Abstract: This article proposes a new way to understand the oppression of ableism beyond inaccessibility or discrimination through the modal device of *counterfactual bodies*. I begin with a brief overview of counterfactual bodies, defined here as the reimagining of disabled individuals without their disability. Some counterfactual bodies, I contend, become vehicles of oppression when distorted by the imperative of cure. Under the imperative of cure, striving to actualize a counterfactual body becomes a morally laden aim for disabled bodies. Next, I outline some of the material, psychological and economic costs of striving to actualize a counterfactual body, which includes the disproportionate distribution of resources, suspended body grief, and pain and suffering. Finally, I consider the conditions under which a counterfactual body becomes oppressive, i.e. a manifestation of ableism. While ultimately concluding that oppressiveness of counterfactual bodies is context dependent, I argue that the imperative of cure is a necessary (but not sufficient) condition for counterfactual bodies to become tools of oppression.

Counterfactual Bodies, Ableism, and Oppression as *Possibilia*

"Can one ever see a disabled body as it is, not as it was or as it should become?"

Eunjung Kim, *Curative Violence*

Consider the following cases:

1. After receiving her diagnosis of fibromyalgia, Liz Moore (2020: 76) describes her state of mind throughout the first few years as follows:

> "I am desperate for a cure, to regain the life I used to have when I hiked and camped and could take a full course load of classes and when reading was easy. Back when I didn't have to remember to take medications or, worse yet, refill the pillboxes."

2. In his memoir and collection of critical essays, Eli Clare (2017: 15) highlights the impossibility of a version of himself without cerebral palsy:

> "But for some of us, even if we accept disability as damage to individual bodies, these tenets quickly become tangled, because an original nondisabled state of being doesn't exist … The vision of me without tremoring hands and slurred speech, with more balance and coordination, doesn't originate from my visceral history. Rather, it arises from an imagination of what I should be like."

3. Elizabeth Engelman (2017) recounts her deaf son's reaction to his cochlear implant, having received his implants just before his third birthday:

> "I said, 'Hi Micah, can you hear mommy?' His hazel eyes widened and he screamed in terror, his body trembling. Shock."

Micah's shock didn't fade. In fact, his shock soon translated into full-throttle resistance that led to physical altercations between Elizabeth and her young child:

> "At home, I wrapped my legs around my toddler and pinned him to the carpet in what looked like a wrestling hold as I tried to keep the processors for his implants on his head. He was crying, and I was crying, and I wondered if my actions could be considered abuse.
> He refused to wear the $18,000 sound processors, and his defiance was feral: head butts to my face, kicks, bites. The back of his head smacked against my jaw, and for a moment everything went black. The [cochlear] implant surgery alone had cost $50,000. Auditory verbal therapy was out of pocket, the doctors were out of network. What choice did I have but to force him?"

Existing philosophical conversations around ableism often prioritize questions of accessibility and the discriminatory inaccessibility of legal, medical, educational, and cultural resources (Linton 1998; Nario-Redmond 2020; Reynolds 2017; Peña-Guzmán and Reynolds 2019; Wieseler 2020; Lewis 2022; Wolbring 2008). Yet this over-reliance on questions of access limits our ability to make sense of other shared experiences within and across disabled communities (Smilges 2023). Turning to the opening testimonies, we might say that inaccessibility explains, to some degree, why Liz Moore can't hike as easily. Yet it fails to capture the long-standing turmoil and grief that followed her change of circumstances. Inaccessibility (or at the very least, a distorted form of access) might partially explain why Elizabeth Engelman forced her young son to wear his cochlear implants even as he violently resisted.[1] But it doesn't explain the trauma that arises when deaf bodies are forced to conform to the hearing world under threats of violence, even (and perhaps especially) from loved ones. And inaccessibility can't explain why friends and strangers seem fixated on the image of Eli Clare without cerebral palsy, even as someone who was born with and lived his whole life with cerebral palsy. Inaccessibility is undoubtedly part of the story of ableism, but there is more to tell. This article aims to begin developing our understanding of ableism beyond questions of accessibility.

Using the novel modal device of *counterfactual bodies,* I argue that tracing the oppressive function of counterfactual bodies provides new insight into our understanding of ableism. My argument begins with a brief overview of counterfactual bodies, the curative origins of oppressive counterfactual bodies, and how they continue to proliferate at the institutional and interpersonal level. Distinguishing between oppressive counterfactual bodies (which I call *pernicious counterfactual bodies)* and their non-oppressive counterparts, I argue that some counterfactual bodies become manifestations of ableism through the imperative of cure. Under the imperative of cure, striving to

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[1] Thank you to the anonymous reviewer who emphasized this point.

actualize counterfactual bodies becomes a morally-laden aim, subsequently turning these pernicious counterfactual bodies into tools of oppression. Next, I outline the oppressive costs of counterfactual bodies, holding that the impetus to actualize counterfactual bodies perpetuates systematic material, psychological and economic harms against disabled bodies. These harms include (but not limited to) the disproportionate distribution of resources, suspended body grief, and suffering and death. Finally, I consider the question of when counterfactual bodies become tools of oppression. While ultimately concluding that the answer to this question is context dependent, I argue that the imperative of cure is a necessary, but not sufficient condition for counterfactual bodies to become pernicious.

A brief note about my terminology in this article—I use the term "disabled" to refer inclusively to Deaf, chronically ill, mad, crip, and neurodivergent individuals. While philosophers have often distinguished between these categories, I use the term expansively because I think it is a mistake to fracture these groups in our philosophical arguments. But even if one disagrees with this approach, my argument will not rely on the assumption that each of these different groups is disabled. Instead, my argument hinges on the weaker claim that these groups experience ableism.

What is a Counterfactual Body?

