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Australasian Philosophical Review, in press

Interrogating Incoherence and Prospects for a Trans-Positive Psychiatry

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Abstract

The core of Vincent and Jane's *Interrogating Incongruence* is critical of the appeal to the concept of incongruence in DSM-5 and ICD-11 characterisations of trans people, a critique taken to be ground-clearing for more trans-positive, psychiatrically-infused medical interventions. I concur with Vincent and Jane's ultimate goals but depart from the view developed in the paper on two fronts. The first is that I remain sceptical about the overall prospects for truly trans-positive psychiatry. Trans should follow homosexuality and other categories of sexual orientation that have been abandoned rather than reformed as constituents of psychiatric diagnosis and categorisation. The second is that I think that the authors' central criticisms of the appeal to incongruence are misplaced.

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Introduction

The core of *Interrogating Incongruence* is critical and focused on the appeal to the concept of incongruence in DSM-5 and ICD-11 characterisations of trans people. This critique is part of a larger meliorative project and might be taken as ground-clearing for more trans-positive, psychiatrically-infused medical interventions. The constructive recommendations that are sketched include a shift to focus on "*feelings* of incongruence, instead of incongruence *simpliciter*" (p.24). Here the authors encourage a socially located critical examination of such feelings within the context of a more complete range of options for people experiencing them.

I concur with the sentiment that this expresses but depart from the view developed in the paper on two fronts. The first is that I remain sceptical about the overall prospects for truly trans-positive psychiatry. Trans should follow homosexuality and other categories of sexual orientation that have been abandoned rather than reformed as constituents of psychiatric diagnosis and categorisation. The second is that I think that the authors' central criticisms of the appeal to incongruence are misplaced.

* I am grateful to the authors for writing a thoughtful and stimulating paper and to the journal for the invitation to share some nascent thoughts about it. I would also like to thank Sophie Grace Chappell, Quinn Eades, Dominic Murphy, and Andrew Perfors for helpful feedback on an earlier draft.

I will set up the basis for the first point (section 1) before concentrating the core of the commentary on the second point (sections 2 and 3). I then turn to why the authors' identification of regressiveness and hostility in DSM-5 and ICD-11 characterisations of trans people are important, return to conclude with some final thoughts about trans-positive psychiatry (sections 4 and 5).

1. Gender Incongruence and Gender Dysphoria

As the authors recognise, the continuing presence of diagnostic categories such as Gender Incongruence (in ICD-11) and Gender Dysphoria (in DSM-5) signal the medical stigmatisation of trans people. Both being trans and the antecedent, deeply felt desire to transition are not simply taken within psychiatry and medicine to be part of natural human variation. Rather, they remain deviations from norms regarded as standing in need of some kind of medical justification or explanation. This identification of trans people and trans desire as exemplifying *marked variation* (Wilson 2018a: ch.5-6) reflects at least three related facts. First, there is a complex historical entanglement of psychiatric classification with public (or common sense) views of trans people and trans desire. Second, contemporary psychiatric classification necessarily modifies past classification schemes that have been deeply stigmatising. Third, diagnostic categories continue to play a core role in warranting medical treatment and how medical expense is (or isn't) covered.

Gender Incongruence and Gender Dysphoria currently have the same kind of standing as Autism Spectrum Disorder in both the DSM-5 and ICD-11, rather than homosexuality, which does not feature in either manual. Yet it is perhaps the history of the removal of homosexuality as a diagnostic category that is more relevant for thinking about trans categories in psychiatric diagnostic systems. Homosexuality was removed by the American Psychiatric Association's Board of Trustees from DSM II in December 1973, though Sexual Orientation

Disturbance was added to a revision of DSM II in 1974, a condition renamed as Ego Dystonic Homosexuality in DSM-III in 1980, this condition being removed altogether only in the 1987 revision to DSM-III. Homosexuality was removed from ICD in 1992. It is only with these removals in 1987 and 1992 that the long process of de-stigmatising homosexuality and homosexual desire within formal, major systems of psychiatric classification was completed.

Interrogating Incongruence does an admirable job of documenting how appeals to incongruence arise within recent diagnostic manuals and treatment policies concerning trans people. Here the authors offer two distinct and precise formulations of the relevant incongruence theses in the conclusion of section 2 (p.8):

IT_1: transgender people's experienced gender is incongruent with their natal sex.

IT_2: transgender people's experienced gender is incongruent with their natal gender.

The authors claim that theses suffer from two problems: they are "conceptually incoherent" and "insidiously regressive and hostile to diversity".

