Gender Incongruence and Fit*†

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Abstract. According to the ICD-11 and DSM-5, transgender people's experienced gender is incongruent with their natal sex or gender and the purpose of gender affirming-healthcare (GAH) interventions is to reduce this incongruence. Vincent and Jane argue that this view is conceptually *incoherent*—the *incoherence thesis*—and propose that the ICD and DSM should be revised to understand transgender people as experiencing a merely *felt* incongruence between their gender and their natal sex or gender—the *feelings revision*. I argue that (i) Vincent and Jane in fact give us no reason to believe the incoherence thesis and that (ii) we may want to resist the combination of the incoherence thesis and the feelings revision because this combination seems to imply that all transgender people have feelings that are misplaced and are, in an importance sense, incorrect or mistaken. I then give a fit-based account of how trans people's experienced gender can be incongruent with their natal sex or gender and how GAH can reduce this incongruence.

I

In 'Interrogating Incongruence', Nicole Vincent and Emma Jane [forthcoming] argue that the way that the ICD-11 and DSM-5 understand transgender people and the purpose of transgender medical interventions is conceptually incoherent and insidiously regressive and propose a way of revising the ICD and DSM to avoid these problems. Vincent and Jane distinguish between our natal sex, our natal gender, and our experienced gender. They use natal sex to cover a broad number of concepts including one's sex characteristics, 'physical sex', 'somatic sex', 'biological sex', and the sex one was assigned at birth [*ibid.*: 7-8]. Our natal gender is the gender that we were assigned at birth, or at any rate early in our life. And our experienced gender is our gender identity, our sense of ourselves as a woman, man, or other gender. Vincent and Jane explain that the ICD-11 and DSM-5 have converged on the following view:

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> *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* [*ibid.*: 3].

Vincent and Jane's core argument against *IT* is that it is *incoherent*; call this the *incoherence thesis*. They argue that given the right understanding of sex and gender, the idea that A's natal sex could be incongruent with A's experienced gender is incoherent. This is because sex and gender are distinct and autonomous; they can and often do vary independently from one another. For instance, many people have a female natal sex but have a male or non-binary experienced gender. And because natal sex and experienced gender are distinct and autonomous it is conceptually incoherent to hold that one's experienced gender can be incongruent with one's natal sex [*ibid.:* 4, 16]. Vincent and Jane argue that although one's experienced gender could be incongruent with one's natal gender the idea that gender-affirming healthcare (GAH) interventions could diminish this incongruence is incoherent. For in order to alter our natal genders we would need a time machine. And GAH interventions do not—and in fact could not—bring one's experienced gender into line with one's natal gender (and we should not want them to do this) [*ibid.*: 16-18].

Vincent and Jane further argue that *IT* is 'deeply though insidiously regressive' because it implies that some combinations of natal sex and gender and experienced gender are wrong or incorrect [*ibid.*: 5, §5]. For instance, *IT* implies that non-binary people who have female sex characteristics have a regrettably misaligned natal sex and experienced gender; and that people who have a male gender identity but also have a vagina have an experienced gender that is regrettably misaligned with their sex. A view that holds that such combinations are incorrect promotes conformity rather than diversity. So, Vincent and Jane argue, *IT* is not progressive and promotes gender conformity rather than gender diversity.

Vincent and Jane then propose that the ICD and DSM replace *IT* with the

> *Feelings Revision*. Transgender people *feel that their* experienced gender is incongruent with their natal sex or gender, and the purpose of transgender medical interventions is to reduce that *felt* incongruence [*ibid.:* 24-25].

Unlike *IT,* the *Feelings Revision* is not insidiously regressive for it does not imply that there are some correct and some incorrect combinations of natal sex, natal gender, and experienced gender. And it is not incoherent. For even if one's experienced gender cannot in fact be incongruent with one's natal sex it can feel like it is, and GAH interventions can diminish such feelings of incongruence.

II

I want to point out two problems with Vincent and Jane's argument. First, we might want to resist the combination of the incoherence thesis and the feelings revision. The *feelings revision* holds that '[t]ransgender people *feel that their* experienced gender is incongruent with their natal sex or gender'. But the *incoherence thesis* holds that the idea that there is such an incongruence is incoherent. In this case, the combination of the *feelings revision* and the *incoherence thesis* entails that transgender people, *qua* transgender people, have a feeling, the content of which is incoherent; transgender people feel that X (their experienced gender) is incongruent with Y (their natal sex or gender) but X could not be incongruent with Y, this idea is incoherent. So, if we accept the combination of these views, transgender people all have a feeling with a content that is incoherent.