One of the striking commonalities across the three opening testimonials is the way in which they center on bodily possibilities. For Moore, the possibilities that are no longer afforded to her body serve as the source of her desperation post-diagnosis. For Clare, the imagined possibilities that were never afforded to his body seem to be the source of his frustration. And for Elizabeth Engelman, the possible body she desires for her son Micah motivates her actions. And other testimonials from other disabled people evince similar experiences of grief, pain, and desperation tethered to possibilities. While philosophers of disability have generally shied away from phenomenological accounts of ableism, I take this complicated relationship to bodily possibilities to be a fruitful starting point for further explorations of ableism. Taking these yearnings for a former life and body, or the constant wishing for an imaginary, non-disabled version of a body seriously, then, *counterfactual bodies* serve as the basis of my analysis of ableism. I define counterfactual bodies as the reimagining of disabled individuals without their disability. In some cases, like Moore, the counterfactual body is fully fleshed out and relies on the previous experiences and memories of inhabiting an abled body. In other cases, like Clare and Engelman, the counterfactual body relies on some combination of disrupted expectations guiding normative assumptions about bodies. And counterfactual bodies are more than a first-person phenomenon. Rather, such counterfactual bodies guide the actions and behaviours of both individuals (loved ones, strangers, and disabled people themselves) as well as societal institutions, in addition to shaping the self-perception of disabled people as deficient or incomplete.

Worth thinking through here is the question of how such counterfactual bodies arise and, perhaps more importantly, how they proliferate. We might turn to the medicalization of disabled bodies (among others) as a possible candidate. Broadly, standards of normalcy for the human body gained significant traction through the work of Adolphe de Quetelet (1796-1874), a Belgian statistician and well-known eugenicist (Davis 1995: 23-49). Applying his statistical training to physical, intellectual, and moral properties, Quetelet formulated the concept of l'*homme moyen* and turned common features into physical, intellectual, and moral exemplars. But the establishment of the mean entailed the corresponding construction of deviance. Within the larger context of Darwinism and its popular eugenicist misapplication to human bodies, deviance was quickly codified as a threat to the progress of the species (Baynton 1996). If average bodies contribute to humanity's physical, intellectual, and moral progress, then deviant, disabled bodies become a threat to said progress, which must be corrected. From this, it's clear to see how morality might require the normalization and "correction" of deviant bodies, tragically leading to violence.[2]

And the notion of correction—better known as cure—is intimately tied to the concept of counterfactual bodies. While not often thought of in modal terms, cures and curative practices rely heavily on the possibilities afforded to bodies. After all, the possibility of a cured body frequently underpins and guides curative procedures. One scholar who has developed the modal dimension of the concept of cure, albeit in slightly different terms, is Eunjung Kim in her book *Curative Violence*.[3] Understanding cure as a process of political, moral, emotional, and economic negotiations between disability and normality, Kim conceives of curative violence as force used to eradicate differences across bodies in the name of improvement (2017: 41). In the tradition of Judith Butler's normative violence, curative violence is motivated by "the imperative of cure"—that is, the idea that the only permissible way to live and engage with disability and disabled body is by striving towards cure (2017: 14-15). Under the curative impetus, violence can unfold in at least two ways:

1. The violence of rejecting the possibilities of life with disability as merely different but equally valuable ways of life, and
2. The physical violence that is preemptively justified under any attempt to cure disabilities.

Taken within the context of the imperative of cure, then, counterfactual bodies originate from our ordinary, innocuous imaginings.[4] Guided by our socially determined standards of normality, comparisons arise between the actual body and the cured imagined body—that is, the counterfactual body—bring non-normative features of the disabled body sharply into view. Under the curative impetus, counterfactual bodies become a morally-laden aim, (falsely) presented as the

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[2] Counterfactual bodies are tied to eugenics, however it is worth noting that not all bodies were (and are) impacted by eugenics equally. While I briefly address this point in the next section, forthcoming projects delve into the question of eugenics, race, and counterfactual bodies.

[3] Thanks to Julia Chang for drawing my attention to Kim's work.

[4] I use "imperative of cure" and "curative impetus" interchangeably.

only viable, livable option and engendering action (including curative violence), to actualize these imagined bodies.[5] Counterfactual bodies, then, become manifestations of ableism, oppressing in the name of (and through) the imperative of cure.

Of course, one might resist my argument on the grounds that the eugenicist origins of curative violence have long since dissipated, given the scientific, medical and political rejection of eugenics post-World War II. There are two responses worth emphasizing here: firstly, it is far from clear that such a rejection took place beyond surface-level renaming of practices and associations. Genetic screening, reproductive selections, and population control might be the most obvious example of historical and intellectual continuity with eugenic projects, but it is far from the only example (Peterson 2024: 254-259). And secondly, claiming that eugenics was rejected in this way does not entail that its underlying ideologies (i.e. the imperative of cure) cannot continue to inform medical, scientific, and political practices and institutions. As Eli Clare argues in *Brilliant Imperfection: Grappling with Cure*, the medical industrial system is a primary example of an institution that perpetuates the imperative of cure (2017: 15). We might think here of the tens of thousands of dollars poured into research dedicated to curing autism in children as one small but representative example of how the imperative of cure underpins the medical industrial system. This is not to say that this is all there is to medical research, nor is it to suggest that all cures are necessarily bad, but instead that the historical and intellectual relationship between eugenicist projects and the medical industrial complex has led to a curative impetus that often goes critically unchecked (Bashford 2010: 540-553).