I shall argue that this first claim of conceptual incoherence is difficult to defend, especially given the authors' own suggestions for a more trans-positive psychiatry (sections 2-3). I shall then argue that the second claim about regressiveness and hostility points to a normative claim about diversity that can be informatively elaborated by reference to the important role of trans narratives in arriving at a more trans-positive psychiatry (section 4). I conclude with a brief reconsideration of the prospects here.

2. Interrogating Incoherence: Experienced Gender and Natal Sex

In their introduction, the authors state the more general incongruence thesis from which IT_1 and IT_2 are derived, as follows:

> IT: Transgender people's experienced gender is *incongruent* with their natal sex or their natal gender, and the purpose of transgender medical interventions is to reduce that *incongruence*. (p.3).

The authors later suggest that "there is another kind of claim that transgender people might make which we think has much merit—namely [1] 'My gender *feels* incongruent with my sex'" (p.23, my numbering). Part of that merit lies in the place that such a first-person report has in trans self-understanding and narrative, as the authors show in the short first-person narrative they include from one of them.

In light of this suggestion, however, we might be puzzled at the claim that IT is conceptually incoherent. For I take (1) to be parallel to (and just as important in the relevant contexts as) the following claims:

(2) My pain feels incongruent with my bodily damage; and

(3) My anxiety feels incongruent with my physical or social situation.

(2) typically reports an important truth for people who experience pain in a body part without having damage in that body part—cases of phantom limb pain are a well-known examples—or who fail to experience pain when bodily damage would usually result in painful experiences—people in short-term shock or with damage to their nociceptive systems are in this situation. Likewise, (3) often reports a significant truth for people diagnosed with phobias (higher levels of anxiety than the physical or social situation warrants) and for people whose anxiety is extremely low or absent in dangerous or threatening situations. Yet it would seem that (2) can be readily paraphrased as (2a) and (2b), and (3) as (3a) and (3b):

(2) My pain feels incongruent with my bodily damage.

(2a) My felt pain is incongruent with my bodily damage.

(2b) My experienced pain is incongruent with my bodily damage.

(3) My anxiety feels incongruent with my social situation.

(3a) My felt anxiety is incongruent with my social situation.

(3b) My experienced anxiety is incongruent with my social situation.

If that is so, then (1) can be likewise paraphrased as (1a) and (1b):

(1) My gender feels incongruent with my natal sex.

(1a) My felt gender is incongruent with my natal sex.

(1b) My experienced gender is incongruent with my natal sex.

This implies that there is a tension between endorsing (1) as part of a trans-positive psychiatry yet claiming that (1b) is conceptually incoherent. It also suggests that it is easier to make sense of talk of incongruence in the case of experienced gender and both natal sex and natal gender than the authors suppose. (Yet matters are complicated here, as we will shortly see.)

Consider now the argument, in section 4.1, that IT_1 is incoherent because sex and gender are "conceptually distinct things that empirically vary independently of one another" (p.16). For this reason, the authors argue, "sex and gender simply cannot be either congruent or incongruent" (p.16). Their argument against IT_1 here relies on one or more claims made in the preceding section and a general principle that links those claims to the rejection of IT_1. Those six claims involve two about sex and three about the relationship between sex, gender, and sexuality. They are that (a) sex is not binary, (b) sex is spectral and multidimensional, (c) sex, gender, and sexuality are conceptually different things, (d) the connections between sex, gender, and sexuality are causal and contingent, rather than conceptual and necessary, (e) considered pairwise, sex, gender, and sexuality have no single empirical alignment, and (f) sex, gender, and sexuality are empirically autonomous in that they vary independently.

Although the opening of section 4 suggests that the argument for the incoherence of IT_1 and IT_2 rely on all six of these claims, so far as I can see, neither (a) nor (b) feature in those arguments. Rather, those arguments rest directly on just (f), with (c)-(e) seemingly being the

basis for (f). The general principle linking these claims to the claim that IT_1 is incoherent is something like this:

> **General Principle 1**: If A and B vary independently and so are empirically autonomous, then A and B can be neither congruent nor incongruent.

Or perhaps the relevant principle is more tightly restricted by having a stronger antecedent:

> **General Principle 2**: If A and B have no single empirical alignment, and vary independently and so are empirically autonomous, then A and B can be neither congruent nor incongruent.

