisions had deep cultural implications and was ultimately effected by pressure from political constituencies—demonstrating that far more was at work than just raw biology and objective science.⁹⁵

The creation of mental illnesses is also driven by financial incentives in the form of pharmaceutical money. While the role of pharmaceutical companies in

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87. See generally Lisa Cosgrove et al., *Financial Ties Between DSM-IV Panel Members and the Pharmaceutical Industry*, 75 *PSYCHOTHERAPY & PSYCHOSOMATICS* 154 (2006) (noting the role expert panels play in determining which particular diagnoses are included in the *DSM*).
88. Benedict Carey, *Psychiatry's Struggle To Revise the Book of Human Troubles*, N.Y. TIMES, Dec. 18, 2008, at A1 (noting that the *DSM*-related debate over gender identity “is already burning hot among transgender people”); Arline Kaplan, *DSM-V Controversies*, *PSYCHIATRIC TIMES*, Jan. 1, 2009, <http://www.psychiatrictimes.com/display/article/10168/1364926>.
89. Carey, *supra* note 88, at A1.
90. Kaplan, *supra* note 88.
91. Karen Franklin, *Psychiatric Bible To Add New Diagnoses: DSM Makeover Process Shrouded in Secrecy*, AM. CHRON., Oct. 15, 2008, <http://www.americanchronicle.com/articles/view/77790>.
92. See HERB KUTCHINS & STUART A. KIRK, *MAKING US CRAZY: DSM: THE PSYCHIATRIC BIBLE AND THE CREATION OF MENTAL DISORDERS* 18, 55-99 (1997) (explaining how protests by gay activists led to the elimination of homosexuality from the *DSM-II* in 1974).
93. See *id.* at 18, 100-25 (explaining how Vietnam veterans fought for and achieved inclusion of Post-Traumatic Stress Disorder in the *DSM* despite the opposition of many leading psychiatric experts).
94. See *id.* at 19, 126-75 (explaining how feminism fought against the inclusion of Masochistic Personality Disorder in the *DSM*, which was later relabeled and rejected as Self-Defeating Personality Disorder).
95. See *id.* at 24 (“[L]ike a large and popular mutual fund, DSM’s holdings are constantly changing as the managers’ estimates and beliefs about the value of those holdings change.”).

the development of diagnoses has historically been less publicized than many of the political interests noted above, the connection between these companies and the *DSM* is starting to receive more press. Pharmaceutical companies have a general financial interest in expanding the number of diagnostic categories (and concomitantly, the total number of persons who can be diagnosed),⁹⁶ and the individual companies also have particular financial interests in medical practitioners prescribing their specific medications.⁹⁷ Pharmaceutical companies also provide substantial funding to the APA.⁹⁸ However, even more direct evidence of financial connections between pharmaceutical companies and the *DSM* has surfaced within the last five years.

In 2006, researchers at the University of Massachusetts and Tufts University published a study entitled *Financial Ties Between DSM-IV Panel Members and the Pharmaceutical Industry*.⁹⁹ This study provided empirical support for what many had suspected all along: Pharmaceutical money was connected to the creation of the *DSM*'s diagnostic categories. In particular, the study found that the majority of *DSM* panel members for the most recently published edition of the *DSM* had substantial financial ties to one or more pharmaceutical companies.¹⁰⁰

96. See *id.* at 13. One forensic psychologist cynically writes:

It's a tried-and-true formula: Do a quick-and-dirty study or two. Find a huge, perhaps escalating, problem that has heretofore been overlooked. Create a product label (aka diagnosis). And, voila! The drug companies will take it from there. A diagnosis that was once just a twinkle in the eye of a creative researcher becomes reified as a concrete entity.

Franklin, *supra* note 91. Since the first edition of the *DSM*, the number of disorders has tripled—an increase paralleled by an increase in sales of drugs. Ron Grossman, *Psychiatry Manual's Secrecy Criticized*, L.A. TIMES, Dec. 29, 2008, at A19.

97. See Benedict Carey & Gardiner Harris, *Psychiatric Association Faces Senate Scrutiny over Drug Industry Ties*, N.Y. TIMES, July 12, 2008, at A13 (noting that, on average, psychiatrists who received at least \$5,000 from newer-generation antipsychotic drugs wrote three times as many prescriptions to children for said drugs than psychiatrists who received less money or none).

98. KUTCHINS & KIRK, *supra* note 92, at 13; Cosgrove et al., *supra* note 87, at 155 (“Pharmaceutical companies provide substantial funding for conventions, journals, and research related to what is included in the *DSM*, because what is considered diagnosable directly impacts the sale of their drugs.”); see also Carey & Harris, *supra* note 97 (noting that in 2006, the latest year for which data was available, the drug industry accounted for thirty percent of the APA's \$62.5 million in financing).

99. Cosgrove et al., *supra* note 87.

100. *Id.* at 156. Revisions of the *DSM* are organized around working groups or panels. Of the 170 *DSM* panel members, ninety-five of them, or fifty-six percent, had one or more financial ties to a company in the pharmaceutical industry. *Id.* However, even this statistic is understated since *DSM* panels for diagnostic categories in which pharmacological interventions are standard treatment had much higher percentages of financial ties to the pharmaceutical industry. *Id.* at 156, 159. For

Even the APA's President later acknowledged publicly that such ties exist and could not be fully eliminated.¹⁰¹ Indeed, in 2008, the Center for Science in the Public Interest found that more than half of the twenty-eight members of the forthcoming *DSM-V* task force have ties to the drug industry.¹⁰²

2. Sensory Impairments

Sensory impairments provide an example of how even diagnoses with seemingly unassailable biological foundations are constructed in significant respects.

Who is blind? We certainly do not live in a world with only two types of people: the blind and the sighted. Similarly, a diagnosis of blindness is not a dividing line between those without sight and those with perfect sight. Indeed, eighty percent of people who are legally blind have some amount of vision.¹⁰³ Rather, the diagnosis of blindness represents a dividing line on a continuum that ranges from perfect sight to total lack of sight. And drawing the line requires judgment about who ought to count as blind (and just how much inability to see the label "blind" entails). Accordingly, a diagnosis of blindness is not just an issue of the body; it is also a social judgment by the medical community

example, one hundred percent of the panel members for the "Mood Disorders Work Group" (8 out of 8) and the "Schizophrenia and Other Psychotic Disorders Work Group" (7 out of 7) had financial ties to the pharmaceutical industry. *Id.* at 156-57. In contrast, the authors note that the panel for "Substance-Related Disorders"—an area in which psychopharmacological treatment is much less likely—had a much lower concentration (1 out of 6). *Id.*

The authors conclude that while receiving financial support from a pharmaceutical company should not disqualify a person from serving on a *DSM* panel, "the public and mental health professionals have a right to know about these financial ties, because pharmaceutical companies have a vested interest in what mental disorders are included in the *DSM*." Cosgrove et al., *supra* note 87, at 159.

101. Kaplan, *supra* note 88 ("We have anticipated and addressed questions about conflicts of interest in the *DSM* process. The abolition of conflict is a myth. . . . [W]hat we can do is to be very clear about what those interests are." (quoting Nada Stotland, APA President)).