While the medical-industrial complex is a significant factor in creating and enforcing counterfactual bodies, it is far from the only institution that ensures their ubiquity. Consider, for

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[5] Readers familiar with the disability studies literature might be asking if counterfactual bodies are not similar to Alison Kafer's" imagined body," as presented in her discussion of Ashley X in *Feminist, Queer, Crip.* Kafer's concept of "imagined body" is temporal and considers the body that Ashley X would develop, whereas my concept of "counterfactual bodies" is modal and concerns the body that disabled people should desire.

example, the fact that most education systems take for granted that the primary modality of language instruction ought to be verbal as opposed to signed. The standards established by these societal institutions often communicate important assumptions about what body will be valued, and perhaps more importantly, what body will be excluded. Another way in which counterfactual bodies are institutionally proliferated is via the wellness industry. Much of the wellness industry is centred on the aim of getting your healthiest and "best" body through quick (and overwhelmingly ineffective) fixes. The wellness industry encourages consumers to think about their counterfactual bodies by promising an easy and efficient means to achieving them. So behind the individual drinking chlorophyll daily or strictly sticking to a carnivore diet, we often find counterfactual bodies shaping such choices and behaviours—sometimes dangerously so.[6]

The medical-industrial complex, our educational systems, and the wellness industry, then, are three key institutions that sustain counterfactual bodies, but counterfactual bodies are not solely proliferated by institutions. Inspiration porn, and its grip on the cultural imaginary, is another place in which we find counterfactual bodies being reinforced by the "success" of the cure, as in the case of audiences flocking to videos of deaf children with new cochlear implants hearing their mother's voice for the first time.[7] And finally, interpersonal interactions might also sustain counterfactual bodies. In their most extreme form, they might look like Elizabeth Engelman pinning down her toddler to insert his implants, but ordinary conversations can do the trick equally well. A parent forcing their child to undergo another surgery, a romantic partner pressuring their partner to take anti-depressants, or any other moment in which a loved one seeks to uncritically force a "cure" onto a disabled body can enforce the counterfactual body. The point here is that our social

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[6] Jane Dryden's "The Gut Microbiome and the Imperative of Normalcy" highlights this by arguing that incredibly complex research on gut health has increasingly become a manner through which society enforces "an imperative of normalcy."

[7] Thanks to Liz Schoppelrei for highlighting the example of inspiration porn.

world—institutions, interpersonal relationships, and social expressions that support the imperative of cure—subsequently sustain counterfactual bodies.

To reiterate, then: thinking beyond ableism as a form of inaccessibility brings us to the question of possibilities and the concept of counterfactual bodies. Counterfactual bodies originate through a familiar comparison between bodies and the normalcy standards, and they are enforced and sustained by the imperative of cure. The curative impetus, enforced by our institutions and other parts of our social world, reaffirms cure as the only viable possibility for disabled people.

And yet, it seems intuitive to say many of these counterfactual imaginings are not manifestations of oppression—far from it. In other words, an account of counterfactual bodies needs to make space for the fact that we imagine alternate versions of ourselves all the time without concern. And not only do such imaginings seem to be non-oppressive, they seem to be core elements of our agency. Consider the work of Catriona Mackenzie and other feminist philosophers who have long defended the importance of engaging in imaginative counterfactual speculation. As Mackenzie has argued, our ability to take on "different possibilities or postures of the self" is a central tenet of our agency (2005: 138). And under conditions of oppression, Mackenzie emphasizes, these imaginings seem even more important because they provide the recourse of imagining a better life.

There is absolutely something right about Mackenzie's picture–imagining oneself otherwise is valuable for people. But it is not the mere fact of imagining otherwise that underpins the oppressiveness of counterfactual bodies. Rather, it is the imagining of possibilities by oneself and others which are distorted by the imperative of cure, subsequently leading to harm motivated by the aim of eradicating embodied differences. While everyone imagines themselves otherwise, not everyone is subject to the imperative to instantiate these imaginings, nor are they subject to unjust systematic harms in the attempt to instantiate said imaginings. It is important, then, to recognize that certain bodies are subject to different aims on account of such possibilities. This is not to say that all imaginings of possibilities are necessarily oppressive to non-normative bodies, but rather that there is a set of possibilities that can be distorted by the imperative of cure and therefore become mechanisms of oppression. If we want to claim that counterfactual bodies can be oppressive, then we need to know how these counterfactual bodies wrong disabled people and at what point they become oppressive.

The Oppressive Costs of Pernicious Counterfactual Bodies

Counterfactual bodies are grounded in the idea that possibilities afforded to our bodies can be distorted, thereby contributing to oppression. But for this modal device to be philosophically useful in elucidating ableism, we need a clearer understanding of how counterfactual bodies come to be distorted in this way. In other words, under what conditions do some counterfactual bodies become vehicles of oppression (as opposed to merely wrong)? And how do these distorted counterfactual bodies impact the lived reality of disabled people? The next two sections, then, are dedicated to sketching out preliminary answers to these questions. For the sake of clarity, I will reserve the term *counterfactual bodies* to refer generally to any sustained reimagining of disabled individuals without their disability and the term *pernicious counterfactual bodies* to refer to those counterfactual bodies which come at the expense of actual disabled bodies under the curative impetus. That is, pernicious counterfactual bodies refer specifically to those bodies which become manifestations of oppression.

Taking seriously the concept of pernicious counterfactual bodies entails that possibilities play a non-negligible role in our structures of oppression. This idea should already be somewhat familiar to philosophers, given its kinship to Feinberg's claim that we can be wronged by being unduly robbed of some set of possibilities. But my claim here is slightly different. Rather than people being wronged in virtue of the denial of possibilities, they are harmed by the sustained proximity of *particular* possibilities which have been distorted. It is not the possibility itself (that is, the counterfactual body) that harms disabled people, but rather the way in which such possibilities become a vehicle for oppressive ideologies like the curative impetus. The pernicious counterfactual body therefore acts as a spectre, haunting disabled bodies, loved ones, and even institutions with the illusion of a non-disabled version of a disabled person. The problem with pernicious counterfactual bodies, however, is not merely the poisonous imaginings, but the way in which the impetus to actualize such counterfactual bodies comes at a material, social, and morally non-negligible cost, therefore leading to oppression.

Broadly inspired by Ann Cudd's account of oppression, then, I outline three ways in which the impetus to actualize pernicious counterfactual bodies perpetuates systematic material, economic, and psychological harms against disabled people (Cudd 2006). While these are not the only ways that pernicious counterfactual bodies can come at the expense of disabled people, they constitute some of the most egregious harms. Alongside the other, more familiar harms of ableism like discrimination and paternalism, pernicious counterfactual bodies operate within a broader context of harm and contribute to the oppression of disabled bodies, not unlike Marilyn Frye's birdcage.