I think that the conditional that expresses the authors' crucial premise linking section 3 to their rejection of IT_1—"if sex and gender are (conceptually) distinct things that (empirically) vary independently of one another, then sex and gender simply cannot be either congruent or incongruent" (p.16)—is false. In addition, the relationship of (c)-(e) to the claim that the authors continue on with—"What sex a person is, is one thing, and their gender is something entirely different" (p.16)—is more complicated than the authors seem to think. Explaining this complication shows why General Principles 1 and 2 are false. If both of these principles are false, as I claim, one can grant all of the claims made about sex, gender, and sexuality in section 3 without accepting the argument against IT_1 in section 4.

To start with the additional claim that sex is one thing and "gender is something entirely different" and its relevance to the acceptance or rejection of these general principles, consider three paired cases involving physical characteristics ascribed to people: (i) weight and mass, (ii) height and weight, and (iii) weight and eye colour. Like at least sex, they are also ascribed to other things (such as animals), but here I consider only their ascription to people. And although height and weight are continuously quantitative traits, consider the common sense categories we use in talking about people's heights and weights: tall, average, and short for height, and heavy, average, and light for weight. In what follows I explore whether each of (i)

– (iii) satisfies the corresponding generic versions of (c), (d), and (e). (I will talk shorthand simply of their satisfying each of (c), (d), and (e) in what follows.)

(i) – (iii) all involve conceptually different things—and so satisfy (c). Beyond that, it is unclear just which of these satisfy (d) and (e). Note that while weight and mass are conceptually different things, the relationship between them remains conceptual, rather than causal, and so (d) is not true of them, as it is of both height and weight, on the one hand, and weight and eye colour, on the other. Do (i) weight and mass satisfy (e) in having no single empirical alignment? Given that we use the same three categories—heavy, average, and light—and that weight and mass can be defined in terms of one another, any person whose weight is heavy will also have a mass that is heavy, given constancy of gravitational field and speed. But once we compare people without holding these factors constant, then a person whose mass is heavy could have a weight that is average or light, and so there is "no single alignment". This unclarity in whether weight and mass satisfy (e) carries over to whether they satisfy (f): do they vary independently and so are "empirically autonomous", despite the conceptual tie between them?

What of (ii) weight and height, and of (iii) weight and eye colour? Perhaps both of (ii) and (iii) satisfy each of (d), (e), and (f), since people in each height category can also fall into any weight category (and vice-versa), and weight also varies independently of having green, blue, and brown eyes (as well as other non-trinary coloured eyes). Yet there remain correlations between human height and weight that are the basis for both statistical and regulative norms about their relationship. In virtue of both sorts of norm, one could speak of height and weight being "incongruent". And it does not seem much of a stretch to think of at least one actual such norm—the medically entrenched BMI, or "body mass index"—as grounding judgments of incongruence. As the names themselves suggest, people whose BMI has them classed as overweight, as well as those whose BMI has them classed as underweight,

have an incongruence between their height and weight, given how the measure is defined. While there is much to be wary of in the appeals to BMI prevalent in both medicine and popular culture, the incoherence of ascriptions of incongruence is amongst them.

Perhaps it is only with (iii) weight and eye colour that we could plausibly accept the incoherence of the claim that ascriptions of weight are incongruent with eye colour. But then this would not stem from their having no single alignment, varying independently, and being empirically autonomous, as (ii) shows. Rather, I want to suggest, it stems from their being conceptually *independent* (and not just distinct) features that, in addition, lack the kinds of correlations that would ground either statistical or regulative norms about their relationship. It is not simply that all the boxes in a 3 x 3 matrix mapping weight categories (heavy, average, light) against eye colours (brown, blue, green) are occupied by actual people. Instead, it is that the empirical facts on the ground do not support norms about how they *ought to be* related.

So (i) – (iii) problems for General Principles 1 and 2, but they also raise the question of how expected gender and natal sex are related. Although these are distinct concepts, it is difficult to defend the view that they are both conceptually independent *and* not related by statistical and regulative norms. Indeed, the authors themselves recognize the existence of such regulative norms. They do so both in section 3 in recounting the view that Barker and Jane (2016) call *the common sense view* and in section 5 in their argument for the regressiveness and hostility to diversity of the appeal to incongruence that infuses medically-informed advice regarding and treatment of trans people. There the authors identify *heteronormativity* as underpinning that regressiveness and hostility. I agree that these clusters of norms, which are widespread in society, are problematic and should be rejected. But that rejection presupposes that they exist. This in turn undercuts, in a further way, the criticism that appeals to incongruence are *conceptually incoherent*.