102. *Psych Working Group Again Rife with Conflicts of Interests*, INTEGRITY IN SCIENCE WATCH: WEEK OF 05/05/08, <http://cspinet.org/integrity/watch/200805051.html#4> (last visited Apr. 3, 2011). Conflict-of-interest concerns were substantial enough to prompt Congress to launch an investigation into the APA's funding and doctors' financial arrangements with drug makers in 2008. See Carey & Harris, *supra* note 97.

103. SHELLEY KINASH, SEEING BEYOND BLINDNESS 5 (2006).

about who ought to be considered “blind.”¹⁰⁴ Deafness may be understood in much the same way.

3. Eating Disorders

One way of examining whether diagnosis is a social creation is to ask whether diagnoses are new or transient, i.e., whether they exist or have existed only at certain times and in certain places (and are thus context-dependent).¹⁰⁵

Although identified in the 1870s, anorexia nervosa was a rare disorder for nearly a century.¹⁰⁶ However, in the 1970s and 1980s, the nature of anorexia’s symptomatology began to change and its incidence increased dramatically in America.¹⁰⁷ Two new (but now common) symptoms emerged: compulsive physical activity and bulimia (bingeing and purging).¹⁰⁸ The reasons given for the symptom of not eating also began to shift from somatic (for example, “I cannot eat because it hurts”) to psychosomatic (for example, “I don’t need to eat; I am too fat”).¹⁰⁹ What exactly happened?

Any attempt to explain changes in anorexia’s incidence and symptomatology from a purely biological perspective fails.¹¹⁰ It is only when one adds in heightened cultural pressure to exercise and be thin, women’s personal freedom, desocialized eating environments, a lack of adolescent supervision, and the ubiquity of food for purchase, that one begins to understand how the cultural climate in America helped make anorexia a common condition with new symptomatology.¹¹¹ Anorexia may thus be seen as a transient mental illness that has flourished at specific times in specific places—namely contemporary ones that extol a particular version of beauty.¹¹² In this respect, “eating disorders appear ultimately to be cultural productions, no matter what biological mechanisms they provoke.”¹¹³

104. See generally Tanya Titchkosky, *Cultural Maps: Which Way to Disability?*, in *DISABILITY/POSTMODERNITY*, *supra* note 6, at 101, 101-11 (exploring the ways in which blindness is socially constructed).

105. In his book on social constructionism, Ian Hacking notes that some mental illnesses are transient in that “they show up only at some times and some places, for reasons which we can only suppose are connected with the culture of those times and places.” HACKING, *supra* note 79, at 100.

106. Joan Jacobs Brumberg, *From Psychiatric Syndrome to “Communicable” Disease: The Case of Anorexia Nervosa*, in *FRAMING DISEASE*, *supra* note 76, at 134, 135.

107. *Id.* at 138-39.

108. *Id.* at 138.

109. *Id.* at 137.

110. *Id.*

111. *Id.*

112. HACKING, *supra* note 79, at 2, 100-01.

113. Brumberg, *supra* note 106, at 149.

4. Intellectual Impairments

Mental retardation is another example of a diagnosis constituted by social norms. With ever-changing criteria and tests, one might reasonably see mental retardation as “a historically contingent way of talking about people who appear to be in need of assistance and who are not very good at IQ tests.”¹¹⁴ Mental retardation is, in this way, a relative concept and a social judgment of sorts.¹¹⁵ None of this indicates that retardation is imaginary or not a real disability. However, the diagnosis is also not a simple reflection of self-evident, physiological facts; it requires an implicit cultural judgment about how much competence is normal, and when deviation from that normality is substantial enough to be considered an impairment.

Or consider learning disabilities (LDs). Much like the diagnoses discussed above under the *DSM*, the dozen or so conditions lumped together under the umbrella term “LD”¹¹⁶ have been legitimated largely by economic and political interests.¹¹⁷ The term “learning disabilities” was itself invented in 1963 by a psychologist attempting to expand the circle of students who could be diagnosed as “disabled” and thus entitled to federal protections and funding.¹¹⁸ By the 1980s, LD diagnoses were soaring and the numbers continue to grow today.¹¹⁹ The scope of what constitutes an LD has continued to widen since the term’s inception, thereby subsuming an increasing number of Americans.¹²⁰

The salient question might be “why?” While some media outlets have loosely attributed the growth of LD diagnoses to factors such as diet, exposure to chemicals, and sedentary lifestyles,¹²¹ most scholars examining the issue have

114. RAPLEY, *supra* note 12, at 42.

115. *Id.* at 41, 42, 202-03.

116. Craig S. Lerner, “Accommodations” for the Learning Disabled: A Level Playing Field or Affirmative Action for Elites?, 57 *VAND. L. REV.* 1043, 1064-65 (2004) (noting that LD is a broad term encompassing dyslexia, dysgraphia, dyspraxia, dyscalculia, dysrationalia, Attention-Deficit/Hyperactivity Disorder (ADD/ADHD), “language-based disability,” and “auditory processing disability”).

117. Kenneth A. Kavale & Steven R. Forness, *The Politics of Learning Disabilities*, 21 *LEARNING DISABILITY Q.* 245, 245 (1998); Lerner, *supra* note 116, at 1058, 1076; see also Kathleen Ross-Kidder, *Interventions with Comorbid Emotional/Behavioral Disordered Children*, in *CONTEMPORARY INTERDISCIPLINARY INTERVENTIONS FOR CHILDREN WITH EMOTIONAL/BEHAVIORAL DISORDERS* 559, 560 (David A. Sabatino & Benjamin L. Brooks eds., 1998) (examining the quandary faced by parents of seemingly intelligent children who had “unmet educational needs,” and the perceived need for those children to receive some type of educational intervention).

118. Lerner, *supra* note 116, at 1058.

119. *Id.* at 1071-73.

120. *Id.* at 1044-45.

121. *Id.* at 1074.

concluded that the growth is due to distinct political and financial interests.¹²² Carl Elliott, a professor at the Center for Bioethics at the University of Minnesota, has argued that the ballooning of such diagnoses is not because people have suddenly detected conditions that were hidden for hundreds of years.¹²³ Rather, he notes it is because “all mental disabilities, even those with biological roots, have a social component.”¹²⁴ Just like the *DSM* diagnoses discussed above, many interests drive this trend, including those of LD educators (who obtain federal aid for each student diagnosed as having an LD); psychologists (who charge thousands of dollars to diagnose students); LD researchers (who are incentivized by the lure of federal grants); attorneys (who can win judgments in ADA cases); and pharmaceutical companies (who have pocketed billions of dollars from medicines that target learning disabilities).¹²⁵

5. Age-Related Impairments

A slightly different case for seeing impairment as socially constructed is where the predicate physical conditions have always existed, but have not always been considered problematic and diagnosed. For example, hip fractures, spinal deformities, and loss of height were all once thought of as normal by-products of aging.¹²⁶ They were not considered impairments or diagnosed in any meaningful way.¹²⁷ However, since 1994, the World Health Organization has classified osteoporosis (a major factor in each of the aforementioned symptoms) as a disease that can be diagnosed, prevented, and treated.¹²⁸ Such institutional shifts have significant consequences because they affect medical norms, which in turn affect the process of diagnosis.¹²⁹ The development of age-related impairments shows that normality and disease do not issue from an unmediated form of biology; instead, biological data are interpreted through existing knowledge of the body and in accordance with cultural standards.¹³⁰

122. See *supra* note 117.

123. Carl Elliott, *Costing an Arm and a Leg*, SLATE, July 10, 2003, <http://slate.msn.com/id/2085402>.

124. *Id.*

125. Lerner, *supra* note 116, at 1077.

126. Jackie Leach Scully, *A Postmodern Disorder: Moral Encounters with Molecular Models of Disability*, in *DISABILITY/POSTMODERNITY*, *supra* note 6, at 48, 48.

