Proposed Addition to DSM:
Gender Incongruence (Distinct Clinical Construct)

There has been one overarching diagnosis of gender dysphoria, but with no clear definition. The area of sex and gender is highly controversial because of a proliferation of terms where meanings have varied over time and between disciplines. An additional source of confusion (when context is lacking) is that in English, "sex" denotes the biological male/female and an act of intercourse. This revision acknowledges that terms and constructs widely used by clinicians from various disciplines create different clinical responses that should have clear recommendations.

Definition: Sex, and in context, sexual, refers to the biological characterizations of male and female (understood in the context of biological reproduction capacity), such as in chromosomes, gonads, sex hormones, and nonambiguous internal and external genitalia.

Disorders of sex development or differences in sex development (DSDs) are included in the historical terms' hermaphroditism and pseudohermaphroditism. DSDs include somatic intersex conditions such as congenital development of ambiguous genitalia (e.g., clitoromegaly, micropenis), congenital disjunction of internal and external sex anatomy (e.g., complete androgen insensitivity syndrome), incomplete development of sex anatomy (e.g., gonadal agenesis), sex chromosome anomalies (e.g., Turner syndrome; Klinefelter syndrome), or disorders of gonadal development (e.g., ovotestes). These are addressed separately.

Definition: Gender is the psychological understanding of self as a specific sex.

Definition: Gender expression is the external presentation of one's gender.

Definition: Gender roles denote the public, sociocultural (and usually legally recognized) roles of boy/girl, man/woman.

Gender assignment or birth-assigned sex/gender recognizes biological sex but by conflating gender with sex. It is an external application of gender roles to the individual.

Dysphoria, or distress, with external expectations or external roles, is a symptom of a condition as yet unspecified. Gender dysphoria was meant to focus on the distress associated with gender identity

disorder. It has become the treatable condition rather than the root issues in order to depathologize the conditions. However, a cough or fever is a symptom and treatment of them will not resolve the underlying issues. Gender dysphoria within this context generally addresses one or more of the following four issues:

1. Distress over appearance
2. Distress over expression
3. Distress over roles
4. Distress over acceptance

Additional comorbidities, such as depression, anxiety, trauma (usually sexual abuse), and dysmorphia are often present and need to be identified and addressed. Treatment of gender dysphoria is often secondary to these issues.

Gender has had, and in specific situations, an additional meaning/context: as an internal understand of the component of "self" as a specific sex. In this, gender is an innate component of self-awareness.

There is a cohort in which distress over appearance is not related to how they are perceived by others or society, but how the individual perceives the congruence of their body to their understanding of self. The use of "gender dysphoria" is, in this case, a misapplication. Within this cohort individuals will state their understanding of self is accurate, but their physiology is incongruent with such understanding.

Gender dysphoria, as currently used, designates a cluster of distress states arising along the axis of gender. It does not and cannot, specify etiology. Within this cluster exist heterogeneous mechanisms: social conflict, developmental identity formation, trauma, body image disturbance, and a smaller cohort characterized by a persistent internal perception of bodily incongruence. Collapsing these into a single diagnosis trades conceptual clarity for social accommodation. A symptom-centered model may justify access to care, but it cannot substitute for diagnosis. Clinical classification requires continued inquiry into underlying mechanisms.

Historically

Pre-DSM through DSM-2: Transvestite + homosexuality

Appearance, i.e., cross-dressing, was usually individuals of one sex using the clothing of the other sex. There was no medicalization but rather a pathologization of the behavior when some dysfunction socially occurred and when paired with sexual behavior it was often seen as homosexuality. The two were often considered part of the same pathology.

When individuals sought medical intervention to alter their physiology from one sex to the other it was considered an extreme version of this pathology and a specific term represented it, transsexualism.

DSM-3: Transsexualism

The term assumed the previous pathology in most literature but recognized the treatment – to seek or have sex reassignment surgery, the surgical removal of the gonads and modification of the primary genitalia – was an extreme response to distress over one's sex in a limited number of patients. The use of the term has fallen out of favor due to the focus on surgery.