In *The Politics of Reality*, Frye argues that oppressed groups are reduced, controlled, and trapped by a network of systematically related forces, and this oppression is only visible at the macroscopic level—that is, if one looks at the whole structure, and the plight of the collective group enmeshed in it. Just as a microscopic perspective might not reveal the network of interconnected wires that prevents a bird from flying free, Frye argues, viewing oppression from a microscopic view similarly disguises the network which constrains oppressed people. But take a step back and suddenly seemingly unrelated wires weave together to form a cage "as confining as the solid walls of a dungeon" (1983: 5). The primary insight behind Frye's account, then, is that the perspective we take can shape and contextualize individual harms as part of a larger system of oppression. Building on this insight, pernicious counterfactual bodies provide another way for us to recognize the impact of the curative impetus on many disabled people across a wide range of different disabilities. Pernicious counterfactual bodies might therefore be understood as one wire constituting the birdcage of ableism. Seemingly innocent imaginings of another body, alongside widespread discrimination, epistemic injustice, and the continued exclusion of disabled bodies, do not exist in isolation from one another. Rather, they operate in relation to one another and, by doing so, trap, control, and oppress the disabled community by making their actual bodies functionally unlivable. In what follows, I outline three categories which demonstrate the systematic material, economic, and psychological harms that arise from the imperative to actualize one's counterfactual body—*disproportionate commitment of resources*, *suspended body grief*, and *pain, suffering, and death*. Worth bearing in mind here is the fact that these categories might be more or less pertinent to different kinds of disabilities; they are meant to serve as a broad starting point rather than an exhaustive list.

I. *Disproportionate Commitment of Resources*

One way in which disabled bodies suffer under the imperative to actualize counterfactual bodies is through the disproportionate commitment of resources, both at the individual and societal levels. By this, I mean the usage of material, psychological, economic, and temporal resources to transform one's actual body into the counterfactual body, including but not limited to money, time, energy, and labour. For an example of how this distribution of resources operates at the individual level, consider the example of June Eric-Udorie, a young woman diagnosed at birth with Congenital Idiopathic Nystagmus. Discussing the impact of relentless visits to the doctor with her mother, Eric-Udorie (2020: 54) notes, "For a huge part of my childhood, I felt like I was a piece of clockwork waiting to be fixed. The feelings started early, with the numerous appointments to eye specialists with my mother, trying to see if there was a way to cure my dancing eyes. 'It is incurable,' the doctor would say, and when we got home my mother would wail, even though the doctor, like many other doctors, simply confirmed what she was told when I was born on that rainy Thursday in 1998."

For Eric-Udorie's mother, the possibility of a daughter without Congenital Idiopathic Nystagmus is worth the countless visits to the doctors and hours wasted on medical tests. The time, energy, and money dedicated to curing her daughter's condition are clear ways that Eric-Udorie's counterfactual body is prioritized and her actual body is subsequently devalued. Without attributing individual malicious attention, this distribution of resources highlights the ways in which the curative impetus covers up alternate possibilities—such as a flourishing life with Congenital Idiopathic Nystagmus—for Eric-Udorie's mother and others. And Eric-Udorie's experience is far from unique, as disabled people will frequently tell of the hours spent in the doctor's office, the money wasted on homeopathic cures, or the energy drained by remedial speech therapy. The disproportionate dedication of these resources toward instantiating the counterfactual body could have been otherwise dedicated to the disabled individual—time spent together rather than at the doctor's office, money for accessible technologies and ease or comfort, and energy dedicated to building and sustaining a relationship of love and acceptance.

At the societal level, we find the same pattern amplified. The resources dedicated to the counterfactual bodies under the guise of "ending Type-1 diabetes," for example, come at the direct cost of supporting disabled individuals with those very conditions. Diabetic bodies need a robust health care system, accommodations during school, accessible work conditions, and affordable food that support stable blood sugar efficiently. But these needs come secondary to the quest to end

Type-1 diabetes through marathons, fundraisers, and the like.[8] At least some of the resources dedicated to eradication would ease the burdens that can arise with Type-1 diabetes, and yet, the counterfactual body comes first.

Finally, it is important to recognize that disproportionate commitments of resources can have radically different impacts depending on one's intersectional identities, especially socio-economic class.[9] For low-income and working-class communities, the imperative to instantiate one's counterfactual body becomes an additional burden to navigate among so many others. So while the disproportionate distribution of resources harms disabled people and their families across the socio-economic spectrum, some groups are more vulnerable to its harm than others.

II. Suspended Body Grief

Actualizing counterfactual bodies might also come at the expense of disabled bodies through their impact on one's relationship with their body and their understanding of their own agency. One way to make sense of this harm is through the concept of "body grief" and the way counterfactual bodies impede the processing of body grief. Initially coined by disabled writer Jayne Mattingly, body grief is the continuous act of learning and confronting one's embodiment, for better or worse. In Mattingly's own words,

"[B]ody grief is a sense of loss — loss of freedom, loss of control, loss of safety, loss of hope. And as with any loss, we can only reach a place of acceptance once we have learned to grieve: a cyclical, and often lifelong process that requires awareness, sharing, storytelling, patience, deep feeling, and the choice to live with our grief."[10]

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[8] This type of example comes from Eli Clare's discussion of Autism Speaks fundraisers in *Brilliant Imperfection: Grappling with Cure* (Duke University Press, 2017), 85-89.

[9] Thanks to Willow Starr for emphasizing this point.

[10] Jayne Mattingly, "Body Grief and Disability Pride Can Coexist," *The Unpublishable,* July 30, 2023, https://jessicadefino.substack.com/p/body-grief-and-disability-pride?utm_source=post-email-title&publication_id=43028&post_id=130990985&isFreemail=false.