127. *Id.*

128. *Id.*

129. See *id.* (noting that there are significant consequences for such classification).

130. *Id.*

C. *The Acts of Diagnosis*

A related way of challenging the assumption that impairment is only biological is by examining the acts of diagnosis. To the extent that diagnosing an individual requires interaction with the patient or interpretation of patient-reported data, social norms become embedded into the ultimate diagnosis.

1. Mental Illness

Mental illness is one area of medicine that relies heavily on patient reporting. For example, in cases of depression, the medical practitioner's diagnosis often relies on the patient's psychological self-assessment, which will almost necessarily be informed by social meanings. A depressed person, to be classified and diagnosed as such, must be able to communicate.¹³¹ Instead of listing off symptoms, the depressed subject must often produce a narrative of her depression.¹³² In producing such a narrative, the person's preconceptions relating to depression and its symptoms will likely be incorporated. The very formation of depression as an impairment thus depends upon patients' internalization of their distress and later articulation to a medical professional.¹³³ In this sense, the diagnosis of depression involves an aggregation of social norms, a person's view of her own symptoms, and a narrative dispensed to the medical professional. Any effort to isolate the part of depression that is biological impairment (as opposed to social disablement) would seem artificial at best.

Other diagnoses can similarly be seen as controlled more by the patient than the physician.¹³⁴ For example, the criteria for Chronic Fatigue Syndrome are patient-centered, permitting the patient to effectively define the disease based on her particular symptomatology.¹³⁵ There has been a steady rise in diagnoses that depend upon patient-reported symptoms—the result of a trend toward “functional” diagnoses, or solutions to “the problem of idiosyncratic suffering not readily explainable by specific pathology.”¹³⁶

Another reason that impairment is less objective and more social than previously theorized is that diagnoses for mental illness involve considerable subjectivity and interpretation on the part of medical practitioners. Psychiatry is

131. Anna Mollow, “*When Black Women Start Going on Prozac . . .*”: *The Politics of Race, Gender, and Emotional Distress in Meri Nana-Ama Danquah’s Willow Weep for Me*, in *THE DISABILITY STUDIES READER*, *supra* note 6, at 283, 290.

132. *Id.* at 290.

133. *Id.* at 290 n.30 (noting that “the formation of depression as an impairment category has depended in large part upon patients’ verbal articulations of their distress”).

134. ARONOWITZ, *supra* note 78, at 31.

135. *Id.* at 31.

136. *Id.* at 16.

not like cardiology or nephrology, where the basic diseases are well understood and identifiable by non-subjective criteria¹³⁷: “No blood tests exist for the disorders in the DSM.”¹³⁸ Rather, patients rely on judgments from practitioners, who in turn rely on subjective phenomena and the manual.¹³⁹ Yet once subjective phenomena (such as finding difficulty in practical life tasks or not doing well on IQ tests) are re-described as symptoms, a cultural condition is transformed into a medically identifiable pathology.¹⁴⁰ There have even been published studies in which psychiatrists, trained in using the *DSM*, cannot even agree on which class of diagnoses (such as “personality disorder”) a disability falls into, much less reach agreement on a specific diagnosis within that class.¹⁴¹ Some disagreement as to application is, of course, natural; still, disagreement illuminates the fact that diagnosis is a process that is not immune from social influences.¹⁴²

2. Intellectual Impairments

Another example of the constructed nature of diagnosis can be found in considering the use of diagnostic assessments to determine diagnoses. Mark Rapley, a professor of psychology at the University of East London, has explored how intellectual disabilities are constructed through the psychological assessments intended to diagnose them.¹⁴³ He notes that this occurs in part

137. Carey, *supra* note 88, at A1 (“This is not cardiology or nephrology, where the basic diseases are well known.” (quoting Edward Shorter, History Professor, University of Toronto)).

138. Dan Vergano, *Study: Medical Manual’s Authors Often Tied to Drugmakers*, USA TODAY, April 20, 2006, at A6 (quoting Lisa Cosgrove, Psychology Professor, University of Massachusetts Boston).

139. *Id.*

140. RAPLEY, *supra* note 12, at 43-44.

141. KUTCHINS & KIRK, *supra* note 92, at 52-53; see also Lars Noah, *Pigeonholing Illness: Medical Diagnosis as a Legal Construct*, 50 HASTINGS L.J. 241, 248 (1999) (“[M]ental health professionals often express greater disagreements about an appropriate diagnosis for a particular patient because the relevant symptoms tend to be non-specific, which means that any number of mental illnesses could account for the particular complaint.”).

142. See KUTCHINS & KIRK, *supra* note 92, at 53 (“Serious confusion about distinguishing mental disorders from nondisordered conditions and the inability of clinicians to use the manual reliably make the development and use of *DSM* vulnerable to a host of nonscientific pressures.”). Even medicine’s technical aspects, which are seemingly unrelated to cultural influences, are “shaped in part by the shared intellectual worlds and institutional structures of particular communities and subcommunities of scientists and physicians.” Rosenberg, *supra* note 76, at xiv.

143. See, e.g., RAPLEY, *supra* note 12; Goodley & Rapley, *supra* note 66.

because of an “acquiescence bias,” in which respondents to surveys have a tendency to indicate a positive answer to questions, or simply agree.¹⁴⁴ This dynamic is amplified in the realm of intellectual disabilities because medical professionals often assume that their patients are incapable of reporting on their own conditions.¹⁴⁵ One result of this bias for assessments is that an interviewee may be shepherded into apparently inconsistent answers by a range of interactional phenomena: the interviewee’s perceived need to reformulate responses to questions;¹⁴⁶ the interviewer’s pursuit of “correct” answers (based on his or her expectations);¹⁴⁷ and the interviewer’s desire to obtain an answer in the official vocabulary of the interview schedule.¹⁴⁸ While it is difficult to provide concise examples of these phenomena, Rapley’s conclusions are supported through extensive use of case studies and examples.¹⁴⁹ In such cases, inconsistencies are produced by the logic of the interviewer’s demands.¹⁵⁰ Rapley concludes that such methods of diagnosis necessarily shift intellectual disability from the realm of an individual, biological problem to an interactional, social product.¹⁵¹

D. *Impairment Exists on a Continuum*

The creation of diagnoses and acts of diagnosis reveal how impairment exists as part of a continuum, rebutting the tempting inference that impairment is itself a binary concept (with a world full of impaired and non-impaired

144. RAPLEY, *supra* note 12, at 80-84.

145. *See id.* at 28-29 (noting that, given the tests employed, it is unsurprising that medical professionals view people with intellectual disabilities as unreliable reporters on their own lives).

146. Because the normal question-and-answer means of verbal exchange is suspended, the imbalance may produce pseudo-acquiescence. *Id.* at 93.

147. Interviewers often do not accept a respondent’s first answer and push the interviewees into self-contradictory responses. *Id.* at 95. However, these contradictions are a logical consequence of the (often convoluted) path of questioning. *See id.* at 94-96.

148. *Id.* at 96-101. Interviewers may suggest improvements to answers to “shepherd[] the respondent’s answer into more acceptably official shape.” *Id.* at 205.