3. Interrogating Incoherence: Experienced Gender and Natal Gender

In section 4.2, the authors argue that IT_2 is incoherent for a different reason, given that experienced gender and natal gender are, unlike experienced gender and natal sex, "in the same category—they *can* stand in relations of congruence with respect to one another" (p.16). Rather, the incoherence here lies in the relationship between "transgender medical interventions", which typically alter sexual characteristics, and the category *gender*. The incoherence in IT_2 is something like a pragmatic ineffectiveness of the medical treatment of natal sex in resolving an incongruence concerning experienced gender. It is pragmatically impossible to remove the putative incongruence through medical interventions. Here the authors argue for this conclusion by considering three ways in which such incongruence might be removed (and the reason they fail to achieve this outcome): by intervening on a present body to change traits present at birth (requires backwards time travel), by altering experienced gender (makes this akin to gay conversion therapy and so brings about congruence in the wrong direction), and by intervening on a present body to causally affect experienced gender (increases the gap between natal and experienced gender).

I agree with the authors that scrutiny is needed in thinking through how medical interventions on the body or mind putatively provide solutions to diagnosed problems. Yet here I think that they have overlooked the fact that both natal sex and natal gender do not simply appear at some time early in an individual's life but *persist throughout much of it*. And it is that persistent state that trans people seek to change, sometimes through medical interventions, as the trans narrative that the authors provide (pp.23-24) and the pair of trans narratives in the following section illustrate. In short, treatments to remove the incongruence between experienced gender and natal gender are not pragmatically incoherent because the latter (like natal sex) persists throughout one's life and is typically what trans people seek, often successfully, to change through medical interventions.

4. Regressiveness, Hostility, Normativity, and Trans Narratives

At the end of section 2 I said that the authors' second criticism of IT_1—that appeals to incongruence more generally are regressive and hostile to diversity—stands in tension with that claim that appeals are conceptually incoherent. Here I want to offer some further support for the important point made in this second criticism by elaborating on how the corrective view of diversity is anchored in trans narratives. I have moderate familiarity with (but no expertise in) these narratives. My understanding of them is informed primarily by my more extensive experience in working jointly with eugenics survivors in developing their own narratives, following their (often mistaken) diagnoses, institutionalisation, sterilisation, and continuing marginalisation from society in their post-institutional lives (EugenicsArchive.ca, Wilson 2015, 2018a, 2018b).

As Quinn Eades has emphasised in personal communication, trans narratives are a crucial part of the project of rehumanising some of the most stigmatised members of our society. But they are themselves diverse and can pull in different directions, and currently there are only limited spaces for their construction and reception, which, in turn, limits the vision of diversity within psychiatric categorisation and medical treatment. To make these points I present just two such recent narrative fragments, aware that they show only a (perhaps unrepresentative) sliver of the diversity across trans experiences.

The first is from a blogpost published on 26th August, 2020, by Andrew Perfors, a cognitive scientist who has recently identified as a trans man and has recognised his long-standing dissociation from his feelings about his sex and gender. That recognition and its effects on the direction of his life are captured in the following narrative extract:

> feeling my emotions meant that I also became excruciatingly aware of how deeply dysphoric I felt about certain parts of my body – how much it unnerved me, how

> disconcerting it was on some fundamental level. I could no longer ignore how terribly alienating I found it to be thought of as a woman. … Late last year I realised that I could not go on like this. I could not live the second half of my life as I'd lived the first, feeling most of the time like a half-alive zombie. Equally, though, I could not live with persistent bodily dysphoria and the emotional turmoil of being constantly viewed as someone that I did not feel myself to be. It was just too painful. To make a long story short, I acknowledged to myself that the only way to avoid both of these extremes was to not only admit that I'm transgender, but to transition medically and socially. (Perfors 2020)

Perfors draws on the DSM-5's category of dysphoria in characterising his experiences of (certain parts of) his body, and points to a disconnect with his feelings and from how he was perceived by others. Here the discomfort or felt incongruence pervades bodily, emotional, and social dimensions to his life experience; the resulting emotional turmoil is clearly structured by normative expectations about body, behaviour, and social roles.