While Mattingly highlights that the experience of body grief is universal, body grief is especially prevalent among disabled bodies, given that disabilities are often accompanied by pain, distinct psychosocial needs, or a mode of engaging with the world in tension with the social, normative, or built environment. This is true whether one is born with a disability or becomes disabled, because living with a disability often involves constantly re-learning how to navigate the ever-changing world with one's distinctive body and embodied needs. These ruptures and moments of forced learning that disabled bodies experience when their needs come into conflict with the world around them generate a familiarity with body grief. And even if one does process their body grief in their everyday context, an unexpected situation or new experience might provoke a new wave of grief. And the stakes of engaging with body grief should be clear. Without some acceptance of one's actual body, with its opportunities and limitations, exercising one's agency becomes much harder. Trying out new (or restarting old) hobbies, finding a more accessible job, taking classes—ordinary moments of life become more complicated in the face of unprocessed grief towards one's actual body.

Yet pernicious counterfactual bodies can constrain disabled bodies from confronting body grief. If disabled bodies are inundated with the pretense of a cure on the horizon and there is no possibility of a flourishing life without a cure, then processing body grief becomes unnecessary. In the ugliest twist of fate, body grief is disrupted by the idea of a counterfactual body, free of disability and grief and betrayal, and full of possibilities. By providing an idealized alternative, counterfactual bodies interrupt the body grief process and prevent disabled bodies from negotiating, learning, and accepting their actual bodies, even if such acceptance is dynamic. As Eunjung Kim (2017: 9) aptly notes, "In that sense, for disabled people normality exists always one moment away, urging us to suspend our life in the present and not to attempt social changes." Suspended body grief, then, robs disabled bodies of the struggle to care for and love ourselves. And perhaps more importantly, it robs us of the valuable lesson that our body may not always meet our expectations, but it is, as Mattingly rightly reminds us, "always on our side" (2025).

It's also important to note that bodygrief does not only impact individuals with physical disabilities. The "body" of body grief is understood expansively, capturing embodied conditions, behaviours, and modes of being in the world. In the case of cognitive and neurodevelopmental disabilities, we might distinguish between disabled bodies with low and medium support needs and high support needs. In lower or medium support neurodevelopmental disabilities (like Dyslexia or ADHD), the common refrains of "try harder" and "just focus" offer one example of how body grief is effectively suspended by the false attribution of control. These refrains stem from a common understanding of dyslexia, for example, as a condition that can be overcome if individuals merely worked harder. But continued exposure to this false idea leads neurodivergent bodies to a vicious cycle of striving (and failing) to actualize a neurotypical counterfactual body, where this cycle is often compounded by frustration and shame (Gohring 2024). In these cycles, we find suspended body grief, where the focus on actualizing one's counterfactual body takes precedence over reconciling with one's body and developing strategies for success. And turning to cases of high support needs (more commonly known as profound cognitive or neurodevelopmental disabilities), we might ask whether they experience suspended body grief. Invoking Eva Feder Kittay's epistemic modesty, I don't have a clear answer and as I understand it, my argument does not depend on the answer to this question (2010: 404). These categories, as mentioned previously, are a starting point rather than an exclusive list.

Yet the notion of suspended body grief does give rise to an important, related question, namely, can one experience body grief for a body not one's own? Here we might distinguish whether it is morally appropriate for loved ones to experience body grief for a body not their own from whether this occurs as a matter of fact. While I address the moral question in further detail elsewhere, it seems clear families *do* experience a kind of body grief around their loved one's disabled body, regardless of whether they should. The examples of Elizabeth Engelman and June Eric-Udorie demonstrate as much. They also demonstrate that it seems *prima facie* wrong for family members to embrace a pernicious counterfactual body and suspend their body grief, rather than engage with their disabled loved one as they are.

III. Pain and Suffering

One final way that the imperative to actualize pernicious counterfactual bodies come at the cost of disabled bodies is through the pain and suffering inflicted onto disabled people. Curing a disability, if possible at all, is rarely a painless or easy process, and experimental procedures developed along the way are similarly rarely painless or easy. If the curative impetus preemptively justifies pain and suffering in the name of cure, then any pain and suffering inflicted to actualize a counterfactual body becomes justified—and these are tricky waters to tread.

This preemptively justified pain can arise as one is undergoing or recovering from a curative treatment. Take, for example, the common use of tobramycin, amikacin, or gentamicin to treat life-threatening respiratory infections in people living with Cystic Fibrosis. Otherwise known as aminoglycosides, these antibiotics have documented negative side effects including nephrotoxicity, neuromuscular blockade, and ototoxicity, better known as induced hearing loss (Tarshish et al. 2016: 6-12). Ototoxicity is especially common, with 2 to 45% of adults with Cystic Fibrosis reporting permanent, aminoglycoside-induced hearing loss (Guthrie 2008: 92). As a life-saving treatment, the importance of aminoglycosides cannot be discounted. But it is equally important to highlight the ways in which assumptions about what kind of pain or suffering is preemptively tolerable to disabled bodies arise in these contexts and often go unaddressed. Cures will never be pain-free nor will they be miraculously free of side effects and long-term consequences, and this entails that individual tolerance for pain and other adverse side effects cannot simply be assumed.[11]

Moreover, even if a cure is successful and minimally painful, post-treatment pain and suffering might also deter individuals from procedures, even if they instantiate counterfactual bodies. Vision restoration procedures, for example, are often touted as miraculous, and accounts of such procedures emphasize the joy and wonder experienced by their previously blind patients. Yet alongside that very real joy and wonder are accounts of widespread fear and depression, sometimes within a single individual. And there is little to no mention of the tragic cases in which vision restoration surgeries have led to suicide (Beauchamp-Pryor 2011: 10-11).