149. *See id.* at 78-110 (providing detailed analyses of conversations between medical professionals and people with intellectual disabilities).

150. *Id.* at 89-90.

151. *See id.* at 202 (“[Intellectual] competence is *very much* a relative concept and moreover one which is, in actual social practices, actively negotiated.”); *id.* at 208 (“I think that it is reasonable to suggest that what we have become used to thinking [of] as an essentialised condition afflicting persons is . . . nothing but a social construct and cultural artifact. . . . Intellectual disability is, then, not a thing-in-the-world awaiting discovery, but rather is a disreputable moral status socially constructed, by psy, as a speakable truth about [people considered intellectually disabled].” (citation and quotation marks omitted)).

people). For example, mental illness diagnoses implicate a wide array of socialized behaviors, including the way in which one responds to stress, how much anxiety or sadness one should feel, and when and how one should sleep, eat, and express oneself sexually.¹⁵² All of these behaviors exist on a continuum and are not binary concepts. This means that in order to make particular diagnoses, a line must be drawn somewhere to mark the point at which normal behavior has crossed into pathology.

Blindness, deafness, disordered eating, and intellectual impairments all represent a range of qualities and/or abilities regarding certain aspects of the body. Who is blind, deaf, bulimic, or mentally retarded is thus a question of degree based on graduated differences. At some point on each continuum, a line must be drawn to effectuate the diagnosis. The same principle applies to the process of diagnosis; there, lines must be drawn to determine whether particular people's behavior or sensory abilities fall within the realm of predetermined disabilities. This line-drawing is complicated and made inconsistent by the interactional phenomena associated with physician and patient. Accordingly, where we draw lines for diagnoses may change over time (creation of diagnoses), or may change depending on the patient and/or physician (acts of diagnosis). The result is that impairment is most aptly understood as a non-binary, spectrum concept. This observation underscores my thesis that impairment, understood as diagnosis, is socially constructed.

E. Perhaps Impairment Was Always Already Disablement

Having explained how biological impairment is often constructed, one might question whether impairment (and ultimately disability) is entirely constructed. After building the case that sex was constructed, Butler similarly questioned whether sex "was always already gender, with the consequence that the distinction between sex and gender turns out to be no distinction at all."¹⁵³ Within the disability framework, given my argument that impairment is thoroughly constructed, we might question whether impairment is always already disablement, with the result that the division between impairment and disablement turns out to be inconsequential. And if the distinction is no distinction at all, what then is left of biology?

This latter question has often consumed the attention of Butler's critics, who argue that she has lost sight of "the concrete, historical body that loves, suffers, and dies."¹⁵⁴ Butler acknowledges that there is indeed something neces-

152. KUTCHINS & KIRK, *supra* note 92, at 15.

153. BUTLER, *GENDER TROUBLE*, *supra* note 7, at 9-10.

154. MOI, *supra* note 35, at 49. See generally Martha C. Nussbaum, *The Professor of Parody: The Hip, Defeatist Feminism of Judith Butler*, *NEW REPUBLIC*, Feb. 22, 1999, at 37 (criticizing Butler's radical social constructionism).

sary and inescapable about such “primary and irrefutable experiences.”¹⁵⁵ She does not claim that there is no material body; just that we can only apprehend that material body through discourse.¹⁵⁶ This means that while the body is not reducible to language,¹⁵⁷ it is only accessible through language.¹⁵⁸ In other words, “there is no reference to a pure body which is not at the same time a further formation of that body.”¹⁵⁹ Her ultimate concern is to interrogate constructions of sex that have come to be seen as essential and natural.¹⁶⁰

Here, I simultaneously converge with and depart from Butler’s project. Like Butler, I am not denying that biology exists, but endeavoring to show how the version of biology with which medical professionals interact is contested and refracted by social interests. I am unconcerned with demarcating culture from nature or social inputs from biology; in many ways, the question of what is left of biology reintroduces that which was problematically an assumption of the gender/sex and disability binaries from the start: the presence of a raw biological core that may be neatly extricated from the concept of woman or disability. I am interested in showing *how* impairment is constructed and the interests that are served by its construction, not in drawing lines to show the boundaries of biology.

Unlike Butler, I am less focused on discourse and more focused on attempting to provide an account of the impaired body that provides political and historical context. Social constructionism has, in recent years, become a trendy and often obtuse way to discuss a subject.¹⁶¹ Here, I have labored to employ social constructionism usefully by providing concrete examples of how impaired bodies are produced.

One final point that bears reiteration is that my argument, as applied to particular disabilities, does not imply that those disabilities are not real or valid. Social constructionism (here, my claim that biological impairment is socially

155. BUTLER, *supra* note 69, at xi, 66-67; *see also* MOYA LLOYD, JUDITH BUTLER: FROM NORMS TO POLITICS 70-71 (2007).

156. *See* Judith Butler, *Sex and Gender in Simone de Beauvoir’s Second Sex*, in 72 YALE FRENCH STUDIES: SIMONE DE BEAUVOIR: WITNESS TO A CENTURY 35, 45 (Hélène V. Wenzel ed., 1986) (“As a locus of cultural interpretations, the body is a material reality which has already been located and defined within a social context. The body is also the situation of having to take up and interpret that set of received interpretations.”); *see also* SARA SALIH, JUDITH BUTLER 74-75 (2002) (arguing that Butler acknowledges the material body, but noting that she also emphasizes discourse as the only way to apprehend that body).

157. BUTLER, *supra* note 69, at 6.

158. *Id.* at 10.

159. *Id.*

160. *Id.* at xi.

161. *See, e.g.*, HACKING, *supra* note 79, at vii-viii, 1-3 (explaining that the language of social constructionism is trendy, overused, and often not very meaningful).

constructed) is often caricatured as asserting that a particular thing is a “mere” construct and thus arbitrary or illegitimate.¹⁶² I am not denying that biology exists; instead, I am challenging the idea that biological accounts of the body (that is to say, diagnoses) are asocial, or merely descriptive. My general point is that we need to think more carefully about disabled identity, not that socially constructed diagnoses are illegitimate.

F. Avenues for Further Research

A number of potentially fruitful avenues for examining the relationship between the gender/sex and disability binaries remain, and I note three of them here. In this vein, creating disability trouble opens new possibilities for continued research rather than closing the book on disabled identity.

First, scholars might document how impairments other than those discussed here are constructed through social inputs. In particular, more work might be done to show how impairment is the construct of a particular regime that polices the diagnosis and identification of disabled bodies.¹⁶³ Second, it might be fruitful to further deconstruct the disability binary by examining disablement. This might involve asking how disablement relates to the biological body, just as deconstructionist feminists questioned how gender relates to the biological body.¹⁶⁴ Third, scholars might explore how to reconstruct the concept of disability. If disability is deconstructed and shown to be more fluid and less dichotomous than previously thought, what is left of the term? In the gender/sex context, feminists have taken a variety of approaches in answering this question, including Natalie Stoljar’s resemblance nominalism,¹⁶⁵ Linda Alcoff’s positionality,¹⁶⁶ and Sally Haslanger’s social subordination.¹⁶⁷ Any or all

162. ARONOWITZ, *supra* note 78, at 14.

163. See Shelley Tremain, *Foucault, Governmentality, and Critical Disability Theory*, in *FOUCAULT AND THE GOVERNMENT OF DISABILITY* 5-6 (Shelley Tremain ed., 2005) (arguing that a vast programmatic apparatus—including asylums, special education programs, telethons, prenatal diagnoses, and quality of life assessments—has “created, classified, codified, managed, and controlled social anomalies through which some people have been divided from others and *objectivized* as (for instance) physically impaired, insane, handicapped, mentally ill, retarded, and deaf”).