DSM-4: Gender identity disorder

This replaced transsexualism, which definitionally was only a treatment focus. GID focused upon the root cause of distress, an incongruence between how someone perceived themselves and their physiology. This perception was, for most, lifelong beginning in early childhood. At this time, there was a distinction made for those with childhood onset and those that stated it only became an issue after puberty onset.

DSM-5: Gender dysphoria

The symptom became the condition. Dysphoria is distress but the cause became obscured. A fever is an indication something is wrong, but only treating the fever risks leaving the underlying issue ignored and persisting. A diagnosis of gender dysphoria only suggests there is a distress over gender, not the root cause which must be diagnosed separately and confirmed before a treatment plan can be recommended.

Recommendation: Gender Incongruence (as a Distinct Clinical Construct)

Returning to the concept of GID, the patient's distress is focused on their perception that there exists a mismatch between their sexed body and their experienced gender. In the absence of disorders of sex development, the body is medically typical; it is the experienced self–body relationship that is incongruent.

Diagnostic Criteria: Gender Incongruence in Children and Adolescents

Clinical Context

Age at presentation varies with development. Very young children may show stable internal patterns of self-reference before they experience distress. Prepubescent children more often present with social conflict related to incongruence. Pubertal youth may experience increasing psychological distress as bodily development intensifies awareness of mismatch.

Because minors do not self-refer, presentation is mediated by parental awareness, which is shaped by cultural expectations, family norms, and social context. Some children may not articulate incongruence until external interactions highlight it. Others may experience incongruence without distress in supportive environments.

Parental concern alone does not constitute diagnosis.

A. Core Condition

A marked and persistent internal incongruence between the individual's *experienced gender* and their *sexed body/assigned sex*, present for at least six months, as manifested by Criterion A1 and at least one of A2–A5:

A1.
A stable, self-referential perception or conviction that one's sexed body is not congruent with one's experienced gender.

- In children, this may be expressed through consistent self-statements ("I am really a ___," "I am not a ___"), or through a persistent, cross-context identity pattern that is not limited to play, imitation, or situational preference.

A2.
Persistent discomfort with one's primary or anticipated secondary sex characteristics, *or* a preoccupation with their incongruence.

A3.
Persistent desire to prevent, remove, or alter sexed bodily characteristics *because* they are experienced as incongruent.

A4.
Persistent desire for sexed bodily characteristics associated with the experienced gender.

A5.
Persistent internal identification with the experienced gender that is not reducible to role preference, peer affiliation, or expressive style.

B. Exclusion

The presentation is not better explained by:

- Gender nonconformity in interests, roles, or expression
- Distress arising solely from external rejection, gender role pressure, or cultural conflict
- Transient exploration of identity without persistence across time and context
- Body image dissatisfaction unrelated to sexed anatomy
- Psychotic or dissociative states in which incongruence is episodic or state-bound

Expression alone is never sufficient to establish the condition.

Specifiers (Not Required for Diagnosis)

- With clinically significant distress
- With functional impairment
- With body-focused sex-trait incongruence
- Without body-focused sex-trait incongruence
- Prepubertal onset
- Pubertal onset

Conceptual Notes

- *Gender incongruence* is a clinical condition, not an identity and not a disorder.
- Adoption of a "transgender" identity is neither necessary nor sufficient for diagnosis.
- *Gender dysphoria* refers to distress that may arise from incongruence or from external conflict and is treated as a response state, not the defining condition.
- Gender nonconformity is a normal variation and is explicitly excluded.

Diagnostic Criteria: Gender Incongruence in Adults

A. Core Condition

A marked and persistent internal incongruence between the individual's *experienced gender* and their *sexed body/assigned sex*, present for at least six months, as manifested by Criterion A1 and at least one of A2–A5:

A1.
A stable, self-referential perception or conviction that one's sexed body is not congruent with one's experienced gender.

- This is experienced as an internal truth about the self, not merely a preference for roles, aesthetics, or social positioning.

A2.
Persistent discomfort with one's primary or secondary sex characteristics, or a preoccupation with their incongruence.

A3.
Persistent desire to prevent, remove, or alter sexed bodily characteristics *because* they are experienced as incongruent.