But what about those for whom there exists no cure who are nevertheless forced to conform, reshape, or mask behaviours and embodied differences in the hopes of passing? We might think here of Applied Behaviour Analysis, a form of therapy that uses systems of rewards and punishments to encourage "appropriate" behaviour and discourage "inappropriate" behaviour in autistic children. Such compliance-based therapies have been rightly criticized for incentivizing children to learn how to identify their autistic traits, mask them, and present as neurotypical, even though long-term masking has been recognized by some to lead to autistic burnout (McCarthy and Wilkenfeld 2020: 31-69). As Dora Raymaker and their research team have argued, autistic burnout often includes chronic exhaustion, increased sensitivity to stimuli and overstimulation, and a reduction of executive function skills, all of which compromise the quality of life of autistic adults (2020: 136-143). Moreover, prolonged autistic burnout can lead to physical and mental health deterioration, difficulties fulfilling daily tasks necessary for independent living, difficulty maintaining jobs or sustaining important relationships, and self-injury, suicidal ideations, and suicide attempts. So

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[11] To be clear, I am not suggesting that deafness is inherently painful or bad, but instead recognizing that it can be traumatic when unexpected, especially if individuals do not have access to signed languages, the Deaf community, support networks, and other communicative resources.

even behaviour-based curative treatments like Applied Behaviour Analysis can lead to distressing consequences for autistic bodies coerced into masking their neurodivergence.

This also leads us to the most dire consequence of the impetus to actualize counterfactual bodies—the death of disabled bodies. If a cured body is accepted as the only way to live a flourishing life, then what happens when one confronts the impossibility of a cure? For a disabled person, this reckoning can lead to the decision that death is better than a life with an incurable disability. Tragically, there isn't much in the way of research on suicide in disability communities. And what research does exist tells a story not focused on how disabilities don't make life worth living, but instead on how society's discrimination and assumptions about disabilities have a deleterious impact on mental health.[12] Contrast this lack of research, as disability activists and researchers emphasize, with the abundance of research and widespread public conversation around medical assistance in dying for people with disabilities. Within these two conversations, we can see how counterfactual bodies might play some role in reaffirming assumptions around "the life worth living" (Reynolds 2022). If the curative impetus tells us that disabilities must be cured and covers up possibilities for a flourishing life with a disability, then it is easy to see how one might attribute high suicide rates among disabled people to their disabilities. And so, instead of conversations dedicated to improving the social and material conditions which might ameliorate depression and suicide rates within the disabled community, we end up with conversations around medical assistance in dying, and who ought to determine when a disabled person's life is no longer worth living (Gill 2004: 185-189). This is not to flatten the complexity around the intersection of suicide and disability, nor is it to assume that there is a singular "disabled" position on the question. Rather, I aim to highlight how conversations around death and disability overwhelmingly rely on assumptions that a flourishing life is rendered impossible by some disabilities, and that this is not unrelated to the curative imperative.

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[12] See Stephanie Woodard's web page "Don't Ignore Suicide in the Disability Community—Live On!"

Trapped in their own bodies, according to this logic, disabled bodies can only be cured at all costs, or "freed" through death.

When Does a Counterfactual Body Become Oppressive?

Having outlined the costs of trying to actualize a pernicious counterfactual body, we turn next to the question of when a counterfactual body becomes pernicious. That is, under what conditions can a counterfactual body be distorted into a tool of oppression?

Counterfactual bodies are far from necessarily oppressive, and it seems clear that the broader category of counterfactual bodies includes those of the kind described by Catriona Mackenzie as central to one's agency.[13] Take, for example, disabled bodies living with cancer, chronic migraines, and IBS.[14] In these cases, it isn't clear that the counterfactual body functions perniciously. Unlike our opening examples, these counterfactual bodies seem to bring into view possibilities and motivate one to care for their actual body in the present moment. And counterfactual bodies seem to be especially important in cases of other life-threatening diseases, given the way they might be intertwined with hope and impact the statistical likelihood of success for treatments. Bearing in mind these non-oppressive counterfactual bodies, then, we move from the question of *how* a counterfactual body can become a tool of ableism to *when* it becomes so. That is, under what conditions does a counterfactual body pit a disabled body's interest against itself?

As I suggested earlier, pernicious counterfactual bodies are a distortion of our ordinary imaginative capacities, which are transformed into a tool of ableism by the curative impetus. The difference between pernicious counterfactual bodies and ordinary counterfactual bodies, then, does

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[13] Thanks to Kate Manne for emphasizing this point.

[14] It is worth noting here that classifying cancer as a type of disability is controversial–especially among cancer patients themselves. But given my expansive definition of disability, my account should be able to capture at least some of these cases. For more information, see Susan Magasi et al's "Cancer Survivors' Disability Experiences and Identities: A Qualitative Exploration to Advance Cancer Equity" in *International Journal of Environmental Research and Public Health*.

not seem to be a difference in kind. Rather, the imperative of cure distorts our ordinary imaginative capacities, thereby turning some counterfactual bodies into tools of oppression. Here I define the curative impetus along the familiar lines of the understanding of cure as both an unreservedly valuable and necessary aim for disabled bodies (Kafer 2013; Kim 2017). Perpetrated by both individuals and institutions, the curative impetus deems the eradication of embodied differences to be an unconditioned good, where such eradication includes but is not limited to physical changes, behavioural changes, and other changes pertaining to (and enacted through) one's body. We might therefore say that counterfactual bodies become vehicles of oppression under the curative impetus because their actualization is deemed an assumed good even if (or when) such instantiation comes at the material, psychological, and economic cost of the disabled person. Framed in this way, the oppressiveness of pernicious counterfactual bodies arises from the curative impetus imbuing the actualization of a counterfactual body with normative urgency and moral import.

But if counterfactual bodies become tools of oppression through the imperative of cure, then there are some questions that need to be addressed. For one, we might wonder whether it is morally salient if there actually exists a cure or curative practices for the disabled person. If so, we might assume that counterfactual bodies can only be oppressive when a cure does not exist. That is, the curative imperative is only oppressive when it violates the principle of *ought implies can*. We also might assume that if some cure is necessary for a disabled person's survival, then the counterfactual body cannot be oppressive. In the remaining half of this section, I'll call into question both of these claims by assessing both ideal and non-ideal curative conditions.[15] Let's begin with the actualization of counterfactual bodies under non-ideal conditions.

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[15] Thanks to Kate Manne for the framing of this analysis.