164. See *supra* note 52 and accompanying text.

165. See Natalie Stoljar, *The Politics of Identity and the Metaphysics of Diversity: Conceptions of Essentialism in Feminist Philosophy*, 8 *PROC. OF THE 20TH WORLD CONGRESS PHIL.* 21, 27-28 (2000) (arguing that “woman” is a “cluster concept” organized on the basis of “different arrangements of features in different individuals”); Stoljar, *supra* note 53, at 283-84 (identifying four clusters that help organize the concept of “woman”).

166. See ALCOFF, *supra* note 53, at 148 (arguing that gender is “a position one occupies and from which one can act politically”); *id.* at 172 (explaining that “women and

of these approaches might be applied in the disability context to reconstruct what exactly is meant, and who exactly is encompassed, by the term “disabled.”

IV. LEGAL IMPLICATIONS

Making disability trouble has myriad policy and legal implications, a few of which I will introduce here. As noted above, work on the gender/sex binary spurred several forms of legal innovation and forever altered legal scholarship on the meaning of gender and sex. Such scholarship came at a critical time and revolutionized what it meant to be a woman. Similarly, the concept of disability is in a unique stage of theoretical development, and the evolution of its meaning may alter both society’s and the judiciary’s perceptions.¹⁶⁸ The medical model of disability has been entrenched as the standard paradigm for understanding disability in both the media and the federal judiciary.¹⁶⁹ As the meaning of disability turns further to social explanations, legal change may well follow.¹⁷⁰

A. *Disability Stereotyping*

The arguments in disability trouble underscore the need for robust protections against disability stereotyping, and reinforce the recent amendments to the ADA’s “regarded as” prong, which protects individuals who are regarded as having a disability and experience employment discrimination on that basis.¹⁷¹

As noted above, one legal response to feminist work on the gender/sex binary was the emergence of sex-stereotyping jurisprudence.¹⁷² In particular, a richer understanding of the meaning of gender and sex paved the way for judges to protect various permutations of gender and sex stereotyping under Title VII.

men are differentiated by virtue of their different relationship of possibility to biological reproduction”).

167. See Haslanger, *supra* note 53, at 6-7 (arguing that “gender is a matter of occupying either a subordinate or a privileged social position”).

168. Indeed, it seems that one way in which consensus was built for protecting subordinated racial and sexual groups was by first advancing a scholarly dialogue about what it means to be, for example, Latina, queer, or a woman who defies gender norms.

169. See generally Areheart, *supra* note 2 (arguing that the medical model of disability has been entrenched as the standard paradigm for understanding disability in both the media and the federal judiciary).

170. See *id.* at 208-09 (explaining that the judiciary’s paradigm of disability is influenced by cultural understandings).

171. See 42 U.S.C. § 12102(1)(C), (3) (Supp. 2010) (defining “disability” in terms of being “regarded as” having an impairment); *id.* § 12112(a) (prohibiting employment discrimination on the basis of disability).

172. See *supra* notes 54-55 and accompanying text.

Similarly, my arguments about disability support recent legal innovations in the area of disability stereotyping.

The ADA has historically protected from employment discrimination individuals who: (1) have “a physical or mental impairment that substantially limits one or more major life activities;” (2) have “a record of such an impairment;” or (3) are “regarded as having such an impairment.”¹⁷³ The third prong covers disability stereotyping and is seemingly expansive, but has been narrowly interpreted by courts. In particular, courts have required not only that a person be regarded as having a mental or physical impairment (a low bar), but also that she be regarded as having an impairment that substantially limits one or more major life activities (a high bar).¹⁷⁴ Accordingly, a suit brought under the “regarded as” prong has faced all the difficulties of proving actual disability in addition to the difficulties associated with proving that any such conception existed in the “theoretical mind” of the employer.¹⁷⁵ The result has been relatively weak disability stereotyping jurisprudence.

Congress passed the ADA Amendments Act of 2008 (ADAAA)¹⁷⁶ to strengthen disability protections.¹⁷⁷ The most significant change was to expand coverage for disability stereotyping. The ADA now expressly provides that in order to meet the requirement of being “regarded as” having an impairment, one does not need to show that an impairment limits, or is perceived to limit, a major life activity.¹⁷⁸ In other words, the ADA’s “regarded as” prong now covers anyone treated adversely because of an impairment, actual or perceived, without requiring a showing of limited bodily functionality.¹⁷⁹ This change is signifi-

173. 42 U.S.C. § 12102(1)(A)-(C) (2006).

174. Pauline T. Kim, *Genetic Discrimination, Genetic Privacy: Rethinking Employee Protections for a Brave New Workplace*, 96 Nw. U. L. REV. 1497, 1529-30 (2002).

175. Areheart, *supra* note 2, at 212 (quoting Claudia Center & Andrew J. Imparato, *Redefining “Disability” Discrimination: A Proposal To Restore Civil Rights Protections for All Workers*, 14 STAN. L. & POL’Y REV. 321, 328 (2003)).

176. ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (codified at 42 U.S.C. § 12102).

177. For further discussion of the ADAAA, see Kevin Barry, *Toward Universalism: What the ADA Amendments Act of 2008 Can and Can’t Do for Disability Rights*, 31 BERKELEY J. EMP. & LAB. L. (forthcoming 2011), available at http://works.bepress.com/kevin_barry/2; Jeanette Cox, *Crossroads and Signposts: The ADA Amendments Act of 2008*, 85 IND. L.J. 187 (2010); Sharona Hoffman, *The Importance of Immutability*, 52 WM. & MARY L. REV. 1483 (2011); Amelia Michele Joiner, *The ADAAA: Opening the Floodgates*, 47 SAN DIEGO L. REV. 331 (2010); Alex. B. Long, *Introducing the New and Improved Americans with Disabilities Act*, 103 Nw. U. L. REV. 217 (2008).

178. 42 U.S.C. § 12102(3)(A) (Supp. 2010).

179. *Id.* (“An individual meets the requirement of ‘being regarded as having such an impairment’ if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or

cant in part because while courts have historically interpreted the “impairment” requirement fairly broadly, they have interpreted the “substantially limits” and “major life activities” requirements more narrowly.¹⁸⁰ Eliminating the latter two requirements for “regarded as” claims will thus ease the burden of proving disability status and likely make the “regarded as” prong the primary vehicle for discrimination claims.¹⁸¹ The reinvigorated “regarded as” prong also makes clear that people’s attitudes disable.¹⁸² By broadening coverage for disability stereotyping, Congress has taken a bold step in the direction of universal nondiscrimination protection.¹⁸³

By troubling the disability binary, this Article provides both sociological and theoretical support for that bold step. The arguments here show that impairment, rightly understood, is complicated—and is far more than just biology. Impairment requires agreement from key social actors, evolves over time, and is fraught with patient- and doctor-imposed subjectivity. Given the fluid and ever-changing nature of impairment (as well as the constant additions of diagnoses), everyone has the potential to be impaired in one way or another, and thus everyone has the potential to be subjected to negative treatment based upon attitudes about those impairments. This Article also supports the idea that attitudinal and institutional barriers, not impairments taken alone, disable people. This account of impairment suggests that courts should be generous in interpreting the scope of impairment and should keep disability stereotyping protections strong by setting a low bar for what is required to show that one is “regarded as” having an impairment.

mental impairment whether or not the impairment limits or is perceived to limit a major life activity.”).