A4.
Persistent desire for sexed bodily characteristics associated with the experienced gender.

A5.
Persistent internal identification with the experienced gender that is not reducible to cultural role preference, peer affiliation, sexual orientation, or expressive style.

B. Exclusion

The presentation is not better explained by:

- Gender nonconformity in interests, roles, or expression
- Distress arising solely from social rejection, stigma, or role conflict
- Body image dissatisfaction unrelated to sexed anatomy
- Transient identity exploration
- Psychotic, dissociative, or mood states in which incongruence is episodic or state-dependent
- Trauma-related self-alienation not specifically centered on sexed anatomy

Expression, identity labels, or community affiliation alone are never sufficient to establish the condition.

Specifiers (Not Required for Diagnosis)

- With clinically significant distress
- With functional impairment
- With body-focused sex-trait incongruence
- Without body-focused sex-trait incongruence
- Early developmental onset
- Adolescent-onset
- Adult-onset

Conceptual Notes

- *Gender incongruence* is a clinical condition, not an identity and not a mental disorder. Gender incongruence presupposes a developmental system in which sexed embodiment and internal self-modeling are ordinarily aligned. The construct is intelligible only in a world where sex-differentiated developmental tuning exists and is usually coherent. Incongruence is not the absence of social conformity, but a divergence in this coupling.
- Adoption of a “transgender” or related identity is neither necessary nor sufficient for diagnosis.
- *Gender dysphoria* refers to distress that may arise from incongruence or from external conflict and is treated as a response state, not the defining condition.
- Gender nonconformity is a normal human variation and is explicitly excluded.

Diagnostic Features

Individuals with gender incongruence have a marked difference between their natal sex and how they experience their gender. This discrepancy is the core component of the diagnosis. If there is evidence of distress, dysphoria, it is clinically significant.

Gender incongruence manifests itself differently in different age groups. The following examples may be less prominent in children raised in surroundings with fewer gender stereotypes.

Prepubertal individuals assigned female at birth with gender incongruence express a marked, persistent conviction that they are a boy, express aversion to the idea of being a girl, or assert they will grow up to be a man. They may express a desire to have a penis or claim to have a penis or that they will grow one when older. They may also state that they do not want to develop breasts or menstruate. Occasionally, they refuse to urinate in a sitting position.

Prepubertal individuals assigned male at birth with gender incongruence may express a marked, persistent conviction that they are a girl or assert that they will grow up to be a woman. They may express aversion to the idea of being a boy. They may state that they find their penis or testes disgusting, that they wish them removed, or that they have, or wish to have, a vagina.

There is no *default* behavioral pattern for males and females. Sex-linked differences appear most clearly at the *extremes* of certain dimensions, not in the middle of daily life. What exists instead is a large overlap zone in which most ordinary human behaviors occur, such as:

1. Object- vs person-orientation
2. Physicality of play
3. Hierarchy sensitivity
4. Territoriality
5. Possessiveness / Resource guarding
6. Assertiveness style
7. Protective orientation
8. Emotional expressivity
9. Risk tolerance
10. Conflict resolution style
11. Empathic attunement
12. Spatial vs verbal processing bias
13. Coalition formation
14. Status signaling
15. Caregiving orientation

Behavior alone cannot diagnose incongruence. These traits are *sex-correlated*, not sex-defining. Behavioral nonconformity is not evidence of internal incongruence.

Increasingly, parents are presenting to specialized clinics after their child has already socially transitioned (present as a member of the opposite sex).

As the onset of puberty for assigned female at birth is somewhere between ages 9 and 13, and between 11 and 14 for assigned male at birth, their symptoms may arise in a developmental phase somewhere between childhood and adolescence. As secondary sex characteristics of younger adolescents are not yet fully developed, these individuals may not state dislike of them, but they are markedly distressed by imminent physical changes. In many, but not all, adolescents and adults with gender incongruence, the discrepancy between experienced gender and physical sex characteristics is accompanied by a desire to be rid of primary and/or secondary sex characteristics and a strong desire to acquire the primary and secondary sex characteristics of another gender.

