(TRANS)GENDER FLUIDITY

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Body Studies, vol. 2, no. 1 (2020): 1-8

Abstract

In order to authenticate their experience, especially to members of the medical community, trans people frequently have to invoke a "wrong body" narrative. By the twentieth century, and somewhat still into the twenty-first century, this conditional trope is a personal narrative that medical professionals often expect from trans people who are seeking medical and surgical methods of gender affirmation. Since the mid-twentieth century, the gender affirming medical treatments and surgeries that some trans people have sought, and continue to seek out, have been deemed permissible by the medical community and, subsequently, legally performed in the United States. This development coupled with increased national visibility of trans people over the past thirty years has led to an upsurge in sensationalized tragihorror stories of formerly self-identified trans people "detransitioning", which are then sometimes used to question or even undermine the legitimacy of trans experience. Detransition, or also referred to as "retransition", is a conjured phenomenon that is meant to describe the experience of a trans person, after already experiencing a gender transition, medical or otherwise, changes their gender, gender presentation, secondary sex characteristics, and/or sex back to their 'birth assigned sex/gender'. I posit that the term 'detransition' negates gender fluidity of trans people by relying on essentalistic understandings of a "true" gender core that arises from popularized understandings of trans experience through the "wrong body" narrative. By utilizing Butler's theory of gender performativity is it possible to recognize, instead of entirely negating, transgender fluidity.

BODY STUDIES JOURNAL
A peer-reviewed open access journal for the interdisciplinary field of Body Studies

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In order to authenticate their experience, especially to members of the medical community, trans people frequently have to invoke a "wrong body" narrative (Stone, 1991; Stryker & Sullivan, 2009; Bettcher, 2014). By the twentieth century, and somewhat still into the twenty-first century, this conditional trope is a personal narrative that medical professionals often expect from trans people who are seeking medical and surgical methods of gender affirmation. Since the mid-twentieth century, the gender affirming medical treatments and surgeries that some trans people have sought, and continue to seek out, have been deemed permissible by the medical community and, subsequently, legally performed in the United States (Stryker & Sullivan, 2009). This development coupled with increased national visibility of trans people over the past thirty years has led to an upsurge in sensationalized tragihorror stories of formerly self-identified trans people "detransitioning", which are then sometimes used to question or even undermine the legitimacy of trans experience. Detransition, or also referred to as "retransition", is a conjured phenomenon that is meant to describe the experience of a trans person, after already experiencing a gender transition, medical or otherwise, changes their gender, gender presentation, secondary sex characteristics, and/or sex back to their 'birth assigned sex/gender'. I posit that the term 'detransition' negates gender fluidity of trans people by relying on essentialistic understandings of a "true" gender core that arises from popularized understandings of trans experience through the "wrong body" narrative. By utilizing Butler's theory of gender performativity is it possible to recognize, instead of entirely negating, transgender fluidity.

With a historical analysis, I will show that that the "wrong body" narrative, which was originally used as psychological diagnostic criteria in earlier editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual (DSM) to characterize the trans experience, has misconstrued trans identity to be both essential and, once reached, static. The "wrong body" narrative invokes the idea that there is an essential true gender that trans people come to realize and attempt to validate through a social and/or medical gender transition (Bettcher, 2014). The reliance on this essentialistic narrative in both historic academic gender clinics and previous diagnosis criteria has impacted current understandings of trans experience. As McQueen points out, "when the sense of false embodiment is grounded in an essentialized wrong body narrative, then it can service to foreclose other forms of gendered subjectivity – namely those which are more ambiguous or fluid with regard to the male/female binary," (McQueen, 2014, pp. 538). I further argue that this foreclosure extends to all possible gender fluidities experienced by trans people since any movement away from their gender, their 'true' gender core which they have already reached, in whatever way, through a previous gender transition, is misconstrued as 'detransitioning'. And even though more gender possibilities and desired means to embody them have been contemporarily realized by medical institutions and popular culture, the notion that trans people come to realize their gender core, transition, in whatever ways, to it, and then statically embody it has continued to persist. With this problematic understanding of trans experience, any embodied gender fluidity, especially fluidities that seem to 'revert back' to birth assigned sex/gender designations, are simplified as trans people misinterpreting their gender core and desiring to embody their 'truth' by 'detransitioning' back.