I. Non-Ideal (Real World) Actualizations of Counterfactual Bodies

If it is the case that the counterfactual body cannot be safely realized without disproportionate consequences for the disabled body, then the counterfactual bodies seem to be oppressive. Reconsidering the examples of Eli Clare, Liz Moore and Micah Engelman, we know that counterfactual bodies are simply not attainable for cerebral palsy, fibromyalgia, and deafness—creating conditions ripe for suspended body grief and physical suffering as resources are poured into the search for a cure. Under such conditions, then, we find a clear violation of the principle of *ought implies can,* and it seems clear that such counterfactual bodies become oppressive.

But what about cases in which a cure does exist, but they result in disproportionate consequences or reduced well-being? Or cures that cannot always be safely realized?. Take, for example, chemotherapy. If the counterfactual body is a body that is cancer-free *and* there exists a treatment to render the body cancer-free, then it seems as though these counterfactual bodies *can* be realized. Does this mean that these bodies are necessarily non-oppressive? Our instinct here might be to say so. And that might very well be the case for many, if not most, disabled bodies under these circumstances—such counterfactual bodies might motivate strength and determination instead of pernicious entrapment and oppression. But it doesn't exclude the possibility that for some disabled bodies, a counterfactual body can be oppressive *even when it is necessary for survival.*

This might strike readers as unintuitive, but consider the case of cancer patients who reject chemotherapy. The decision to reject such treatments is a complicated one that remains understudied. But first-hand accounts from physicians whose patients reject chemotherapy tell of a story that coheres with a curative impetus, pernicious counterfactual bodies, and curative violence in the form of preemptively justified suffering. Researchers estimate that up to 19% of cancer patients have either wholly or partially refused chemotherapy, citing reasons that notably include "fear of adverse side effects of cancer treatment (particularly chemotherapy)" among others (Frenkel 2013:

634-636). After all, chemotherapies often do more than treat cancer, frequently turning otherwise able-bodied cancer patients into disabled cancer survivors (Nekhlyudov et al. 2022: 222-229). And that might be a worthwhile trade-off for some (or even most) people, but it will not be the case for everyone. While such refusal has sometimes been attributed to a lack of education by some (Chang et al. 2021: 618), internationally recognized expert in integrative oncology, Moshe Frenkel (2013: 634), emphasizes otherwise:

> "Patients are often aware of the serious side effects and complications that are likely to accompany conventional therapies, and some have witnessed the ultimate futility of such interventions. They weigh the evidence and often make choices that reflect their underlying values and beliefs rather than rely on medical evidence or advice as the determining factor."

It is here, then, that we find divergence between the oppressiveness of a counterfactual body and the necessity of cure. For some, the physical and emotional cost of chemotherapy is not preemptively justified. As Suzanna, one of Frenkel's patients, explained it:

> "Look, chemotherapy would add only 6% to my survival rate. But I would lose my hair, which is so precious to me, it would affect my social interactions, and I would suffer nausea and vomiting. In fact, the oncologist gave me a list of side effects two pages long! I've decided that I am willing to risk losing the theoretical 6% advantage chemotherapy would give me. Chemo would destroy my quality of life. I am not doing it."

For these patients, the curative treatment is simply not worth the physical and emotional costs. But such rejection comes at a steep price. Patients who refuse medical advice and recommended treatments are deemed "difficult," and the quality of their medical care subsequently suffers as physicians struggle to navigate their professional responsibilities in the face of such "noncompliance" (Frenkel 2013: 634-636; Asija 2012: 3-6). Whether due to disagreement with the patient's decision or a lack of guidance on what such care might look like, Frenkel highlights that health care workers “often feel uncomfortable, troubled, and even distressed” when dealing with patients who refuse treatment, which leads to communicative breakdown that can impact the quality of future care. Framed in terms of the curative impetus, such difficulties might be attributed to what seems to be a rejection of a realizable counterfactual body. Under the curative imperative, disabled bodies struggle to ask what forms of pain, violence, and suffering they are willing to undergo for the sake of a cure. But if we cannot explore concerns around cure (or reject some curative treatment without compromising the quality of one’s medical care), then such counterfactual bodies become pernicious tools of oppression.

And while the example of cancer patients might strike some as orthogonal to our ordinary intuitions about disability, it’s worth emphasizing that my argument is not strictly meant to apply to those who identify as disabled, but rather to the broader category of those who experience ableism. Moreover, we see a similar pattern in the case of the discontinuation of mood stabilizers by people living with Bipolar Disorder, with the discontinuation linked to increased risks of hospitalization, suicides, and higher mortality rates (Lintunen et al. 2023: 403). The point here is that these cases are not as rare as they may seem, and we ought not assume that the necessity of treatment for survival insulates bodies from the oppressiveness of the curative impetus.

Having said that, one might reject these conclusions on the grounds that they are empirical facts that can be ameliorated. That is, I have misdiagnosed the problem, and it is the side effects and impacts of curative treatments that generate oppressive conditions, and these can be improved. Just because there is no safely realizable cure now, the counterargument runs, does not entail that there will never be a safely realizable cure, and under safely realizable cures, counterfactual bodies will not be oppressive. I disagree, and in what follows, I argue that even under ideal conditions of actualizing one’s counterfactual body, such bodies can still be oppressive.

II. Ideal Actualizations of Counterfactual Bodies

Setting aside the unfortunate realities of our non-ideal world, let's consider ideal conditions for a cure. What if we imagine a pill that eradicates disabilities without pain, suffering, or any side effects? Would counterfactual bodies still be oppressive in a world with this perfect little cure?

My answer to this question is yes, and it ultimately comes down to the second form of curative violence identified by Kim. Even in a world with this cure pill, the curative impetus will unjustly distort the possibilities available to disabled people, rendering impossible the possibility of life with disability as merely different but equally valuable. The core wrong of ableism, as I have tried to emphasize, is the way in which the curative impetus frames cure as an unconditioned good. We can value the development and implementation of cures, but we must also make space for disabled bodies who do not need cures, want cures, or reject cures. If the curative impetus makes striving for a cure the only viable form of life, then counterfactual bodies will continue to become vehicles of oppression.