Associated Features

When visible signs of puberty develop, individuals assigned male at birth may shave their facial, body , and leg hair at the first signs of growth. They sometimes bind their genitals to make erections less visible. Individuals assigned female a birth may bind their breasts, walk with a stoop, or use loose sweaters to make breasts less visible. Increasingly, adolescents request, or may obtain without medical prescription and supervision, drugs that suppress production of gonadal steroids (e.g., gonadotropin-releasing hormone [GnRH] agonists) or that block gonadal hormone actions (e.g., spironolactone).

Clinically referred adolescents and adults want hormone treatment and a substantial percentage want surgical alteration of their sex characteristics. Natal females seek to have their breasts removed. Adolescents living in an accepting environment may openly state the desire to be treated as their experienced gender and dress partly or completely as their experienced gender, have a hairstyle typical of their experienced gender, and/or adopt a new first name consistent with their experienced gender.

Older adolescents or adults, when sexually active often do not show or allow partners to touch their sexual organs. Sexual activity is avoided or is constrained by the preference that their genitals not be seen or touched by their partners.

Adolescents and adults with gender incongruence before gender treatment and legal gender change are at increased risk for mental health problems including suicidal ideation, suicide attempts, and suicides and this must be addressed prior to any medical intervention. After gender reassignment, adjustment may vary, and suicide risk and mental health problems may persist depending upon environmental factors.

In prepubertal children, increasing age is associated with more behavioral or emotional problems, often related to growing social nonacceptance of gender-nonconforming behavior. Such distress may occur in children with or without gender incongruence and reflects social conflict rather than the internal condition itself.

Prevalence

There are currently no large-scale population studies that directly measure the prevalence of internal gender incongruence as a distinct clinical construct. Most existing research is based on treatment-seeking samples associated with diagnoses such as gender dysphoria, which do not distinguish underlying causes or mechanisms.

Clinical prevalence estimates derived from surgical or specialty referral populations have historically been low. For example, in some health registry studies, the number of individuals seeking surgery has been estimated at less than approximately 1 in 2,800 (≈0.035%) for individuals assigned male at birth and 1 in 5,200 (≈0.019%) for individuals assigned female at birth. These figures reflect who accessed care during specific time periods, not the true base rate of the underlying condition.

Because many adults with internal gender incongruence or related distress do not seek medical or surgical care — due to personal choice, environmental factors, or lack of access — clinical prevalence rates are likely underestimates of the true frequency of incongruence.

General population surveys in the United States, Europe, and other regions suggest significantly higher proportions of people self-report gender-related experiences, identities, or forms of discordance between assigned sex and self-perception. However, varied methods of assessment, differences in wording, and the inclusion of broad identity labels (e.g., transgender, gender diverse) make direct comparison across studies difficult, and these survey results should not be interpreted as precise estimates of the specific construct of internal gender incongruence.

Development and Course

Because expression of gender incongruence varies with age, there are separate criteria sets for children versus adolescents and adults.

Criteria for children are defined in a more concrete, behavioral manner than those for adolescents and adults. Factors related to distress and impairment also vary with age. Young children are less likely to express extreme and persistent anatomic or social distress. In older children and pre-pubescent adolescents, factors often focus on social coherence and acceptance. For teens, focus is on physiological development.

A very young child may show signs of distress (e.g., intense crying) only when parents tell the child that he or she is “really” not a member of another gender but only “desires” to be or prevent the child from play and playmates of the opposite sex. Distress may not be manifest in social environments supportive of the child’s gender nonconformity and may emerge only if there is parental/social interference with the child’s gender variance. In adolescents and adults, distress may arise from a strong incongruence between experienced gender and birth-assigned sex. lling"Such distress may, however, be mitigated by supportive environments and knowledge that biomedical treatments exist to reduce incongruence."

("Philosophical Puzzles about Transgenderism - The National Catholic ...") Impairment (e.g., school refusal, development of depression, anxiety, peer and behavioral problems, and substance abuse) may occur in association with gender incongruence, particularly in unsupportive environments or when comorbid conditions are present.