Prior to 1966, American medical ethics widely debated 'transsexual surgeries', such as surgical alternation of secondary sex characteristics and genital reassignment surgery (GRS) (Stryker & Sullivan, 2009). As Stryker and Sullivan explain, "the early attention to 'sex change' was accorded primarily to male-to-female individuals, and the procedures involved consisted more often than not of penectomies and orchidectomies rather than vaginoplasty," (Stryker & Sullivan, 2009, pp. 54). The removal of healthy tissue, such as a penis and testes, infringed upon both national mayhem laws and medical non-maleficence, the latter of which obliges medical professionals to first do no harm to their patients. This forced some American trans people with the financial

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means to seek their desired surgeries in other countries. In most of these instances the, "orchidectomies and penectomies, often carried out as first and second steps in a surgical series, were considered by the recipients and the surgeons alike to constitute the actual 'sex change,' whereas vaginoplasty, in the event it was ultimately carried out as a third step (which was not always the case), was considered an optional 'plastic' or 'cosmetic' procedure," (Stryker & Sullivan, 2009, pp. 55). In the infrequent occurrences that trans individuals did want a vaginoplasty after having a penectomy and orchidectomy, most struggled to find willing surgeons in the country who would elect to perform them despite the fact that performing a vaginoplasty post-castration would no longer infringe on either the mayhem law or on the non-maleficence medical clause (Stryker & Sullivan, 2009). It was not until the medical discourse drastically changed in the late 1960s to allow for treatment of 'gender dysphoria syndrome' that trans people began being forced to transition to essentialistic understandings of womanhood and manhood.

The Transsexual Phenomenon was published by Dr. Harry Benjamin in 1966, which significantly impacted the American medical, legal, and cultural views of trans people since he posited that it was indeed possible for some trans people to 'successfully' assume the 'other' gender and sex with adequate medical support (Stryker & Sullivan, 2009; Stone, 1991). Subsequently, a few academic gender clinics were opened across the United State in order to help those trans people, primarily trans women, who, "unambiguously expressed Benjamin's original [transsexual diagnosis] criterion in its simplest form: The sense of being in the "wrong" body," (Stone, 1991, pp. 10).

Attempting to screen for an accurate diagnosis of 'gender dysphoria syndrome' or what is now in classified in the fifth edition of the *American Diagnostic and Statistical Manual* as Gender Dysphoria (GD) is nearly impossible to root in objectivity (Stone, 1991). It seems nearly impossible to achieve objectivity when this subjective experience effectively undermines Westernized social constructions of sex and gender that are rooted in biological essentialism. After considerable research to create a clinically appropriate way to measure gender dysphoria, professionals had to solely rely on Benjamin's subjective "wrong body" criteria within their practices. This resulted in medical professionals relying on essentialistic ideals about gender to inform their vetting system when choosing their 'ideal' candidates for treatment in their gender clinics.

Upon entering academic gender clinics, trans women frequently referred to Benjamin's *The Transsexual Phenomenon* (1966) in order to 'persuade' any and all physicians to prescribe hormone replacement therapy (HRT) and perform gender affirming procedures and surgeries on them (Stone, 1991; Reay, 2014). This was done by 'transsexual candidates' reciting aspects from The Transsexual Phenomenon (1966) that Benjamin deemed necessary for potential candidates to present with in order to be diagnosed with and treated for gender dysphoria syndrome, which effectively reinforced this problematic "wrong body" narrative as hegemonized by the medical institution (Stone, 1991). Of course, this was not without some stipulations since the "final decisions of eligibility for gender reassignment were made by the [gender clinic] staff on the basis of an individual sense of the 'appropriateness of the individual to their gender of choice'," which was inevitably based in racist, sexist, homophobic, and essentialistic notions of gender (Stone, 1991, pp. 290, original emphasis). For example, some medical professionals felt that, "the [trans women] who presented as wanting to be women didn't always "behave like" women," and would refer their selected candidates to charm school in order to fulfill gender roles and presentations that were expected of women at the time (Stone, 1991, pp. 290). This subjective policy was enacted by most gender clinics in order to fulfill their own agendas, which was to give significant supporting evidence that a "complete" gender transition, one with prescribed HRT and performed GRS, would rid of the gender dysphoria syndrome that their trans patients were diagnosed with (Stone, 1991; Reay, 2014).

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The drastic policy change in American medicine between the early to mid-twentieth century led to a hegemonized reinforcement of woman/feminine/vulva and, conversely, man/masculine/penis. Prior to this reinforcement of cisnormative sex/gender congruency, trans people had more autonomy to subvert this essentialized dichotomy as demonstrated in Stryker and Sullivan's examples of some trans people only seeking penectomies and orchidectomies, which arguably made them ambiguous since genitalia was no longer present. The expectations of 'congruency' between sex, gender, and gender presentation not only limited which trans people were recognized by the medical institution and subsequently given access to medical methods of gender affirmation, but also served to reinforce sex/gender essentialism that trans people were then expected to embody as they socially and/or medically transitioned (Stone, 1991).