The second is from Sophie Grace Chappell, one of the few (openly) trans philosophers in the United Kingdom and a contributor to the present symposium. In an interview in Philosophers Magazine published on 14th August, 2020, Chappell reflects on what it is to be a trans woman:

> To be a trans woman, as I understand it and as I've experienced it, is to be born with a male body, and to have a deep and enduring wish to have a female body instead. It's not about gender at all; at least at the most basic level, it's entirely about biological sex. It's not about thinking that you have a Girly Essence or a Lady Brain, or that your mind (or soul?) is female but your body male, or that you were the Queen of Sheba in a previous incarnation, or some dodgy hippy metaphysics like that. You might think that as well, of course, but that's not the heart of the matter. At root it's very simply

> about wanting to be female; female-bodied. But not just wanting it a bit; wanting it in a way that is all-consuming, that goes to the roots of your psyche. And that drives you mad if you don't do something about it. (Kazez and Chappell 2020)

Unlike Perfors, Chappell conveys an experience of discord or what we might well call felt incongruence between *desire* and embodied sex. Her trans experience is one of desperately wanting to be female-bodied while recognising that she is male-bodied. Part of the resulting despair (as the broader narrative makes clear) derives from failures of others important in her life to take that discord and the underlying desire seriously. For Chappell, the experiential element is centred around a strongly felt desire, one that she sees as having little, if anything, to do with gender. Chappell's narrative, or at least this peek into it, may be thought to challenge the view that the felt incongruence is mediated by externally imposed social norms, making that felt incongruence appear to derive from a relative direct "misalignment" between bodily sex and desire itself.

However superficial or deep the differences are between these two narrative fragments, each makes claims inconsistent with the experience of at least some trans people and likely would be rejected by them. Perhaps this is a ground for general scepticism about the evidential value of first-person narratives, as Dominic Murphy has suggested to me. I think instead that an appreciation of the disagreement and tensions between such first-person narratives is critical to recognising the true diversity in the relevant experiences. This recognition is important for acknowledging what I have called the *engaged individuality* of marginalised people in projects of rehumanisation and to cease thinking of them as *sorts* or *kinds* of people altogether (Wilson 2018a: ch.1). The complexities here should inform thinking about the full range of sex-gender options available to trans people that *Interrogating Incongruence* concludes with.

5. The Prospects for a Trans-Positive Psychiatry

I have argued that the appeals to incongruence in both DSM-5 and ICD-11 are not conceptually incoherent, *as Interrogating Incongruence* has claimed and argued. In this respect, I think that characterisations of trans people and trans desire within psychiatric categorisation and diagnosis are not as bad as the authors claim. One might well wonder then what has happened to the initial scepticism that I expressed at the outset about the prospects for a trans-positive psychiatry.

I have concurred with the authors that regressive and hostile norms within psychiatrically-based medical interventions in the lives of trans people need to be replaced by more diversity-friendly norms. This is not simply a matter of allowing trans people to "be themselves", for to be themselves trans people need to change themselves, sometimes require medical intervention to do so, and always benefit from re-establishing supportive personal and social networks that are often disrupted through their journeys. Insofar as receiving some kind of psychiatric diagnosis remains required for that medical intervention, we can continue to advocate for the kinds of changes that the authors suggest in their positive proposals in section 7. Here it is better to be like Autism Spectrum Disorder in DSM-5 than like Autism in DSMI-IV, better to be like homosexuality in DSM-IV than in DSMII-III. But a truly trans-positive psychiatry with be one that embraces trans experience without psychiatry and features psychiatry without transgender as a category at all.

References

Barker, Chris, and Emma A. Jane, 2016, *Cultural Studies: Theory and Practice*., 5th ed. London: SAGE.

EugenicsArchive.ca: http://eugenicsarchive.ca/discover/our-stories

Kazez, Jean, and Sophie G. Chappell, 2020, "Sophie Grace Chappell Talks Sex and Gender", *Philosophers Magazine*, 14 August, 2020. https://www.philosophersmag.com/interviews/219-sophie-grace-chappell-talks-sex-and-gender.

Perfors, Andy, 2020, "I'm transgender and that's ok". https://perfors.net/blog/im-transgender-thats-okay/. 26 August, 2020.

Wilson, Robert A., 2015, "The Role of Oral History in Surviving a Eugenic Past", in Steven High (ed.), *Beyond Testimony and Trauma: Oral History in the Aftermath of Mass Violence.* Vancouver, BC: University of British Columbia Press, pp.119-138.

Wilson, Robert A., 2018a, *The Eugenic Mind Project*. Cambridge, MA: MIT Press.

Wilson, Robert A., 2018b, "Eugenics Never Went Away", *Aeon Magazine*, https://aeon.co/essays/eugenics-today-where-eugenic-sterilisation-continues-now , 5th June, 2018.