Gender dysphoria without a disorder of sex development

For clinic-referred children studied in Canada and the Netherlands, onset of a marked incongruence between the child's physical/natal sex and the child's experienced gender, as reflected in statements and behaviors is usually between ages 2 and 4 years. This corresponds to the development time period in which most children begin expressing gendered behaviors and interests. For some preschool-age children, both marked and persistent gender-atypical behaviors *in conjunction with* expressed self-referential statements of being may be present. In other cases, the incongruence appears later, usually at entry into elementary school. Children may sometimes express discomfort with their sexual anatomy or will state the desire to have a sexual anatomy corresponding to their experienced gender ("anatomic dysphoria"). Expressions of anatomic dysphoria become more common as children with gender incongruence approach and anticipate puberty.

In cases of reported late-onset or pubertal/postpubertal-onset gender incongruence individuals report having had a desire to be of another gender in childhood that was not expressed verbally to others or had gender-nonconforming behavior that did not meet the criteria for gender incongruence in childhood. Parents of individuals with pubertal/postpubertal-onset often report surprise, as they saw no signs of gender incongruence during childhood. These presentations differ developmentally from prepubertal-onset and require careful assessment to identify other conditions that may be mischaracterized as gender incongruence.

Risk and Prognostic Factors

Temperamental. Among individuals with prepubertal-onset gender incongruence, gender-variant behavior may be observed as early as preschool age.

Environmental. Environmental factors have been found to disrupt hormonal development but have not been causally linked to gender incongruence. Evidence of environmental factors may be clinically significant but not diagnostic.

Genetic and physiological. As to endocrine findings in individuals with gender incongruence, no endogenous systemic abnormalities in sex-hormone levels have been found in 46,XY individuals, whereas there appear to be increased androgen levels (in the range fund in hirsute women but far below

normal male levels) in 46,XX individuals. Overall, current evidence is insufficient to label gender incongruence as a form of intersexuality limited to the central nervous system.

In some DSD cohorts characterized by prenatal exposure to elevated androgens, a higher proportion of patient-initiated gender change from female to male has been observed. These associations suggest possible developmental influences on gendered self-perception but do not establish causation or define gender incongruence as a disorder of sex development.

Sex- and Gender-Related Diagnostic Issues

Sex differences in referral rates to specialty clinics reflect patterns of health-care utilization and social context rather than the prevalence or natural history of gender incongruence itself. In children, sex rations of individuals assigned male at birth to individuals assigned female at birth range from 1.25:1 to 4.3:1. Studies show increasing numbers of children and adolescents presenting to specialty clinics, presentation at younger ages, more frequent early social transition, and a shift to a greater number of individuals assigned female at birth in adolescents and young adults than individuals assigned male at birth. In adults, estimates generally suggest more individuals assigned male at birth seeking related care, ratios ranging from 1:1 to 6.1:1 in most studies in the United States and Europe. These figures derive from treatment-seeking populations and are not distinguished by clearly defined cohorts of gender incongruence or by the specific nature of care sought.

Consequently, changes in referral patterns should not be interpreted as changes in the underlying prevalence, developmental course, or sex distribution of gender incongruence. They more plausibly reflect shifts in social awareness, diagnostic practice, and access to services.

Culture-Related Diagnostic Issues

Individuals with gender incongruence have been reported across many countries and cultural contexts around the world. Experiences that resemble gender incongruence have been reported in individuals living in cultural contexts with institutionalized gender categories other than men/boys or women/girls that sanction gender nonconforming development. These include India, Sri Lanka, Myanmar, Oman, Samoa, Thailand, and Indigenous Peoples of North America. It is unclear however, in such cultural contexts, whether the diagnostic criteria for gender incongruence would be met with these individuals.

The prevalence of coexisting mental health problems differs among cultures, these differences may also be related to differences in attitudes toward gender nonconformity in children, adolescents, and adults. However, also in some non-Western cultures, anxiety has been found to be relatively common in individuals with gender incongruence, even in cultures with accepting attitudes toward gender-variant behavior.

Association With Suicidal Thoughts or Behavior

Most research on suicidality in gender-related populations has been conducted in transgender or gender-diverse samples and in clinic-referred individuals diagnosed with gender dysphoria. These studies do not distinguish individuals with narrowly defined gender incongruence from those whose presentations are primarily characterized by gender nonconformity, identity exploration, or socially mediated distress.