This account provides evidence of a few dichotomies sanctioned by historical and current medical discourse that work to uphold an essentialistic notion of detransition; the "all or nothing" ideology behind accessing medical methods of gender affirmation as well as the hegemonized reinforcement of man/masculine/penis and woman/feminine/vulva. With the rise of the academic gender clinics, the American medical institution also created an "all or nothing" narrative that trans people were expected to desire and comply with when identifying as trans let alone when contemplating if they even desired certain medical methods of gender affirmation. Stryker and Sullivan explain that prior to the rise of the academic gender clinics throughout the country, trans people had more autonomy in deciding what medical and surgical methods of gender affirmation they sought. This fact alone clearly points to a troubling dichotomy that was nearly impossible for both non-normative as well as normative trans people to navigate. The "all or nothing" ideology greatly shaped the hegemonized reinforcement of gender/gender presentation/sex congruency. Within the provided history, it is apparent that academic clinics were not interested in helping gender dysphoric trans people, but instead sculpt legible women that embodied essential 'congruency' as constructed by cisnormative and heteronormative ideology. The foundation of these two historically impactful dichotomies is the anticipated "wrong body" narrative, which serves to legitimize trans people by, at least, the medical community as long as they meet subjective requirements to undergo all treatments and surgeries in order to have a static, congruent gender.

Over the past fifty years, the American medical community has changed its treatment approach for trans people, but it is still not entirely impervious to the historical impact that the "wrong body" narrative has had. In the current medical discourse, ideas about medical and surgical methods of gender affirmation continue to be perceived as a fluid way to reach the 'true', and subsequently static, gender core. Before having access to medical and surgical methods of gender affirmation, trans people are expected to identify their actual 'true' gender, ideally through therapy and a GD diagnosis (Bouman et al., 2014). This occurs because many medical professionals posit that the results of gender affirming treatments or surgeries are impossible to reverse, such as GRS (Bouman et al, 2014; Djordjevic et al., 2016). Medical professionals emphasize a thorough assessment of trans identified patients since underlying psychiatric and psychological issues can 'truly' be misinterpreted as gender dysphoria (Djordjevic et al., 2016; Pehl, 2018). In his article, Djordjevic warns that, "motivation for SRS in our patients was not aimed at achieving sexual and gender congruence… Before the primary transition, they did not fulfil the complete diagnostic criteria for a gender identity disorder diagnosis (early or late onset) and criteria for personality disorder (eg, borderline)," (Djordjevic et al., 2016). Within the medical community, there is a deep concern to ensure that people are 'truly' experiencing gender dysphoria instead of providing the 'correct' diagnosis. These concerns arise from the few, but nevertheless, sensationalized cases of 'former' trans people who claim to 'detransition', which alludes to a grave medical error that can result in a potential malpractice liability. Despite numerous attempts to create an objective diagnosis that characterizes trans experience, medical professionals

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still have to rely on personal histories and subjective understandings of self that are often only validated when narratives of embodied gender essentialism are invoked through the notion of an inherently "wrong body".

To a certain extent, trans people have also worked to reaffirm this essentialistic "wrong body" narrative. When self-demand surgeries were replaced with a new process that mandated a diagnosis, trans people referred to the only literature available about trans experience, one which widely circulated within their communities since it so heavily relied on in medical communities, The Transsexual Phenomenon (Stone, 1991; Reay, 2014). For Benjamin, the primary criteria to diagnosis a person as suffering from gender dysphoria syndrome was an early onset feeling of being in the "wrong body". This particular narrative, which has become transnormative over time, has never been applicable to all trans people and their multitude of personal experiences. Nevertheless, the trans people who desired certain medical and surgical methods of gender affirmation were forced to alter their narrative into a transnormative one that incorporated feelings of being in the "wrong body" in order to meet diagnostic criteria. This essentialistic narrative, which has been expected by medical professionals, has been recited by many trans people for many decades in order for medical and surgical methods of gender affirmation to be accessible for those trans people desiring them.