So, if we imagine this cure pill that can treat any and all disabilities, many disabled people would likely take the pill. The ability to fit in among neurotypicals, easing recurrent physical pain, wanting to return to one's previous life—all of these reasons will motivate people to accept the cure pill and realize their counterfactual bodies. Some disabled people will choose a cure in every possible world (curative impetus or not), and there is nothing wrong with accepting a cure to live in one's body with peace.

But there are other disabled people whose decision to accept a cure might depend on whether they can live a flourishing life with their disability. What would it mean for disabled bodies to truly live a flourishing life with a disability? For starters, it would require recognizing that disabilities are more than just deviant bodies. It would require recognizing Deaf Gain and the idea that deafness brings unique perspective and distinctive perceptual skills that contribute to human diversity (Bauman and Murray 2014). It would require recognizing that non-disabled bodies are not necessarily morally, physically, and aesthetically superior to disabled bodies. It would require recognizing the incredible beauty and joy that disabled artists have produced, like wheelchair dancing. It would require recognizing that these accomplishments arose *because* of disabilities, not despite them, and they could not have arisen without some resistance to the oppressive constraints of a counterfactual body. It would require recognizing that even if disabled bodies offer nothing unique or exceptional to the world, they still deserve the opportunity to live a life content in the body that they have. And it would require understanding that some bodies will continue to choose a cure. That is what would be required to imagine a world in which disabled bodies can live flourishing lives as they navigate their complicated, contradictory and ever-unfolding relationships with their bodies. A world in which disabled bodies can simply live *in* their bodies.

Consider again young Micah, who underwent cochlear implant surgery before his third birthday. His deafness was devalued and deemed a threat to his well-being, with cochlear implant surgery framed as its cure. But if we suspend the belief that deafness is necessarily inferior to hearing, then being deaf is merely another way to be in the world—neither better nor worse, just different. Thankfully, Elizabeth eventually came to exactly this conclusion and gave up on Micah's counterfactual body. She embraced her child as he was, enrolling him in American Sign Language classes and allowing him to remove his cochlear implant. As she (2017) explains,
"Micah's first sign was 'flower.' To sign 'flower,' the right hand grasps an imaginary stem and holds it first against the right nostril and then against the left, and like a flower, Micah blossomed one new sign at a time and took his implants off his head for good."

Taken together, then, we see that counterfactual bodies become pernicious under the imperative of cure. Whether one's counterfactual body becomes pernicious depends on contextual factors, including intersecting identities and material resources, so the imperative of cure is not sufficient. But minimally, we can conclude that the curative impetus is necessary for counterfactual bodies to become oppressive.

Concluding Thoughts

In this final section, I consider some implications of my argument with an eye toward future research on counterfactual bodies.

At this point, one might be wondering how counterfactual bodies fit into contemporary debates around possible worlds. If pernicious counterfactual bodies are oppressive, shouldn't I have more to say about the nature of these possible worlds? Or how are we afforded epistemic access to them? Additionally, this account also seems to assume that individuals are consistent across different possible worlds—otherwise known as transworld identity—yet this is (to put it mildly) a contested assumption. Some philosophers have accepted the possibility of transworld identity by defending the existence of individual "essences" or essential properties. Others have declared it incoherent or have jettisoned the idea in favour of counterpart theory—a theory proposed by David Lewis (1968) which argues for counterparts across possible worlds rather than identical bodies.

Helping myself to the language of possible worlds and counterfactuals is no accident, and while I do not have the space here to adequately address the complexity of these questions, I can offer some clarity on how I understand this project to relate to the established literature. Firstly, this account does not demand particular conceptions of the nature of possible worlds, nor does it take a strong position on the question of transworld identity. Many views on the nature of and our epistemic access to possible worlds cohere with this conceptual framework because possibilities operate as a tool of oppression—it exists as the birdcage, to return to Frye's metaphor. We can disagree about the nature of the wires running along the cage while accepting that birds are indeed trapped by the cage. Similarly, we can disagree on the nature of possible worlds while agreeing that disabled people can be trapped by the curative impetus and the counterfactual bodies of these possible worlds. In other words, what is relevant here is the logical function that these possible worlds play, not their metaphysical constitution. So if one is a realist about possible worlds, then disabled bodies are trapped by alternative worlds that they will never be able to actualize. And if one is a non-realist about possible worlds, then disabled bodies are trapped by impossible, abstract thoughts. Either way, disabled people are trapped.

Similarly, if one accepts transworld identity, then disabled bodies are oppressed by the possibility of who they could have been. If one accepts counterpart theory, then disabled bodies might be trapped by different versions of themselves. And if one rejects identity or counterparts across possible worlds, then the tragedy of counterfactual bodies becomes all the more bitter. Rejecting the logical coherence of possible worlds doesn't evaporate the social existence of counterfactual bodies—rather, it entails that ableist values and structures have trapped disabled bodies in incoherent imaginings, and disabled people are all the more wronged on account of it.

Additionally, we might consider how counterfactual bodies impact other groups beyond disabilities. For example, it seems obvious that the curative impetus also extends towards fat and trans bodies. Far from being a drawback of this account, this is a benefit insofar as it offers clarity to the murky shared experiences between disabled bodies, fat bodies, trans and non-binary bodies. Writers, activists, and theorists are increasingly bringing together these embodied experiences with the implicit understanding that there is some shared experience or common variable, but with little to say on what *exactly* is shared among them (Clare 2017; Lakshmi Piepzna-Samarasinha 2018; Lakshmi Piepzna-Samarasinha 2022; Kafer 2013). Counterfactual bodies offer one way of understanding such commonalities without reducing relevant differences or complexities.

Finally, it's worth reflecting briefly on the notion that possibilities can become tools of oppression. I tentatively conceive of counterfactual bodies as a feature of "modal oppression"—a novel framework that uses the concepts of modal logic to explain how possibilities impermissibly shape our world, actions, and behaviours. Through the language of modality, then, we can better understand ableism by taking seriously the conceptual, complex relationship between possibilities and the curative impetus. And with this understanding in hand, we can finally begin seeing disabled people as they truly are.

To perceive one as they are, not as they could be—could any form of justice not begin from this simple act?

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