180. Areheart, *supra* note 2, at 211.

181. Barry, *supra* note 177 (manuscript at 264-66). Although one may seek reasonable accommodations under the “regarded as” prong, the ADAAA does not require covered entities to provide them on that basis alone. 42 U.S.C. § 12201(h). Accordingly, the “actual disability” and “record of disability” prongs, which continue to require some sort of limitation of bodily function or life activity, *id.* § 12102(1)(A)-(B), will likely be the primary vehicle for accommodation claims. Barry, *supra* note 177 (manuscript at 264-66).

182. Barry, *supra* note 177 (manuscript at 278); *see also id.* (manuscript at 282) (“By protecting nearly everyone from discrimination based on impairments, the ADAAA’s ‘regarded as’ prong relieves people of the need to show that they are different because of the way their impairments limit them. Now all they need show is that *others* limited them because of their impairments.”).

183. *See generally id.* (arguing that the ADAAA represents a move “toward universalism”).

B. *Per Se Disabilities*

The arguments presented in this Article also support amending the ADA to include *per se* disabilities that are generally stigmatized. Doing so would protect certain established, stigmatized conditions regardless of whether they substantially limit one or more major life activities. *Per se* disabilities would be automatically covered without any showing of limitation. Impairments not on the *per se* list would still need to meet the general requirement for showing actual disability: that one must have “a physical or mental impairment that substantially limits one or more major life activities.”¹⁸⁴ A *per se* list of disabilities was considered in the negotiations over the recent amendments to the ADA, but was ultimately omitted from the proposed legislative language.¹⁸⁵

The arguments in Part III of this Article support the addition of a *per se* list to the ADA because there is a short distance between understanding impairments as being constructed by culture and understanding impairments as being constructed by a culture that stigmatizes those impairments. For example, the diagnosis of mental retardation is also a social stigma in that the decision to pathologize a particular level of mental competence simultaneously imbues that level with a stigma. Similarly, blindness and deafness carry a certain stigma that results from the implicit social judgment about what amount of hearing or sight is less than normal. Understanding how particular impairments are socially constructed sheds light on how they are also culturally stigmatized. And the existence of broad-based stigma for certain conditions, in turn, counsels in favor of ADA coverage.

It might initially appear that this recommendation is in tension with the arguments in Part III regarding the fluid, subjective nature of impairment since a *per se* list could imply that certain diagnoses are static or relatively objective. However, using the level of stigma associated with impairments—and not medical criteria—to determine which impairments should be on the *per se* list would obviate any concern about “objective” biology serving as the basis for such a list. And while it is true that some stigmatizing impairments may lose

184. 42 U.S.C. § 12102(1)(A).

185. The *per se* list in the proposed legislative language read as follows:

Absent, artificial or replacement limbs, hands, feet or vital organs; amyotrophic lateral sclerosis; bipolar disorder; blindness or significant vision loss (as defined in (8)); cancer; cerebral palsy; chronic obstructive pulmonary disease; Crohn’s disease; cystic fibrosis; deafness or substantial abnormal hearing loss; diabetes; substantial disfigurement; epilepsy (seizure disorders); coronary heart disease or heart attacks; human immunodeficiency virus (HIV infection) or AIDS; kidney or renal diseases (excluding kidney stones); lupus; major depressive disorder; mental retardation (intellectual disabilities); multiple sclerosis; muscular dystrophy; spinal cord injury; Parkinson’s disease; pervasive developmental disorders; rheumatoid arthritis; schizophrenia; and acquired brain injury.

Barry, *supra* note 177 (manuscript at 269 n.389).

their stigma over time, this possibility could be addressed by a provision delegating to the EEOC authority to monitor the relative levels of stigma attached to the listed impairments and to make recommendations to Congress on a periodic basis.¹⁸⁶

Admittedly, there are reasons for *not* having a *per se* list of impairments. First, a *per se* list could be seen as dividing the disability community into those who are “in” and those who are “out.”¹⁸⁷ In this way, a *per se* list might decrease solidarity within the disability community as a whole.¹⁸⁸ Indeed, in the negotiations over the recent amendments to the ADA, disability activists opposed the inclusion of such a list on just this ground.¹⁸⁹ Second, a *per se* list might incite courts to “ratchet up” the level of severity that is required for impairments not on the *per se* list.¹⁹⁰

Despite these drawbacks, the benefit of such a list is obvious. It would ensure that the ADA covers certain disabilities that are generally stigmatized and severe. For example, why force every plaintiff with epilepsy to prove that he or she is deserving of the ADA’s protections? A *per se* list would create consistency in protecting impairments that have previously been protected on a notoriously inconsistent basis, such as diabetes.¹⁹¹ Such a change would also be consonant with the vision of the ADA’s framers in at least one critical respect: the drafters of the ADA never intended that one person with a particular condition be covered by the ADA while another with the very same condition goes uncovered.¹⁹²

186. For example, the recently enacted Genetic Information Nondiscrimination Act provides that “6 years after the date of enactment of this Act, there shall be established a commission, to be known as the Genetic Nondiscrimination Study Commission[,]. . . to review the developing science of genetics and to make recommendations to Congress regarding whether to provide a disparate impact cause of action under this Act.” Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, § 208(b), 122 Stat. 881, 917 (2008) (codified at 42 U.S.C. § 2000ff-7). A similar provision, directing the EEOC to monitor the impairments on the *per se* list and make recommendations regarding additions or subtractions to Congress a few years later, could be included in my proposed amendment.

187. Barry, *supra* note 177 (manuscript at 270).

188. *Id.*

189. *Id.*

190. *Id.* (manuscript at 269-70) (noting that courts could conclude that “if absent limbs and cancer were considered ‘disabilities’ under the *per se* list, non-listed impairments must rise to that level of severity in order to ‘materially restrict’”).

191. See Areheart, *supra* note 2, at 213 n.242 (comparing federal court decisions reaching differing conclusions on whether a diabetic plaintiff should be entitled to protection under the ADA).

192. Chai Feldblum, *Definition of Disability Under the Federal Anti-Discrimination Law*, 21 BERKELEY J. EMP. & LAB. L. 91, 151-52 (1999).

One might question whether implementing this recommendation would cause too many plaintiffs to survive summary judgment. Yet substantial hurdles would still remain. A plaintiff would still need to show both that she was qualified for the position she sought and that discrimination on the basis of a protected disability was the reason for an adverse employment decision.¹⁹³ Moreover, in a case under the ADA seeking accommodation, the plaintiff would still need to show that her request was reasonable and would not cause the employer undue hardship.¹⁹⁴

More importantly, it is imperative to recall the broad remedial intent of the original ADA.¹⁹⁵ This broad remedial scope is underscored by the recent amendments, which add the following rule of construction: “The definition of disability in this chapter shall be construed in favor of broad coverage of individuals under this chapter, to the maximum extent permitted by the terms of this chapter.”¹⁹⁶ Also, the ADAAA clarified that “the primary object of attention in cases brought under the ADA should be whether entities covered under the ADA have complied with their obligations” and not “whether an individual’s impairment is a disability under the ADA.”¹⁹⁷ Adding a *per se* list would thus be consistent with the express thrust of the recently amended ADA.