The reliance on a diagnosis that characterizes trans experience, which has now manifested itself as the experience of being in "the wrong body", is to distinguish who is 'really' trans and who is 'really' cisgender but experiencing a mental phenomenon or illness that presents itself as gender dysphoria. The intensive interrogation of people's "core gender" and the validity of people's diverse gender experiences has created a binary understanding of transgender and cisgender, which both medical professionals and the American trans community have worked to create and uphold. As Enke explains, transgender is commonly understood as someone transitioning away from their birth assigned sex/gender and, conversely, cisgender is intended to describe those who align with their birth assigned sex/gender (Enke, 2013). The transgender/cisgender dichotomy essentializes perceived differences between the two and creates static identity categories by utilizing notions of a 'gender core'. While trans people might experience gender fluidity as they transition to their 'true' 'gender core', it is then expected that the fluidity ceases once their 'true' gender is assumed and successfully validated socially and/or medically. When a trans person experiences gender fluidity after having successfully assumed their 'true' 'gender core', in whatever methods, the dichotomies at play, the sex/gender binary and transgender/cisgender, negate this experience by reconceptualizing their gender fluidity as an instance of 'detransitioning' back to a 'true' cis 'gender core'. The transgender/cisgender dichotomy is a fundamental component to notions of 'detransition' since it reinforces two essential and static identity categories and negates gender fluid possibilities.

It is imperative to subvert the essentialized "wrong body" narrative, cisnormative ideals of gender congruency, and the transgender/cisgender binary in order to realize the possibilities of (trans)gender fluidities. This can be achieved by problematizing the notion of a "gender core", which is an imperative aspect to the "wrong body" narrative. In Butler's text, "Bodily Inscriptions, Performative Subversions," (1990) she discusses how gender is performative instead of real, true, or apparent by problematizing gender identity categories entirely. In a later section of her chapter, Butler works to deconstruct the essentialistic notion of a 'gender core' by introducing the notion of gender performativity,

> Such acts, gestures, enactments, generally construed, are *performative* in the sense that the essence or identity that they otherwise purport to express are *fabrications* manufactured and sustained through corporeal signs and other discursive means. That the gendered body is performative suggest that it has no ontological status apart from the various acts which constitute its reality… In other words, acts and

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> gestures, articulated and enacted desires create the illusion of an interior and organizing gender core, an illusion discursively maintained for the purposes of the regulation of sexuality within the obligatory frame of reproductive heterosexuality.
> Butler, 1990, pp. 136, original emphasis

In this passage, Butler posits that a gender identity organized by a gender core is actually only an illusion created by cultural expectations of (hetero)normative gender presentation and expression, which is what makes gender a cultural performance that can really only occur beyond oneself. While Butler's theory is agreed upon in certain academic and queer communities, this theoretical framework continues to be difficult to apply to trans experience. I posit this is because of the historical impact of the "wrong body" narrative since it is so deeply rooted in a notion of assuming one's 'true' 'gender core' through medical and surgical methods of gender affirmation. It is imperative to recognize how gender performativity continues to extend to trans people even after they 'transition', socially, medically, and/or surgically, by recognizing that the "…truth of gender is a fabrication and if a true gender is a fantasy instituted and inscribed on the surface of bodies, then it seems that genders can be neither true nor false, but are only produced as the truth effects of a discourse of primary and stable identity," (Butler, 1990, pp. 136).

The "wrong body" narrative validates a true, essentialistic 'gender core', which, as Butler explains, is a false perception of gender since the experience is always socially situated beyond oneself. This narrative works to validate the two dichotomies of cisgender and transgender and woman/vulva/feminine and man/penis/masculine that then trans experience is constrained by instead of subverting these essentialistic cisnormative gender ideals. By extending Butler's theory of gender performativity to those of trans experience, which destabilizes notions of an inherent gendered self, there is a possibility to recognize authentic experiences of (trans)gender fluidity instead of simply negating them all as instances of 'detransitioning'.

(Trans)gender fluidity has existed and will continue to exist beyond notions of regret and subsequently assumed desires to 'detransition' back to cisgenderhood. Trans experience has historically been mis-conceptualized as an essentialistic experience of being trapped in "the wrong body" and needing to validate one's 'gender core' through all available medical and surgical methods of gender affirmation. The "wrong body" narrative has been relied upon throughout the years by medical professionals as diagnostic criteria and then compulsively recited by those trans people who have sought or are seeking access to medical and/or surgical methods of gender affirmation. This narrative validates problematic notions of a true 'gender core' and effectively situates trans people in essentialistic dichotomies of binary gender congruency and transgender/cisgender identity categories. By extending Butler's theory of gender performativity to those of trans experience, there is a possibility to subvert essentialistic ideals of trans people needing to validate their "gender core" through all possible medical and surgical methods to reach their static 'truth'. Gender fluidity is a legitimate experience for trans people who have previously 'transitioned', either socially, medically, and/or surgically, that should not be altogether reduced or negated to a tragihorror instance of 'detransition' to cisgenderhood.

About the Author

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