It seems to me that we have some reason at least to resist this conclusion. The view that all transgender people have a feeling that has an incoherent content seems to imply that all transgender people have a feeling that is in an important sense misplaced, mistaken, or incorrect. If I am angry at my partner for something that they didn't do, or for something that doesn't merit anger, then my anger is misplaced. Anger in this case is also incorrect for it is unfitting, my partner does not merit

anger, and attitudes that are unfitting are, in an important sense at least, incorrect.[1] Similarly, if I feel that it is yesterday today, I have a feeling with an incoherent content and so I have a feeling that is misplaced and is not correct; it is a feeling that it is not fitting for me to have and is not called for by my information or context.[2] So, feelings with false and incoherent contents seem to be feelings that it is not fitting or correct for us to have, they are feelings that are misplaced, and are feelings that seem to be in an important sense incorrect and mistaken.

Vincent and Jane [*ibid.* 17] are explicit that they hold that trans people's experienced gender is their veridical gender. But this does not stop the combination of the *incoherence thesis* and the *feelings revision* from implying that all transgender people have a feeling that has an incoherent content and is thereby to that extent misplaced, incorrect, and mistaken. And we may want to resist the conclusion that all members of a marginalized group, who have historically been thought of as suffering from a mental disorder, necessarily have a feeling that is misplaced, and is in an important sense incorrect and mistaken; we may particularly want to publicly resist affirming this view as we would if we proposed that the ICD and DSM be revised in line with the *feelings revision* for the reason that the *incoherence thesis* is true.[3]

A second problem with Vincent and Jane's argument is that we do not have sufficient reason to accept the *incoherence thesis*. Vincent and Jane's argument for the incoherence thesis is that natal sex and experienced gender are conceptually distinct and autonomous; one does not determine the other. This means that even if there is some link between them, these two things are sufficiently autonomous and independent such that one cannot be incongruent with another. The general principle here is that

> Conceptually distinct and autonomous things cannot be incongruent.

[1] See e.g. Howard [2018] and Howard and Rowland [forthcoming].
[2] See *ibid.*
[3] See e.g. Bettcher [2007] and Serano [2016: ch. 2].

But we should reject this principle. Suppose that you admire someone who is thoroughly evil and not in any way admirable. Your admiration is incongruent with the features of this person; it is not fitting admiration. Yet your admiration is autonomous and distinct from that person: it is a mental state, they are a (different) person. Similarly, we might envy someone's life that turns out to be entirely un-enviable. Our envy doesn't fit their life, but our envy and their life are distinct autonomous things. Or suppose that we believe that *p* but that our belief that *p* does not fit the evidence regarding whether *p*, which does not support the conclusion that *p*. Our belief that *p* is incongruent with the evidence regarding whether *p*. Mental attitudes and thoughts can be incongruent with external reality even though mental attitudes and thoughts and external reality are conceptually distinct and autonomous things. So, conceptually distinct autonomous things can be incongruent. So, we lack good reason to accept the incoherence thesis.

But can trans people's experienced genders be incongruent with their natal sex? Can an account of how this is possible avoid Vincent and Jane's objection that the idea that there can be such incongruence is insidiously regressive? In the rest of this commentary, I'll give an account of how our experienced gender can be incongruent with our natal sex or gender that is not insidiously regressive and I'll explain how GAH interventions can diminish this incongruence.

III

Sometimes part of our experienced gender involves or is tied to the desire for, or the judgment that we should have, sex characteristics that we do not currently have. For instance, many trans men desire to have male secondary sex characteristics, such as thick facial hair and no breasts, or judge that they should have such male sex characteristics rather than the female sex characteristics that they currently have. [4] Similarly, sometimes our experienced gender involves (or is tied to) the desire to be treated as, or the experience that we should be treated as (or should treat ourselves as), a gender other than the gender that we were assigned at birth or that we are currently treated as a

[4] See also Serano [2016: 79].

member of. For instance, trans woman Abby Stein [2019: 238], describing her experience of marrying as a groom says, '…a final thought ran across my mind. I should be sitting on that side of the table. I should be the bride'. Explaining their gender identity, Kate Bornstein [2016: 29] says that '[g]ender identity answers [the] question: "To which gender (class) do I want to belong?"' And discussing her life after socially transitioning, Rhyannon Styles [2017: 106] says, 'In London I present as female, I wear women's clothes and wear make-up everyday. I use female toilets, people call me "her" and "she" and this makes me very happy. It finally feels that I am living as I should'.

Suppose that Alex was assigned male at birth, is currently socially positioned and treated as a man and has entirely male sex characteristics. In this case, Alex has male sex characteristics, and has had since birth, or since an early age; Alex's natal sex is male. According to dominant social theories of gender, to be a member of gender *G* is just to be treated in particular ways, e.g. for one to be a woman is for one to be oppressed and subordinated or constrained and enabled in particular ways because one is taken to have bodily features that play a female biological role in reproduction.[5] So, Alex's natal gender just consists in the gender they were positioned and treated as a member of since birth and continue to be treated as a member of. But suppose that

(i) Alex desires to have female sex characteristics or to be socially treated as a woman; and/or that
(ii) Alex judges that they should have such characteristics or should be so treated.