C. Greater Acceptance of Legal Solutions

The arguments giving rise to disability trouble ought to also increase public support for legal protections for people with disabilities.

While equality and antisubordination norms should themselves be sufficient to justify policies that help disabled persons, it may—as a practical matter—be useful to provide other justifications.¹⁹⁸ Indeed, many people seem to view policies directed toward helping people with disabilities achieve equality of opportunity as unwarranted, preferential treatment.¹⁹⁹ This hostility may even

193. 42 U.S.C. § 12112(a) (2006).

194. *Id.* § 12112(b)(5)(A).

195. Areheart, *supra* note 2, at 230-31 (discussing broad remedial intent of the ADA).

196. 42 U.S.C. § 12102(4)(A) (Supp. 2010).

197. ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2, 122 Stat. 3553, 3554 (2008).

198. See Michelle A. Travis, *Lashing Back at the ADA Backlash: How the Americans with Disabilities Act Benefits Americans Without Disabilities*, 76 TENN. L. REV. 311, 312 (2009) (“While ideally the goals of equality and self-sufficiency for individuals with disabilities should be enough to justify the ADA, and the majority’s self-interest should not determine disability policy, practical politics may require identifying and highlighting benefits to nondisabled workers to help maintain support for the law.”).

199. *Id.*; see also Areheart, *supra* note 2, at 190 (“[M]any people seem to view discrimination against disabled people as rational—the result of their own bodies’ deficiencies—and distinguishable from other forms of discrimination. The result is that even people who avoid other forms of discrimination may be apt to rational-

increase if the ADAAA has its intended effect of increasing the scope of the ADA.²⁰⁰

The big-picture insight of this Article is that disability has an even more substantial social origin than previously acknowledged. And a social origin at least arguably implies social responsibility.²⁰¹ As theorizing continues to illuminate the fact that disability disadvantage flows from social structures and practices, the view that society has some responsibility to remedy that disadvantage will naturally follow.²⁰² Indeed, the idea that social cause justifies social responsibility may be traced back to the civil rights movements of the 1960s. One could posit that as minorities integrated into mainstream society and people recognized that racial divisions had their primary bases in social practices rather than biological differences, support for social and political solutions increased. This increase in support seemed to issue from a collective sense of what was just.

Similarly, troubling the disability binary may lead to greater acceptance of legal solutions by disrupting the perceived divisions between disabled and non-disabled people. Much of the “us-them” mindset stems from people viewing disability as simply and utterly biological; in particular, a biologically reductionist view allows a non-disabled person to easily differentiate herself from those considered disabled. Yet as disability is shown to be more constructed and less fixed, society should begin to understand the increasing contingency of being labeled “disabled.” Such contingency should make people more aware of the need to protect broadly against disability discrimination.

One might question, however, whether this argument could have the effect of *decreasing* support for legal protections. In particular, if disability is less biological and more socially constructed, is it not just as likely that people will become more skeptical toward legal protections for people with disabilities? Similarly, one might question whether social accounts of causation make people less sympathetic toward people with disabilities (and thus less likely to support legal interventions).

While biologically reductionist accounts may, as a practical matter, encourage greater sympathy and persuade more people to favor disability protections,²⁰³ popular support is only one goal of the disability rights movement. In order to accomplish long-term workplace and social integration, it is also

ize disability discrimination.”); Samuel R. Bagenstos, *Implicit Bias, “Science,” and Antidiscrimination Law*, 1 HARV. L. & POL’Y REV. 477, 491 (2007) (noting that adverse reaction to the ADA is centrally about the fact that it “targets *rational* employer conduct”).

200. Travis, *supra* note 198, at 320.

201. *But see* Samaha, *supra* note 11 (arguing that the causation account of the social model prescribes no normative response).

202. Areheart, *supra* note 2, at 189 (citing Crossley, *Reasonable Accommodation*, *supra* note 21, at 877).

203. *See id.* at 198-204 (demonstrating how focusing on disabled people’s medical limitations may lead to popular, and charitable, support).

imperative that society realize that no huge gulf exists between people designated as disabled and those not so designated. While sympathy may yield formal support for disability rights in the short term, it is difficult for people to pity disabled persons and also to view them as having the same entitlement to rights as people without disabilities (which is one long-term goal of disability advocates).²⁰⁴ The arguments in Part III that impairments are socially constructed are a step in the direction of illuminating disabled persons as not essentially different. Additionally, the argument that society *ought* to account for the ills it helps create is a normative argument about what is *just*. While this may or may not correspond to what seems fair to the majority of the population, as explained above, there is historical precedent for the idea that social cause justifies social responsibility, even if people's prejudices persist.

D. Healthcare Policy

This Article also signals the need to pay close attention to the costs and health effects associated with creating new diseases and impairments.

Access to healthcare is generally structured around "the legitimacy built into agreed-upon diagnoses."²⁰⁵ Given this Article's explanation in Section III.B of the multiple interests that affect the process by which an impairment is created, and given that one of those interests is the economic incentives of certain industries, the medical community must be vigilant in assessing the costs and benefits associated with creating and insuring new impairments.²⁰⁶ In particular, insuring and treating new diseases or other conditions is not a costless enterprise. There are real costs to medical professionals, who typically pass those costs on to insurance companies, which in turn pass their costs on to consumers in the form of insurance premiums. This cost-passing enterprise matters because the creation of some diagnoses may be financially lucrative for companies, but may not confer meaningful health gains on patients.

Accordingly, it is vital to understand how social inputs help constitute certain diagnoses. Indeed, the issue of cost is more salient than ever given the large financial burden, which all Americans will shoulder, associated with the historic health care legislation that was signed into law in 2010.²⁰⁷ Additionally,

204. *Id.* at 201; see also Michael Ashley Stein, *Same Struggle, Different Difference: ADA Accommodations as Antidiscrimination*, 153 U. PA. L. REV. 579, 625-26 (2004) (observing that recognizing disabled persons as equal to people without disabilities "requires a general transformation in social attitudes, most especially acknowledgement of disability rights as *rights* rather than as a product of goodwill").

205. Rosenberg, *supra* note 76, at xiv.

206. See ARONOWITZ, *supra* note 78, at 37.

207. Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 42 U.S.C.).

given advances within the realm of genetic information,²⁰⁸ it is possible that new diagnoses will emerge. In an era of expanding health care coverage, all costs must be more closely examined.

E. Less Reliance on Medical Diagnoses

The arguments presented in this Article call for less reliance by courts on medical diagnoses at the summary judgment stage of cases brought under the ADA.²⁰⁹ Specifically, in making disability trouble, I reject the notion that medical labels and diagnoses are objective. The discussion in Section III.B explains how many conditions that stand to qualify as disabilities under the ADA do not involve definitive tests, but rather depend on non-objective social phenomena.²¹⁰ Also, many diagnostic labels are themselves social creations devised in response to economic and political circumstances.²¹¹ Moreover, medical professionals may, through their acts of diagnosing patients, create the very symptoms constitutive of the conditions for which they are testing.²¹² In sum, one key insight of this Article is that diagnoses are less objective and less reliable than often presumed.²¹³ Also, given the previously discussed fact that many diagnoses rely heavily on patient input, the arguments in this Article suggest that disabled persons are capable of testifying about their conditions and the effect they have on major life activities.