Within the present framework, these findings are best understood as reflecting the impact of clinically significant distress, comorbid psychopathology, and adverse social environments, rather than as intrinsic features of gender incongruence itself. Individuals with gender incongruence may experience little or no suicidality in the absence of such factors.

Accordingly, all individuals presenting with gender-related concerns—particularly adolescents and those with depression, anxiety, trauma history, or exposure to victimization—should be routinely assessed for suicidal ideation and self-harm risk and provided with appropriate mental health care. Suicidality should be conceptualized as a marker of distress and comorbidity, not as a defining feature of gender incongruence.

Functional Consequences of Gender Incongruence

Gender nonconformity, which may or may not accompany gender incongruence, can appear in early childhood and may interfere with daily activities in unsupportive environments. In older children, gender-nonconforming behavior may affect peer relationships, contribute to isolation, and lead to distress. Many children experience teasing, harassment, or pressure to conform to sex-typical appearance and behavior, particularly in nonaccepting contexts. These consequences arise from social response to nonconformity rather than from gender incongruence itself.

In adolescents and adults with gender incongruence, functional impairment most often reflects the presence of clinically significant distress, comorbid mental health conditions, or adverse social environments. Relationship difficulties, including sexual relationship problems, may occur, and functioning at school or work may be affected.

Across the lifespan, individuals whose gender-related differences are visible or stigmatized may be exposed to discrimination and victimization, with downstream effects including negative self-concept, depression, suicidality, and other mental disorder co-occurrence, school dropout, and economic marginalization. These outcomes are mediated by social conditions and access to support, not by the internal condition of gender incongruence itself. Structural barriers within health and mental health systems may further impede care.

Differential Diagnosis

Nonconformity to gender roles. Gender incongruence should be distinguished from simple nonconformity to stereotypical gender role behavior by the strong assertion of being or desire to be the sex than the assigned one and by the extent and pervasiveness of that desire/assertion. The diagnosis is

not meant to merely describe nonconformity of stereotypical gender role behavior. Given the increased openness of gender -diverse expression by individuals across the entire range of the transgender spectrum, it is important that the clinical diagnosis be limited to those individuals who meet the specific criteria for gender incongruence; distress and impairment, when present, are clinically significant specifiers.

Transvestic Disorder. Transvestic disorder in DSM-5 is a paraphilic disorder involving sexual arousal from cross-dressing plus distress/impairment; It is not a precursor by default.

Body dysmorphic disorder. An individual with body dysmorphic disorder focuses on the alteration or removal of a specific body part because it is perceived as abnormally formed, not because it represents a repudiated assigned gender. When appearance concerns are better explained by body dysmorphic disorder and are not centered on sexed anatomy as incongruent with experienced gender, the presentation does not meet criteria for gender incongruence.

Autism spectrum disorder. In individuals with autism spectrum disorder, diagnosing gender incongruence can be challenging. It can be difficult to differentiate potential co-occurring gender incongruence from an autistic preoccupation because of the concrete and rigid thinking around gender roles and/or poor understanding of social relationships character of autism spectrum disorder.

Schizophrenia and other psychotic disorders. In schizophrenia, there may be delusions of belonging to some other gender. In the absence of psychotic symptoms, insistence by an individual with gender incongruence that he or she is another gender is not considered a delusion. Schizophrenia (or other psychotic disorders) and gender incongruence may co-occur, but strict criteria and longitudinal study is required. Sexual delusions, which may include beliefs about sex or gender change may occur in up to 20% of individuals with schizophrenia. They can usually be differentiated from gender incongruence by their bizarre content and by waxing and waning with remissions and exacerbations of psychotic episodes.

Other clinical presentations. Some individuals with an emasculinization desire who develop an alternative, nonmale/nonfemale gender identity and some males seek genital surgery for either aesthetic reasons or to remove psychological effects of androgens without changing male identity, do not meet the diagnostic criteria.

Comorbidity

Clinically referred children with gender incongruence show elevated levels of anxiety, disruptive, impulse-control, and depressive disorders.