In this case we can say that Alex's thoughts and attitudes that are part of or are tied to their experienced gender do not fit with, and are incongruent with, their natal sex and/or natal gender. In terms of lack of fit and incongruence, this incongruence or lack of fit is just like the lack of fit between, for instance, a desire to live in the same city or country as your partner and not living there with them. Desires are normally understood to have a mind-to-world direction of fit such that desires get the world to fit them: my desire for a cup of coffee motivates me to get the world to fit

[5] See e.g. Ásta [2018] and Haslanger [2012].

this desire, to get the coffee. When you desire to have X and you do not have X there is a lack of fit between your desires and the world. So, there is an incongruence or lack of fit between (i) and Alex's natal sex or gender; Alex desires their physical sex or social gender position/class to be different from the way that it currently is. We can understand the incongruence between (ii) and Alex's natal sex or gender in a similar way. Alex judges that they should have certain bodily features or should be treated as a woman but they do not have these features and Alex is not treated as a woman. If there is a lack of fit or congruence between our desire that *X* and the world when not-*X*, then we should similarly say that there is a lack of fit or congruence between our judgments and the world when we judge that we should have features *X* or should be treated as a *G* but we do not have features *X* or are not treated as a *G*.

This account of how one's experienced gender and one's natal sex and/or gender can be incongruent does not have regressive implications. For it does not imply that if we have experienced gender *G*, we must have the natal sex or gender associated with *G*s or else our experienced gender and natal sex or gender are incongruent. For instance, someone who was assigned female at birth can have a male experienced gender and not experience having female sex characteristics—or all female sex characteristics—as at odds with his experienced gender. This is because one can have a male experienced gender without desiring that one has male sex characteristics or judging that one should have such sex characteristics[6]; one can have a male experienced gender just because one desires to be socially treated/positioned as a man or judges that one should be socially treated/positioned as a man. Such a person has an experienced gender that does not fit with and is incongruent with their natal gender, since their natal gender—which is the gender they continue to be socially treated as—does not match their desires and judgments regarding how they should be treated.

So, the account that I've been suggesting of how our experienced gender can be incongruent with our natal sex and gender does not imply that some combinations of physical sex/assigned gender at

[6] E.g. as Andler [2017: 889-890] discusses, pornographic actor and producer Buck Angel has a male experienced gender but does not desire to—or judge that he should—no longer have a vagina.

birth/experienced genders are correct or right and others are not. It does imply that there is something incorrect, incongruent, or misaligned about having an experienced gender that is such that one desires to be socially treated as gender *G*, or judges that one should be treated as a *G*, when one is not socially treated as a *G*. But this is not an insidiously regressive consequence. Trans and gender diverse people who want to be, or judge that they should be, treated as gender *G* but are not socially treated as a *G* think that something is going wrong here: they should be treated as a *G* and they are not; society should do better!

We can now understand how it can be true that

> *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.

I've explained how a trans person *A*'s experienced gender can be incongruent with their current physical sex characteristics or the way that they are currently socially treated. When *A*'s sex characteristics/the gender they are currently positioned or treated as a member of are the sex characteristics that they were born with/the gender they have been socially positioned or treated as since birth, then *A*'s experienced gender is incongruent with their natal sex or gender. If *A*'s experienced gender is incongruent with their current sex characteristics, then gender-affirming healthcare (GAH) directly reduces the incongruence by changing their sex characteristics. But when a person's experienced gender is not at odds with their current sex characteristics GAH can still reduce the incongruence between their experienced gender and social treatment as a particular gender. For instance, many trans women are not socially treated as women because they have certain bodily features associated with men such as course facial hair or the evidence of such or a male distribution of bodily or facial fat, and GAH interventions change these characteristics.[7] So, even when someone's experienced gender is not directly incongruent with any of their physical sex

[7] See Rowland [forthcoming] and the references therein.

characteristics, GAH can still indirectly reduce incongruence between *A*'s social treatment and experienced gender by giving *A* features that make it more likely that they will be socially positioned or treated as the gender that lines up with their experienced gender.

Note that trans people who have changed their sex characteristics or are treated as the gender they want to be treated as still have experienced genders that are incongruent with either their natal sex or gender. This is because: they judge that they should be treated as, or desire to be treated as, the gender that they are currently socially positioned as rather than as the gender they were assigned at birth; and/or they judge that they should have, or desire to have, the sex characteristics that they currently have rather than the sex characteristics that were part of, or are associated with, their natal sex.

So, we need not accept Vincent and Jane's feelings revision; there is a good account of how trans people's experiences of their genders are incongruent with their natal sex and/or gender and how GAH interventions can reduce this incongruence that is not insidiously regressive. We should accept this account rather than holding the view that it is incoherent for trans people's gender identities to be incongruent with their sex or their gendered social position, since, as I argued in §2, we have not been given reason to accept this view and we seem to have reason to reject the view that all trans people have a feeling, the content of which is incoherent.

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