Before examining courts' reliance on medical diagnoses, it may be useful to examine the prima facie requirements under the "actual disability" prong of the ADA, where the issue of medical evidence typically arises. Actual disability contains three separate requirements: (1) There must be a physical or mental impairment; (2) the impairment must be substantially limiting; and (3) the

208. For example, scientists have recently discovered that a gene associated with height is linked to a genetic variant that predisposes its carriers to certain types of disease. Steve Connor, *Newly Discovered Height Gene Has Disease Link*, INDEPENDENT, Sept. 3, 2007, at 13 (quoting Mike Weedon of the Peninsula Medical School).

209. Cf. Noah, *supra* note 141, at 303-06 (calling for courts and agencies to reduce reliance on medical diagnoses); Deirdre M. Smith, *Who Says You're Disabled? The Role of Medical Evidence in the ADA Definition of Disability*, 82 TUL. L. REV. 1 (2007) (calling for courts to reduce their reliance on medical evidence at the summary judgment stage when a plaintiff seeks to establish a claim of disability under the ADA.).

210. See *supra* Subsection III.B.1.

211. See *supra* Section III.B.

212. See *supra* Section III.C.

213. This argument fits under the broader Foucauldian claim that medical institutions operate under a veneer of objectivity, but are in fact social institutions that rest on social knowledge and social judgments. See generally FOUCAULT AND THE GOVERNMENT OF DISABILITY, *supra* note 163.

impairment must substantially limit a major life activity.²¹⁴ It is the second requirement—that the impairment *substantially limit* a major life activity—that has garnered the majority of federal courts’ attention.²¹⁵

Though making a *prima facie* case of actual disability does not require any evidence beyond what would be known first-hand by the plaintiff,²¹⁶ courts often require medical evidence from plaintiffs at the summary judgment stage.²¹⁷ Indeed, courts rely heavily on medical diagnoses for determining whether plaintiffs satisfy the definition for actual disability,²¹⁸ and they have been willing to grant summary judgment for defendants solely because plaintiffs did not present medical evidence in support of their disabilities.²¹⁹ Moreover, courts often require medical evidence not only to help determine whether an impairment is present, but also to help determine whether the impairment is substantially limiting.²²⁰ Courts’ reliance on medical diagnoses may even increase since the ADAAA has made it easier for an individual seeking protection under the ADA to establish that she has a disability within the meaning of the ADA. Courts may feel that retaining the medical evidence hurdle helps to counterbalance the ADAAA’s statutorily imposed loosening of the ADA’s threshold requirements.

Yet the *de facto* requirement of medical evidence for establishing a *prima facie* case under the ADA is unprincipled. As an initial matter, neither the ADA

214. 42 U.S.C. § 12102(1)(A) (Supp. 2010).

215. Areheart, *supra* note 2, at 211-12.

216. See Smith, *supra* note 209, at 35 (noting that the judge’s function at the summary judgment stage does not involve “weigh[ing] the evidence and determin[ing] the truth of the matter” (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986))).

217. *Id.* at 19-24.

218. *Id.* at 20 (“[T]he dominant trend . . . is to assign a central and indispensable role to medical professionals in establishing disability for purposes of the ADA.”). Smith notes that some courts have taken an intermediate approach—which they believe to be the “majority rule”—in which the necessity of medical evidence depends upon the type of disability claimed and whether it is found by the court to be within the comprehension of an average lay juror. *Id.* at 24 & n.96. However, the Second Circuit approach of requiring medical evidence in order to establish a *prima facie* case under the ADA is the approach taken by a majority of courts. *Id.* at 24 n.96.

219. *Id.* at 40-42.

220. See, e.g., *Machin-Rodriguez v. C&C P’ship Coca Cola P.R.*, No. 03-1746, 2005 U.S. Dist. LEXIS 42937, at *13 (D.P.R. Sept. 20, 2005) (“Plaintiff’s medical evidence is completely devoid of any reference as to the effect that Plaintiff’s depression has had, if any, on his major life activities.”); *Baerga v. Hosp. for Special Surgery*, 15 Am. Disabilities Cas. (BNA) 111, 116 (S.D.N.Y. Sept. 30, 2003) (“Plaintiff’s failure to provide medical documentation of his alleged sleeping difficulties renders his ‘substantial limitation’ showing insufficient as a matter of law.”).

nor the EEOC's regulations require such evidence.²²¹ Additionally, because no list of presumptive or *per se* disabilities currently exists,²²² a plaintiff's ability to qualify as having an actual disability under the ADA depends on the functional effect that an impairment has on his or her life. This inquiry into the substantiality of the impairment involves facts about which the plaintiff is uniquely suited to testify. For example, a plaintiff is particularly well-equipped to testify regarding whether his back pain or medication prevents him from performing certain major life activities.²²³ A physician would only be able to authoritatively testify as to back pain's general effect on people, and such testimony would stand in stark contrast to the individualized inquiry mandated by the ADA.²²⁴

Finally, and most notably, my argument that courts should not require medical evidence to show substantiality under the ADA's "actual disability" prong is about establishing a *prima facie* case—what is required to make it to a fact-finder—and not about what is ultimately persuasive to a fact-finder. It may well be appropriate (and persuasive) for a jury to consider medical evidence and testimony as part of a plaintiff's case.²²⁵ My argument is that a plaintiff ought to create a fact issue on the substantiality requirement by his or her testimony alone. Requiring medical evidence at the summary judgment stage essentially delegates what should be a jury's credibility determination to physicians.²²⁶ Such a requirement places an additional hurdle in front of ADA plaintiffs that is not required by the statute or the EEOC's regulations.²²⁷

CONCLUSION

Disability scholarship is now in a critical stage. Theoretically, work on disability is young and entering a second wave of critical development.²²⁸ Jurisprudentially, disability is at a pivotal stage as courts prepare to reinterpret the provisions of the ADA in light of recent amendments. It is both timely and

221. Smith, *supra* note 209, at 7.

222. See *supra* Section IV.B.

223. Smith, *supra* note 209, at 67.

224. See *Bragdon v. Abbott*, 524 U.S. 624, 657 (1998) (explaining that the ADA mandates "an individualized inquiry" for determining whether one has a covered disability).

225. See Smith, *supra* note 209, at 62 ("A plaintiff who proceeds to trial without some medical evidence to support her claims of harm does so at her own peril, but, of course, courts allow imperiled claims to go to trial all the time.").

226. *Id.* at 41.

227. Smith, *supra* note 209, at 7.

228. See Lennard J. Davis, *Preface to the Second Edition*, in *THE DISABILITY STUDIES READER*, *supra* note 6, at xiii, xiii (explaining that disability scholarship is entering a second wave of development in which "the foundational 'truths' come under new scrutiny").

appropriate to rethink the meaning of disability, and this requires attention to the core explanatory construct in disability theory: the disability binary.

This Article advances the conversation about disability identity in a way that is attentive to related areas of scholarship, especially feminist work on the gender/sex binary. In this way, disability scholarship may draw on the richness of others' contributions and avoid wheel-reinventing. There are legal implications to rethinking disability identity, and this Article identifies several of them. Hopefully, scholars and activists will build upon these insights to further bridge disability theory and practice.